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HEALTH CARE DEBATE—MY WAY OR THE WRONG WAY

Moderator: NANCY F. NELSON
Panelists: JAN MALCOLM*
J. PATRICK ROONEY†
Recorder: STEVEN N. WANDER

Two nonactuarial "experts" representing opposing health care reform solutions will present their alternative views.

MS. NANCY F. NELSON: I am a principal in the Minneapolis Office of Tillinghast. This presentation will be structured like a debate.

I am pleased to tell you that we have two individuals with us who have extensive credentials in the areas of health care financing and delivery. Both have been very visibly involved with issues of health care reform. The program describes the session as featuring experts with opposing points of view. I believe we have met that criteria.

Our first speaker is Jan Malcolm. Jan is senior vice president of government relations and public programs for Health Partners in Minnesota. Her responsibilities include the development and communication of public policy positions and the management of government programs and contracts. Health Partners is one of Minnesota's largest health maintenance organizations (HMOs) with over 600,000 members. Health Partners was formed through the merger of Group Health and MedCenters HMOs in 1992. Health Partners is rapidly becoming a fully integrated delivery system and merged with Ramsey Hospital of St. Paul in late 1993.

Jan has more than 16 years of experience in the health care industry. She began her career with InterStudy, which is a nationally known health care think tank headed by Dr. Paul Elwood. She has been a vice president of planning and government relations for Partners National Health Plan which was the management company of Med-Centers HMO. Before her current position, she was the vice president of public policy and programs for Group Health, Inc.

Jan has served on the Minnesota Health Care Commission, which is the Minnesota Governor's Commission on Health Plan Regulatory Reform, the Metropolitan Health Planning Board, and the Minnesota Council of HMOs, of which she is currently chair-elect. She is also currently the chair of the Medicare Subcommittee of the Group Health Association of America and has been active in the development of the Group Health Association of America's Physicians on Federal Reform. Group Health Association of America is the major trade association for HMOs in the United States. Jan is a graduate of Dartmouth College.

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*Ms. Malcolm, not a member of the sponsoring organizations, is Senior Vice President, Government Relations and Public Programs of Health Partners in Minneapolis, MN.

†Mr. Rooney, not a member of the sponsoring organizations, is Chairman of the Board of Golden Rule Insurance Company in Indianapolis, IN.

I would also like to introduce our second speaker, J. Patrick Rooney, chair of the board of Golden Rule Insurance Company. Mr. Rooney has been characterized by the business community and national press as an innovative insurance marketer and an advocate of social causes. Mr. Rooney joined Golden Rule after graduating from St. John's University in Minnesota. Golden Rule's home office is in Lawrenceville, Illinois and its executive and marketing offices are located in Indianapolis.

Mr. Rooney was elected to the position of chair and CEO in 1976. Under his direction, Golden Rule embarked on a period of major growth and expansion to become a national firm offering health and life insurance products in 49 states. The company has grown rapidly. In 1981, the company had revenues of $89 million. In 1993 that number exceeded $820 million, with assets exceeding $1 billion. Golden Rule is a leading provider of individual major medical insurance products. Much of the firm's growth stems from the development of its inflation guard product, which is a million dollar major medical product launched in 1981. This product has been a top seller; more than 75,000 independent insurance brokers offer Golden Rule products nationwide.

Mr. Rooney gained national prominence in 1991-92 with his proposals for solving the nation's health care crisis. He proposed medical care savings accounts or medical Individual Retirement Account (IRAs) which would be designed to control medical care spending and provide all Americans with access to affordable health care, based on tax fairness.

His arguments against the current proposals for national health care and mandated health insurance have been highly publicized. He has launched a national campaign to inform the public about medical savings accounts and to encourage tax equity by changing current tax laws.

MS. JAN MALCOLM: I always believe in declaring one's biases right up front. Therefore, let me tell you just a little bit more about Health Partners and about my background. First, I was relieved to see on the program that both Pat and I are nonactuarial experts. I am most certainly not an actuary. I am a philosopher by training and it will probably show. I am at a serious disadvantage if we get too deeply into discussions of numbers.

Nancy's introduction told you a little bit about Health Partners. It is, as she said, sort of a living example of how health care delivery and financing are integrating and changing, at least in the Minneapolis/St. Paul marketplace. I have spent my career either in health policy research and analysis or in various management positions inside group-practice-based HMOs. Therefore, my biases stem from a belief that the organization of care delivery and the incentives that drive the care delivery system matter a great deal.

My biases are further shaped by having grown up in an intensely competitive health care market, and believing that competition, if properly structured, can indeed work in health care.

Nancy asked both Pat and I to respond to some fairly general questions as we lay out our visions of reform. In terms of laying out my goals for reform or my vision of the

right way to do health care reform, I would like to start by talking about the values framework that should underlie the health reform debate.

It may seem like a strange place to start, but I would like to submit to you that there is a lack of concurrence on this piece of the debate. The values underlying health reform may be the problem that prevents health reform from happening. We have not spent much time as a society or in the community of professionals, or in geographical communities, talking about what the values are that underlie the health system.

There are some values that Pat and I probably share. Health care reform needs to be framed in an ethically sound manner. It seems to me that public opinion polls are fairly clear on the question that universal access to care is a generally shared, moral principle in this country. The problem comes when we start to define what universal access to care really means. In any reform proposal, there is a balance between community good and individual good. This is probably the one point where Pat's proposals for medical savings accounts and my proposals, which tend to be more along the lines of the managed competition designs, differ more than anywhere else. How do you balance community versus individual autonomy and good?

