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Session 108IF
The Changing Roles of Federal and State Governments in Regulating Health Care

Track: Health

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Recorder: BURTON D. JAY

Summary: In recent years health care regulation has expanded, particularly at the federal level with the Health Insurance Portability and Accountability Act of 1996, benefits mandates, financial requirements, and patient protection. Panelists discuss:

- *The roles of the federal and state governments in regulating health care insurance*
- *The potential overlaps of these jurisdictions*
- *How are the various players (insurance companies and health plans, providers, state regulators, and so on) being affected?*

Session attendees have the opportunity to share their experiences and express their concerns with dealing with federal and state regulations.

Mr. Burton D. Jay: I'm from Mutual of Omaha. Our speaker is Tom Leibowitz. Tom is an FSA with nine years of health care actuarial experience. After completing graduate school at the University of Connecticut, he worked at Blue Cross and Blue Shield of Massachusetts. From there, he went to Private Health Care Systems, a national managed care company. He now works at Actuarial Management Corporation, an actuarial consulting firm in Northern California. I'll turn it over to Tom.

Mr. Thomas Leibowitz: This session is supposed to be an interactive forum. I'm going to be fairly brief. In doing the session, I realized that it's really tough to look at the changing roles of state and federal government and health care without showing the correlation between that and the changing roles of the state and federal Government in general. Everything I say is my opinion.

Let's discuss the changing roles of federal and state governments and health care. There are a lot of things that really shape the modern health care system that have to do with the federal government and the state government, such as all the regulations we've learned about, while taking exams, and wage and price controls during World War II. Tax laws and tax-advantaged benefits, have really done a lot to get us where we are in terms of modern health care. Things like those did shape

where we are today, but they weren't really something that was intentionally done by legislatures. It was just something that happened more as a result of circumstance, as a result of court cases, and as a result of interpretations. It wasn't so much that anyone intentionally set policy.

I've split this presentation up into three different sections, and these sections are going to overlap to some extent. It's really almost impossible to keep them completely separate. One is the role of state governments and state insurance departments. Another is the increasing role of the federal government. The third is the changing (especially recently) perspective that the government has towards HMOs.

Something that you should get out of this presentation is an understanding of the traditional roles and where the foundation for everything came from.

What are the motivations behind the Department of Insurance? What does it do, and why does it do things? I'll discuss why insurance companies have done what they've done over the past several years. Finally, we will recognize a lot of these changes not just as changes in the relationship of the government to health care, but also as changes in the government in general, and how the government acts and behaves and what its attitudes are.

Traditionally, the primary role of the state insurance department has been one of protecting the interests of the citizens of the state. The big key, of course, is how it does that. And how it does that has changed significantly. The historical method of the department of insurance for ensuring that it is protecting its constituency has been to make sure that the insurance companies that it works with are financially sound. This doesn't apply to health only. The insurance departments have minimum capital and surplus requirements, and they want to make sure the pricing levels are adequate. You probably don't find insurance departments saying that your rates are too low very often. They make sure that your reserves are sufficient. The basic idea is that if a company is fiscally strong, it's going to be able to meet its obligations. The most important role of an insurance company is to pay claims when they come along. The more financially sound the company is, the greater its ability to do that.

But the role has recently shifted in terms of state insurance departments and how they're viewing health care. The role of the state government has increased significantly in terms of the level of intervention. There has been a change in the mindset in terms of the laws that have been passed. There is significantly less focus on insurer strength, and more focus on protecting the insureds. The way that has been done, for the most part, is by restricting insurance companies. There has been sort of a shifting mindset towards insurers not working together with insureds, but insurers working against insureds. There has been this competition or animosity-based relationship. So there has been this move away from insurer solvency, toward patient advocacy. It doesn't always end up being in the patient's or the member's best interest.

What sort of changes have we seen in terms of state legislation and health care? We've seen all sorts of mandated benefits. We're seeing more and more of them all the time as legislatures are seeing that somebody has a need somewhere and it seems easy enough to just code it into the law rather than just hope that insurers will be nice and offer the benefits.