A value that I am sure we share is that reform should be economically smart. As a society, we believe that we should spend money on health care. However, we are reaching a consensus point that what we are spending is not producing commensurate returns for our investment.

We should be basing reform on concepts of informed consumer choice. I think consumer choice is one of the biggest red herrings in the health reform debate right now. I think it should be a key driving force in the debate, but in today's world the concept of consumer choice is fiction. What I would like to see us talking about is informed consumer choice—choice in a system where quality is measured and consumers have the ability to make decisions about their health care based on the quality of the provider. Today, choice is a much ballyhooed concept, but informed consumer choice is very rarely discussed.

As a core, reform should have respect for medical professional values. I think we all believe the medical profession has a degree of professional expertise. It has a moral code of its own that we would like to be able to apply to the benefit of not only the individual patient, but of society as a whole. We should not be building reform in such a way that the medical professional values that have served us as a society become countermanded or overridden by bureaucrats, whether they be public sector bureaucrats or private sector bureaucrats.

There is a bit of a subtle distinction, or maybe unclear distinction between goals based on values versus other sorts of goals. Let us move on to some more explicit policy goals that I would like to lay out for reform. The first one moves beyond the notion of universal access to care, to a concept of equitable access to care. I think we all agree that in most communities in our country we already have a form of guaranteed access to care. We are proud of the fact, as a general rule, that our emergency rooms do not turn people away. People tend to get care when they need it.

Is the access that we are offering to our citizens today equitable? Is it just? Is it fair? Is it economically sound? Are we comfortable with the quality and the outcomes we are getting from our current approach to assuring equitable access to care? I submit that the data are fairly compelling that we are failing rather seriously on this score.

In fact, the uninsured are getting a great deal of care. It might be interesting for you to file away the fact that the amount of health care used by the uninsured is about 60% of the amount used by the insured. We are already spending a significant amount of money on care for the uninsured, but we are not getting much for it. After adjusting the data for demographic differences, it shows that, after hospitalization, the uninsured are three times as likely to die of the same illnesses or maladies as the insured are. I think the data are clear—it matters whether people have access to insurance, or just access to care.

Affordability certainly has to be a key policy goal. If we are going to be talking about any form of universal coverage, or a mandate, we must be sure that the mandated burden is an affordable one. Whether the payer is the individual, the employer, or the public sector, affordability is a key goal.

I believe cost control is a longer term question. Our society needs to structure reform so that we have costs in a relatively stable, or ideally, even a declining relationship to economic growth.

Improved quality should be an explicit goal of reform. We should not be satisfied as medical professionals, or as a society, with the range of quality that is out there today. It is true that American health care is of the highest quality in the world, but it is not true that it is uniform. The range of quality performance that is out there is very significant. It ought to be a goal of reform to reduce unacceptable variations in quality to assure uniformly high standards of quality in a continually improving way. I think an explicit goal of reform also should be to focus on the improving health of the population.

I believe it is a scandal that health care has gotten away for as long as it has without having to document the impact of health care on outcomes. The lack of attention to outcomes in the past has really been quite stunning. It should be given thought as we go forward with reform. How are we going to do a better job of assuring that we are measuring the outcomes of care, not only at the individual patient level but also at the societal level? You have all heard the joke, "the operation was a success, but the patient died." Both statements can be true, depending on your perspective.

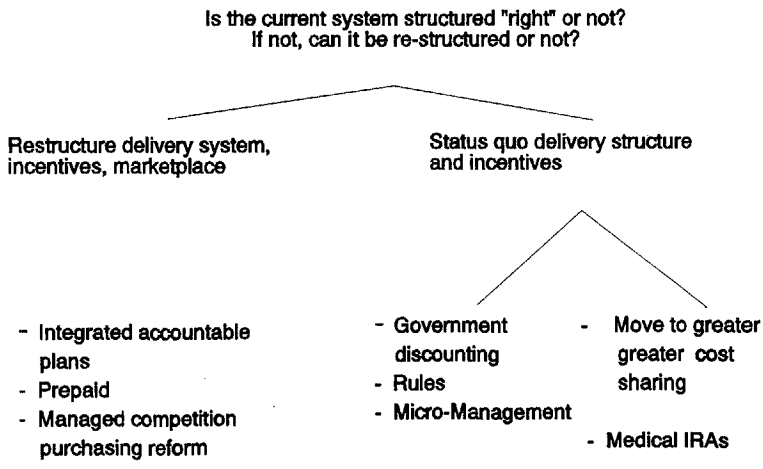
We are very good at inventing new heroic technologies and intervening in ever more dramatic ways, while, at the very same time, infant mortality goes up and general measures of health status go down. It depends on what we are measuring and what we are prioritizing.

The goal of reform is to simultaneously attempt to expand access while trying to control cost and maintain economic competitiveness. If you buy any of my arguments about the fact that our current approach to guaranteeing access to care is not cutting it from an equity or an efficiency perspective, then we have a couple of basic choices if we want to expand access.

Do we think that the current organization of health care services is structured appropriately, or do we think there is something wrong with the way it is structured? If we think there is something wrong with the way it is structured, do we think there is anything we can do about it? I think most of the reform proposals are split along this question. The managed competition proposals say what we should be doing to improve productivity, quality and efficiency in health care is restructuring the delivery system. We also need to change incentives, and create a different kind of marketplace so that competitive forces can ensure the delivery system produces greater value.

The managed competition approach is to accomplish this through changing the way health care services are packaged in an integrated way. (See Chart 1.) This approach changes the financing mechanism from an indemnity, retrospective, fee-for-service type of payment to prepayment. It does all the things included in managed competition purchasing reform, such as aggregating the purchasers and reinstituting individual level choice among multiple competing options. I am assuming for the purpose of this discussion that you are fairly well versed in what the basic premises of managed competition are. I just wanted to visually suggest that the debate really does split along this question of whether we think it is important to restructure the delivery system and incentives or not.

CHART 1
FUNDAMENTAL CHOICES



If we are on the right-hand side of the chart, should we deal with the delivery system and the incentive system as they are structured by trying, through government interventions, to do more with government price setting, government discounting, and rules and regulations about the practice of medicine? Should we try, as I think Mr. Rooney's proposals do, to change the marketplace on the level of the individual

consumer by putting the consumer more in the driver's seat, but remaining within the currently organized delivery system?

As I told you, I definitely have a bias on this score. My bias is that I do not believe we are going to succeed in expanding access, improving quality control and improving cost unless we tackle the structure and incentives of the delivery system itself. Why is that? I believe the current health care environment that we are in is one characterized predominantly by fragmented independent businesses that do not add up to a system from an overall perspective. There are independent competing business units that are operating with interests that conflict in many ways. Each unit is trying to maximize their piece of the health care dollar by maximizing volume and profitability at the subunit level rather than at the overall systems level. We do not have a health care system, we have a patchwork quilt of subsystems.

In this country in our dominant financing system, which is the fee-for-service approach, we have what I consider to be seriously misplaced incentives. Those incentives reward volume, complexity, rework and poor quality, and fragmentation of service delivery. Fee-for-service reimbursement goes further to actually discourage prevention and efficiency. There is no reward for prevention in a fee-for-service reimbursement system. This is a very serious flaw in the main system.

The current system is notable for its lack of measurement of quality and outcomes. When you think about it, not only does that reflect an orientation, or a lack of orientation, to caring about measuring outcomes and quality, it also reflects a structural flaw in the system. How do you measure quality in a nonsystem? Where is the accountability in the fee-for-service nonsystem approach to health care delivery? How are you going to figure out anything at all about outcomes or efficiency when there is no denominator? There is no link between the population and a defined group of providers in a nonsystem; therefore, it is almost impossible to measure quality and outcomes. In the current world, we are, without question, competing, but we are competing over some dubious things, like whether the way we have been competing in the past adds value to consumers, to purchasers, or to society as a whole.

Within the health insurance industry, we have largely been competing over risk avoidance. We make money, no question about it, by attracting a healthier mix of people than the plans we are competing against. That is the way the system has been structured. That is what we are rewarded for and, in fact, required to do in order to succeed in business. At the provider level, we have been rewarded for competing over unproven and/or redundant technology. That is what the patients want and what *Newsweek* is full of every week. That is what the financing system has rewarded, higher reimbursement levels for the newest thing. One of my fears as this whole debate rolls on is that competition has gotten a very bad rap.

People at all levels in the federal government and in state legislatures, have said about the purchaser community, "Well, we have tried competition, but it has not worked." I am not sure that this is a very useful recipe for improving cost, quality and health care if we are competing over those kinds of dynamics.

The question is, can we restructure the market so that we are competing over something else? Nancy asked us to lay out the component parts of what would be

the ideal reform package from our perspectives. I will lay out for you a scenario that looks like some hybrid of the various managed competition proposals that are before Congress right now. This is from the perspective that what we need to do is fundamentally change health care delivery and incentives and the relationship of the population to the care system. I find many attractive features in the managed competition design.

In my ideal reform package, literally everyone would be affected. I think this is a broad community challenge to figure out how we want different performance out of the health care system than what we have so richly rewarded to date. It is going to affect all of us, and we all should be affected. No segment of the health insurance system or the health provider system should be unaffected or unchallenged by reform if reform is to truly deal with the systemic issues that underlie the current problems we have.

In this prescription we would most definitely be able to create systems of care and hold them accountable. We would prepay them, and we would reverse the financial incentives and pay systems of care for the totality of patient care, and pay them for keeping people well, and treating them when they are sick.

Universal coverage, I believe, is a prerequisite to assuring equitable access to care. I do not know that there is much debate about what the data show in terms of the correlation between insurance coverage and access to appropriate levels of care. Timely care with the lowest level of intervention gives better outcomes. I believe universal coverage is a part of what we need to be building. I also believe the only way to achieve universal coverage is by mandate. I do not see how we can achieve universal coverage in a voluntary system; how can we can ever hope to pull in people with low incomes and the lowest cost users in the system. You are in a better position than I am to know how many young immortals there really are out there who are currently outside of the risk pool. How much value and cost stabilizing might they bring into the market if they were, in fact, part of the risk pool?

I do think a mandate is what we need at some point. How would you apply the mandate? Should it be on individuals or employers? I think there might be a different answer if you were talking pure policy, or if you were talking politics. Quite frankly, from our perspective as a provider organization, we do not think we have any particular expertise to lend on where the mandate should be placed. That is a debate better left to economists and people who are considered to be more expert in the labor market than we are. Therefore, we do not really have a position on who should be mandated. Politics would seem to indicate that employers are a more acceptable target for a mandate, or that there be a dual mandate on both employers and individuals.

In this scenario though, I think it is essential, as the managed competition packages are laid out, that the employer and/or publicly financed premium contribution must be limited. We need to create a climate for greater price competition, greater price sensitivity and tax equity. I agree with Pat's concern about the huge inequities of the current tax system in terms of how it treats health insurance. It causes us to talk about a willingness and an ability to limit the employer and public subsidies and tax subsidies going into this system. We will encourage people to pay out-of-pocket for

plans above some formula, based on the low-cost plan or average of low-cost plans in a market area.

The subsidy for the low-income folks who are going to need to be helped in any mandate scenario should either be financed by a progressive tax source or perhaps by a tax on health services. This is what we have done in Minnesota. Some of you may know that we financed our beginning steps to universal coverage with a tax on provider services. It was very unpopular in the provider world. If we go to a system where whatever subsidy pool we are trying to create is funded out of the same general revenue pot that education and roads are funded out of, we can look forward to a repeat of Medicare and Medicaid funding levels. The provider industry ought to think real hard and long about what would be the better financing source for a subsidy pool. Would it make sense to finance subsidies by taxing health services themselves in the context of the universal coverage system? We would actually be taxing the financing flow for health care.

This would let the market decide how far we could go toward fully subsidized universal coverage. The market would have to bear those costs. It would be a different way of approaching the question of whether there has to be limits on the amount of subsidy that we have available and who should set those limits? Should that be done through an overt political budgetary process? This has yielded fairly predictable results in terms of Medicare and Medicaid funding levels. Should we build that into the insurance premium and let the market absorb it and compete on that basis?

I have a couple of final points on the "ideal package." I would like to see passive health alliances meaning that they would not be regulatory agencies, they would not negotiate prices, and they would not select which health plans could be offered. They literally would be market makers by pooling the individual market and the small group market, perhaps up to size 200 in a market. They would be mandatory and exclusive for that market size. For that reason, I think less regulation would actually be required if we had a health alliance type of a structure being the sole market for individual and small-group coverage.

When you think about it, if we are going to have a market inside of pools and outside of pools, or multiple competing pools, we are going to have to create many rules and regulations to make sure that there is not much gaming between those different segments of the market.

However, I would be very concerned if the alliance became the only market. We would like to see it structured so that, whatever the alliance is, it accounts for one-half or less of the total market. It would be important for larger employers operating outside of the alliance structure to also offer multiple choices of plans if part of the goal here, as I think it should be, is to return choice to the individual employee.

I would argue for a fairly comprehensive standard benefit package. The reason is that I think there is a huge difference between trying to figure out how to finance necessary and effective health care and other ways of looking at a more traditional casualty insurance approach. I do not think we are talking about insurance, nor should we be talking about insurance here in quite the same way.

If we are talking about financing necessary, appropriate and effective health services, I am not sure the traditional insurance concept is best. All population subgroups should be included in the reform scenario. We should be dealing with needed wraparound services for certain special-need populations on an as-needed basis, rather than on a categorical-definition basis. It is just not the case that all Medicaid recipients need the same things or that no commercially insured people need the kind of wraparound services that the low-income population typically gets.

Finally, uniform federal rules for all states should be enforced. There is a real danger, as reform unwinds in the waning months of this year, that we will see a deferral back to the states to do their own thing. This would make life miserable for large multi-state employers and health plan companies trying to do business across state lines. It would create the kind of patchwork social policy that we have seen for two decades or more in Medicaid. I am not sure why we would accept this as an adequate response to the problem.

Table 1 is a comparison of my "ideal" proposal with what is out there now, and, as someone said, this is changing so fast that it is a dubious utility anyway. I think I will just kind of skip past this and come back to a discussion of how this approach compares and contrasts with the medical IRA approach after Mr. Rooney has a chance to speak.

TABLE 1
COMPARISON OF IDEAL PROPOSAL

	Clinton	Cooper	Stark
AHPs/"PACTs"	X	X	X
Mandate	X		X
Subsidies	X		Individual
Contribution formulas	X		
Tax Cap		X	
Alliances	Mandatory <5000 Regulatory	Mandatory <1000	States option
Benefits	X	X (NHB)	X (Medicare)
All Populations	No Medicare		Separate
Federal rules	?	?	?

MR. J. PATRICK ROONEY: I would like to say that there is a wonderful article on the back page of *The Wall Street Journal* today [June 15, 1994] by Hillary Stout about health care. It talks about the insurance mechanism; it would be worthwhile for you to read it. If you cannot get it here, ask me afterwards and I will send you a photo-copy.

In the back of the room there is a booklet that tells about medical savings accounts. In this booklet, I want to call your attention to an article by Nat Hentoff. This article appeared on May 14 in *The Washington Post* and we have been trying for three weeks to get permission to give you a copy of it. Nat Hentoff's article, in my

opinion, is the single best piece I have ever read on the Clinton managed care proposal.

It includes information that makes one think Nat was at Jackson Hole. I had a radicalizing event at the Jackson Hole Group in August 1993, and when I read Nat Hentoff's article, I wondered whether he was hiding behind the sofa and heard the same discussion I heard.

I want to tell you I am in possession of a very valuable piece of information. It is a survey that a Democratic member of Congress, who is a member of the House Ways and Means Committee, has just completed of 5,936 registered voters in his Congressional District. These people are obviously very important to him. His first question on the survey is, based on current information, what is your opinion of the Clinton health care plan? They had four choices of opinion. They were: very positive, somewhat positive, somewhat negative, or very negative.

I am told by people that are in this polling business that what really counts is the extremes. The people in the middle could be moved tomorrow with some new piece of information. This poll says that 6.4% of the people are very positive and 54.9% of the people are negative. That is extreme. If you add the people that are somewhat negative, that is another 21.1%, which would bring the negatives over 75%. This to me is an extraordinarily important piece of information. It was not given by some political work group, but by the voters in this Congressperson's own district.

I want to give you a couple of other pieces of information from the survey. Would you be willing to pay more taxes to help cover those currently without health insurance? One out of five people, 19.7%, said yes, they would be willing to pay more taxes. However, 76.1% of the people said no, they would not be willing to pay more taxes to take care of the people that did not have health benefits.

Another very important response in this survey is 88% of the people said they have health insurance provided either through their employer or bought on their own. Should the government mandate that all employers provide health insurance to their employees? Now you know from the standpoint of the individual that is a cheap out. This is not a difficult thing to say yes to because it is not coming out of my pocket. However, 67.1% of the respondents of the 5,900 voters in that district said, no, the government should not have an employer mandate.

You may have seen in the paper that Senator Daniel P. Moynihan (D-NY) and Senator Bob Packwood (R-OR) had a meeting on June 14. I saw Senator Packwood last night in Washington at a Republican fund-raising dinner. He told me personally about the meeting that took place yesterday [June 14, 1994] with the president. In a nutshell, the senior member of the Senate Finance Committee, Senator Moynihan, and ranking republican in the Senate Finance Committee, Senator Packwood, told the President they did not have the votes in the Senate Finance Committee for his plan. The President told them, in that case, do not vote on it because he cannot afford to have it go down.

Senator Packwood went on to explain that it is not merely that there are not votes for President Clinton's plan at the present time, there are not enough votes for any

plan, including the Cooper/Breaux or the Chaffee Plan. None of those plans has enough support in the Senate Finance Committee to get out.

What is at stake in the Clinton health care plan and the Cooper/Breaux health care plan? The Cooper/Breaux health care plan is the brain child of the Jackson Hole Group. Jackson Hole's idea is managed competition, and there are two essential ingredients.

The first is that the health care will be provided not merely by an insurance plan, but by a plan where the insurance program, the hospital and the doctor are financially at risk together. Dr. Elwood has just published a criticism of the Chaffee Plan. He says the first point is that the health care plan must both finance the plan and provide for the care. Today they are calling them accountable health care plans.

The original term was accountable health care partnership, and that is significant because it means the doctor would be financially at stake in connection with the patient's care. I am talking about your care, my care, and the care of our children. Let me quote to you, if I can, an article that appeared in *The New Republic* that refers to the Clinton health care plan. It says "cutting or delaying payments to doctors, other health care workers, and hospitals, to stay in budget is an integral mechanism in the administration's bill." Here is a quote from the bill describing prospective budgeting, "The plan shall reduce the amount of payment otherwise made to providers through a withhold or delay in payment or adjustments, in such manner and by such amount as necessary to assure that expenditures will not exceed budget."

The word on this is gradually getting out to the public. There are some people that understand that the Clinton health care plan and the Cooper/Breaux health care plan will impose financial constraints on the top and that there will be control on the doctor. The doctor will be called a primary care gatekeeper/physician. There will be financial incentives, or there will be financial punishments if the doctor provides too much care.

Recently there was a meeting in Washington, D.C. of pollsters on the subject of health care. The pollsters reported that the public is very uncomfortable with the idea that the government could limit the amount of health care that could be provided. The pollsters reported two different opinions.

They said that the public is not that adverse to price controls because they think the price controls might benefit them. The public is, however, very adverse to financial restrictions that would have the effect of limiting the amount of health care that could be provided.

I said there are two essential features of managed competition. One is that the medical care would be paid for per member, per month and that there would be an accountable health plan or accountable health partnership where the doctor is financially at risk if too much care is provided.

The second important ingredient is that you will all end up going to a primary care physician. For example, my wife fell on the ice and hit her knee, and it hurt enough so that she went directly to an orthopedist. If you are in this kind of plan, you are

not going to be able to go to an orthopedist. If you have a chest pain, you are not going to be able to go to a cardiologist. You are going to have to go to your primary care gatekeeper/physician.

Is that what you want? I happen to know of a case in which a woman who was diabetic was taking insulin shots in her arm three times a day. She went to her primary care gatekeeper/physician and said to him, "I do not feel well. I want to go to a diabetes specialist." He would not let her, because, after all, he was responsible for keeping the cost of the plan down. Is that what you want for yourselves?

The Nat Hentoff article says the key element of the Clinton health plan is less health care ahead. If government controlled health reforms are based on managing cost rather than managing care, every medical decision will be determined by how much the care costs.

As I reported to you, these pollsters said that the American people did not like the idea that the federal government could control the amount of health care that would be available to you and to your family.

I had a profound experience at the Jackson Hole Group last August. There was a discussion about whether a person would be allowed to go outside of their managed care network. This network was going to be established under the Clinton Bill or the Cooper Bill. Would the individual be able to go outside of the network and simply pay the incremental difference in cost? I was amazed that I was the only insurance person in that room that thought the people should be able to go outside of the managed care network. By the way, we are in the managed care business as well. There were three physicians there that were advocating that the patient be able to go outside of the network and pay only the incremental difference in cost. In other words, the insurance plan would go with them. It would pay the same benefits if they went inside of the network, but, if it cost more to go to a specialist of their own choice, they would have to pay the difference in cost.

What was amazing to me is the reaction of the insurance community. The insurance community that was represented said absolutely no. If you go outside of the network, the doctors outside of the network will charge more because the patient is going to pay the difference in charges. The nonnetwork doctors are also going to do more and our insurance plan is going to have to pay for it. The insurance executives were all opposed to letting the people go outside of the network. Now, since that time, there have been political concessions in the legislation such that Dr. Elwood is now in favor of letting the people go outside of the network and pay the difference in cost.

Where do we go from here in terms of my view? First of all, as far as health care plans, I think we should not mess with the system we have. We already have managed care plans and we have insurance plans. The people have choices and they can go into a managed care plan or they can go into an insurance plan. The insurance plan pays for the doctor or hospital you go to. If you are in a managed care plan, and you are not getting enough coverage, you can change plans and go back into a conventional insurance plan.

If all the plans are the same, my expression for it is "HMOs über alles." If you know German, that means health maintenance organizations over all. If we were all in HMOs, the only sensible way to compete would be on price.

By popular opinion, what we have today is working because you have a voice in the matter. If you do not like it, you can go from managed care to conventional insurance. If you find the conventional insurance too expensive, and you think the managed care plan is better, or better for you, you can change.

However, the empirical evidence is that for employers with 500 employees or less, 84% pay more for managed care than for conventional insurance.

With that, I am a major advocate of medical savings accounts. Let me tell you basically how medical savings accounts work. Most employers spend a stack of money on health insurance and the employees usually pay part of it. At our company, the employees are paying 25% of the cost of that stack of money.

The employer would take off one-third of the money that is presently being spent and buy a catastrophic insurance program. The catastrophic insurance plan would pay everything beyond $2,000, for example. The United Mine Workers have catastrophic insurance that pays everything above $1,000.

The employer would put the savings into an account for you and you would pay the small medical bills yourself. If you did not spend all the money, you could keep the remaining portion. Last spring, our employees asked, "Why don't we do it here?" Our response to the employees was that the money that would go into the medical savings account would have to be taxable income to them. The employees said that maybe some of them would like that, so we gave the employees a choice. You could continue the traditional insurance that we have had until now or we will buy a catastrophic plan for you. I am going to use family coverage as an example because it varies from single coverage.

For a family, a husband and wife, or wife and husband and/or children, our catastrophic insurance plan pays everything beyond $3,000. We put the savings into a medical savings account for the employees.

It has been a fabulous success. Who has it been most successful with? It has been the most successful with our lower-income employees like single mothers who are raising two or three children. She has this money in the medical savings account so that she has first-dollar coverage. If she has a child crying with an ear infection, she can take that child to the doctor and she is reimbursed in full. She has no out-of-pocket cost at all until after she has exhausted her medical savings account.

Ninety-three percent of the employees did not use all the money in their medical savings account. We paid an outside firm to do a major telephone survey of our employees. It turns out that people that exhausted the fund liked it just as well as the people that spent less than the amount of the fund, apparently because they figured they would spend less next year.

Our employees have a cash fund that they can spend on medical care. They have an out-of-pocket payment and then the catastrophic insurance takes over. Once they reach the attachment point of the catastrophic insurance, it pays 100%. The result of this is fabulous, because what happens is the propensity to consume medical care changes when a person is spending their own money.

Our combined costs for our traditional insurance, the claim benefits paid by the company on the benefit plan, and the amount that we paid out under the catastrophic insurance was only 52% of premium. Our employees took home $468,000 that they had saved out of their medical savings account at the end of the year.

One woman came up to me recently and said, "See the caps on my teeth. You paid for those." Our insurance did not provide dental coverage, but when she had the money in the medical savings account, and had not spent it all, she could pay for the caps on her teeth. She is happy and I am happy and yet, she is in control. She can go to any doctor she wants to.

One of the things that I am going to wrap up with is that it stops abuse. As an insurance company, we see a great deal of abuse with chiropractic visits. Patients go to the chiropractor, and the chiropractor may have them come back again and again. When the people are spending their own money, they go back only as long as it improves their situation. They agree to pay for another X-ray only as long as they see it to be beneficial. The minute it stops benefiting the people, they quit spending their money. Most chiropractic bills are small. They are under $3,000. We are not telling our employees to go to the chiropractor or not to go. They have the cash in the fund and they make the decision whether to go to the chiropractor. I have been to a chiropractor on a number of occasions, but I do not keep going back again and again.

Patients can decide what is good for themselves. The medical savings plan has put the people in control. There has been new legislation just introduced. It is called the Bipartisan Health Security Reform Package. It includes tax fairness and portability. It guarantees people that, if they have insurance now, they can leave their job and keep their insurance until they get a new job. They would then be guaranteed that they could get on the group insurance plan at their new job. If people are in the system, they would be guaranteed that they could stay in the system. If people drop out of the system, and stay out until they get sick, they will be able to get back in through state risk pools. That legislation includes medical savings accounts. It is HR4410, introduced by Democrat Representative Andrew J. Jacobs (D-IN), and Republican Representative James M. Inhofe (R-OK). It is very likely that this piece of legislation may join with Representative J. Roy Rowland's (D-GA) and Representative Michael Bilirakis' (R-FL), and they may work together. Neither of these plans include a government purchasing organization, nor do they mandate that the health plan has to be both a financing mechanism and a provider of care.

MS. NELSON: Right now I will have two short chances for responses and then we will turn to questions.

MS. MALCOLM: I will try to keep this brief. First of all, I am not surprised by the public polling results. I think that really illustrates the lack of understanding or

concurrence on the part of the public about what is wrong with the current system as it is structured.

We all probably have good stories and bad stories to tell about what has happened to us personally or somebody that we know. In terms of systematic understanding of how the current health care system is structured, and what some of the results of it are, we are blissfully ignorant. As a public we tend to be ignorant about the truth of quality performance and the variability in outcomes and quality across the system.

I do not think the public has the first clue about the issues of equity in access, financing, outcomes, cost shifting or the complex relationships between various financing sources. I do not think the public has a clue how little we know about the outcomes of medical care or how little we can really quantify the health improvement value of the resources being spent.

We all think we have great quality at the individual level. Nobody is too terribly aware of how little we measure that. I do not think there is very much discussion or awareness of the question of incentives and how that shapes provider behavior on either side. I would certainly agree that one has to attend to the provider incentives created in a capitated environment. It is certainly possible to do capitation badly as well as to do capitation well in terms of the validity of the numbers and the appropriateness of the balance of the incentives. I certainly share Mr. Rooney's concern that capitation is a recipe for lack of service and poor quality.

I have seen, however, many examples where capitated financing produces more care and more measurable quality than a fee-for-service system. From the provider's perspective, it is not at all impossible to be paid more under a capitated system. This is true especially when one adds to the formula reimbursement tied to patient satisfaction, quality measures and the impact to population health measures. You pay the providers more for reducing rates of premature birth. You pay the providers more for increasing cancer detection at early stages of disease. Not only is the survivability greater, but the total cost of care is less. Providers should be rewarded, financially rewarded, for improving health status and preventing as well as treating. As I mentioned, that is just sort of a different paradigm in terms of how badly broken you think the current financial incentive structure and care delivery structure is or is not.

On the question of should there only be HMOs and should patients be locked into HMOs, I certainly do not think so. I do not think that is what the managed competition designs have in mind. There is nothing that I know of that requires that all plans be of the type that Mr. Rooney described, in terms of having to put the providers at risk.

I think the issue is structuring the market in a way such that consumers have an ability to choose among multiple types of plans. That is not happening so much in the marketplace as it is structured today. One of the big trends of recent years is that more and more employers have restricted choices to their employees and now frequently offer only one plan. That may be fine or it may not be fine, depending upon whether that is the plan the employees would have chosen had they had a multiple choice of offerings.

I am not sure that we can meet Mr. Rooney's goal of allowing people to have choices between meaningful alternatives, unless we do a fairly systematic reform, given the way the market has trended in recent years.

My questions or my concerns about the medical savings account approach really have to do with where the leverage is to change provider behavior? Is it realistic and reasonable to assume that the leverage can be at the individual patient level to change the provider structure or provider incentives? Are individuals in the best position to shop for price or quality on an incident-by-incident basis? I have some real concerns about whether consumers are ever in an ideal position to have the information they need to negotiate price with providers.

Mr. Rooney has an interesting point about the chiropractic example and the fact that patients, if they have a direct financial incentive, have clearer incentive to care about the units of service. I think you can achieve that by having copayments be part of whatever plan you build as well and by having patients involved in some piece of the cost for each service. I believe it is a rather radical approach to say to the patient you are totally on your own to shop for coverage. We hope you pick a good quality provider and one whose costs are reasonable so that you do not spend down your medical savings account too quickly.

I also think incidence of care is the wrong unit of analysis. The wrong way to judge quality and cost effectiveness is on a one-at-a-time basis. I am not sure where the cost savings potential of medical savings accounts are from an actuarial perspective.

It seems to be the case that the majority of dollars are spent by a vast minority of the population. The people who are generating the cost are those who go over the top of that catastrophic threshold. That is where the dollars are. I think there is room for the medical savings account concept within a more sweeping market reform design. Absent that, I do not see that the medical savings account in and of itself does anything to change cost or utilization behavior where all the bucks are at the high end, over the top of the threshold.

I am not sure there are, in fact, that many administrative savings in the plan, which is one of its apparent attractions and virtues. Somebody has to keep track of the claims to figure out when you have reached your deductible so the catastrophic policy applies. You have to be in a position to adjudicate whether a withdrawal from the medical savings account is for a good or a bad reason. I really worry if the medical savings account money does not have to be used for health care services—especially for the low-income population that Mr. Rooney mentioned. I would worry about there being too much of a financial incentive to take that money as pay and spend it on food or rent, rather than spending it on primary or preventive care that, ironically, may have helped to prevent ongoing larger cost problems down the road.

MR. ROONEY: The information we have is from our employees. I was with a couple of employees that are single mothers and we had a seminar about the subject. They said they were able to get care for their children in a financially easier fashion than before. We would like to have the American people happy and medical savings accounts will make them happy.

There is a financial incentive to shop around. I gave you a copy of a letter from one of our employees. In the letter, dated June 1, she tells me how she shopped around for some tests and ended up saving $671. Incredibly, she was able to do this with a more prestigious group than her original choice.

All I can tell you is that it works. Why should we deprive the American people of the ability to make decisions for themselves?

MS. NELSON: Hopefully we will have some audience questions. First, I would like to get your reaction to a question that has come to mind as we talked. We have talked about having a medical savings account or having a prepaid plan. My question is, are there any services that we should make sure are 100% available to the population? In particular, I am thinking about services related to prenatal care or immunization of young children; these are preventive services and the people who are benefiting, like children, are not in a position to make a buying decision for themselves. Maybe we could start questions with that.

MR. ROONEY: We know that there is considerable information available in connection with the low-income population. We do not exactly know why women with low incomes do not go to the doctor when they get pregnant. Maybe they do not know where to go. Maybe they have other things on their mind. In Indianapolis, there are several services available to low-income mothers. The problem is not that they cannot go, rather they do not go. How do you motivate them to go?

MS. MALCOLM: I would agree that coverage of services does not equate necessarily to getting the services. There are issues beyond financial barriers to care that we have to attend to in order to feel like we have an economic payoff, a quality payoff and a community public health payoff. I certainly would put the kinds of examples that Nancy mentioned in that category. We would be hard pressed to find enough ways of encouraging good prenatal care. There is more that could be done than we have the ability to do as care systems, even when money is not the limiting factor. It certainly is something that we should make sure is a part of whatever package people have. Again, I worry if we are dealing with catastrophic types of policies. People will perceive that they are spending their own money. It may be a disincentive to spend that money on primary and preventive care when pressed with the very real-life trade-offs that, luckily and probably not many of us have to make. A large part of the population does have to decide if an immunization is really that important. Or, for example, is my pap smear or my screening test for X, Y or Z really that important? That is part of why I worry, and think that we should not be thinking about health care financing in just traditional insurance terms. We are trying to finance services at least as much as we are trying to spread the risk in an insurance way.

MR. JOHN A. MAURER: My comment is for Jan, and do not worry, this is a philosophical point. If you are trying to design the best approach or the perfect world, is it not best to get people there in a voluntary manner rather than coercing them to get there? What if reforms along the lines of tax equity and medical savings accounts might induce these young healthy folks that are now staying out of the system into the system? Would you be satisfied with full coverage in a voluntary sense? I am talking in the same way that the government uses the term full employment. Let us say through voluntary reforms and incentives we could reach 95-96% of the

population. Would you still insist that mandates are necessary to bring in the other 4% or 5%?

MS. MALCOLM: I think it is a reasonable question. When do you reach the point of diminishing returns when it is going to cost you more to try to get that last few recalcitrant percentage than it may be worth in terms of the benefits to the risk pool by pulling them in. I think that is a fair point. However, what I wonder about is the incentives we are building into the system. We need to say, as a public policy matter, that everybody needs to participate in the financing of health care the way we say everybody needs to participate in the financing of education and some other things. We have set up a system in which we are inviting people to do the economically rational thing, and playing the game of waiting to see how long we can stay out of the health system before it becomes of economic value to us to get in, either under a medical savings account or something else. I worry that in a voluntary market we would have to perpetuate layers upon layers of rules and regulations. There is not much further we can or should go on insurance reform in terms of rating compression or limitations of preexisting conditions and all the rest of that stuff in a voluntary market.

We may have problems if we leave people the ability to stay out of the market and come in at a later point in time at the same premium rate that they would have had if they had been in the system all along. In the worst case scenario, someone could come into the system with a known health condition and be able to get right at coverage because the insurance laws have changed to the point where we are no longer doing any sort of medical underwriting. I think we are just creating a crazy set of incentives. I am still, perhaps simplistically, very focused on the question, what are the incentives for the public to be insured or not insured? Or to be insured at what level? What level of preventive and primary care should be provided? We worry about financing high-tech, heroic, expensive technology without paying much attention to whether it even works, or without figuring out how we can best finance primary and preventive care. What I expect will come out of this whole reform debate is some sort of a phase in, and an approach that says, if we do not get to 98% coverage by the year X, then maybe we need to visit the question of mandates.

I do not think there is, as Mr. Rooney was saying, the political will to do mandates at this stage of the game. I think we will probably try the voluntary approach. It is important to keep the trigger out there and to start having some better public debate about the impact on the community of some people staying out of the financing system. It is not as though they do not get care from the system. It is not as though we do not all help pay for that in some way.

MS. ELIZABETH C. TOWELL: My question is to Ms. Malcolm. I belong to an HMO and I found that it takes many defensive measures that probably really do not benefit me. I did not really get a choice to say, no I do not want this measure. Do you have any ideas how you could squeeze that waste out of the system?

MS. MALCOLM: I do not think that just because it is an HMO or just because the providers are prepaid it means that they are not subject to concerns about defensive medicine and public expectations. It is true that I have sat with our medical director

on numerous occasions when he has found himself approving some rather extraordinary care.

The reason he is doing it is not necessarily because he thinks the care is of proven benefit to the patient or that perhaps there are not more cost-effective ways to proceed. It is the business about the court of public opinion and getting tried on the ten o'clock news or in the newspaper for not living up to whatever the community's standard of care is. I think HMOs or other providers can operate impervious to what those consumer expectations are.

I think part of squeezing out the waste of defensive medicine has everything to do with changing the malpractice rules and changing the public expectation for how we are spending health care dollars. I am hopeful that out of all this debate about health care reform the worst thing that could happen is that it falls off, the public decides it is too complicated and they do not want us to mess around with it. We will stop talking about it and then we will continue to moan and groan about why costs are going up at double digit rates. That is because we never will engage that public conversation in what we are spending the dollars on. What are we or are we not getting at the community level for it.

MR. ROONEY: There is an additional fact that I would like to mention. I talked about the success of the medical savings plan, but I do not think I said specifically how many employees we have in it.

When it was first started, 80% of our employees chose to participate and, because of the success, 89% of our employees are now in the medical savings account plan. The other 11% are entitled to stay in the traditional insurance. You need to understand that it is not compulsory.