State governments are also imposing rating restrictions. Some states require unisex rating. Others have maximums in terms of how high you can rate your youngest people versus your oldest people. There is small group reform legislation, which includes restrictions on underwriting exclusions for preexisting conditions, commission structures, and minimum group sizes. Small group reform started the whole notion that you have to offer insurance to groups of two to fifty people. It is one to fifty people in some states. There are any-willing-provider laws. Under these laws, if you have a network, you have to allow any doctor who meets your criteria to join, whether or not it's going to actually help you in your network development. There are also restrictions in terms of certain states dictating what sort of entities can and can't have primary care physicians and require referrals.

The intentions are very good and noble. The intentions are to make health insurance more affordable and comprehensive and to increase accessibility to care. There are some poor people and some who are not poor financially, but are helpless people out on their own. The state is making it easier for them to get the coverage they need. In reality, however, what tends to happen is costs go up. As more services are required paying for those services will result in an increase in cost. It can also result in something that was definitely not the intention of any legislature who's thinking, "We should have, for example, mental health parity." They are not thinking that if there is a fixed amount of money, that's going towards paying for health care benefits; when there are mandated benefits, then there will be a shift. For example, if you have mental health parity, you might get double the mental health benefit that you had before, but you'll probably have a higher office co-payment and a higher deductible. It's not actually giving people more benefits; it's a matter of restructuring the benefits that are provided.

Then we have the National Association of Insurance Commissioners (NAIC). The states are the ones that regulate insurance, for the most part. It makes sense to have consistency among the different states. It makes life much easier for all of us, at least those of us who work in multiple states. The NAIC drafts legislation and makes recommendations, then the states review their recommendations and often follow what's called NAIC model legislation. The NAIC has been given the task of determining which insurance topics should be regulated by state governments, and how these laws should be written. The states often follow the NAIC's lead, and enact this NAIC legislation. It really has the potential for positive impact. My view of how the NAIC should work, and I don't know if it's the NAIC's view or not, is that if you have a whole bunch of states that try a whole bunch of different laws on the same topic, and address things in a whole bunch of different ways, then you have the opportunity to see what works and what doesn't. You can pick out the best pieces and create what I would think of as optimum legislation. In reality, however, I believe that there's often a big push to get legislation through. As a

result, you often see regulations passed by 18 or 20 states that have the same language that is less than optimal. Let's couch it that way.

The federal government has traditionally had a very high-level role in health care. So when it has been involved, the impact has really been huge. What it has traditionally done is worked towards getting everybody coverage, which expands the scope of who has access to care. Medicare and Medicaid are examples of such federal programs. More recently, in the 1980s, the federal government enacted the Consolidated Omnibus Reconciliation Act of 1986 (COBRA). For the first time, the government was actually getting involved in group insurance. The idea was still the same. COBRA requires employers to offer continuation of coverage to employees whether they quit or they're fired. So COBRA makes sure that people have accessibility to coverage.

The federal government has recently become more active. It is starting to mandate some benefits. The Clinton Plan, in 1993, incorporated the potential for some sort of nationally based health care system. Of course, as we all know, it was unsuccessful, and it was met with a big backlash, but this backlash was very temporary. Over the past few years, we've seen the passage of the Health Insurance Portability and Accessibility Act (HIPAA), as well as the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act, and the Women's Health and Cancer Rights Act. These were all passed within the last three years. There's no reason to assume that it's not going to continue.

HIPPA is, in some ways, consistent with traditional federal legislation in that it makes insurance available to people by making insurance coverage portable for people who move from one employer to another. It also mandates the offering of coverage. How's it really different? How's it a big break from traditional health federal involvement? It forces carriers to take uninsurable risks. If somebody's sick, terribly ill, and working at one employer and switch to another employer, then insurers are required to give them coverage. Not only must you offer them coverage, but you can't rate them up or have pre-existing conditions or that sort of thing. It's really forcing a subsidization. It's more or less like rent control in which the burden of the expense is shifted to a specific entity, (from an insured to an insurer, or from a tenant to a landlord) rather than having some sort of government subsidization.

HMOs and the federal government. The interaction between the federal government, or the relationship, has changed significantly over time. Up until the mid-1990s, HMOs and the federal governments had a very amenable relationship. There were things like the federally qualified HMO designation, and HMO mandate legislation. This legislation provided that if an employer offers multiple choice, it has to offer an HMO. Medicare risk programs were designed so the federal government worked directly with HMOs to offer Medicare-sponsored health care coverage to senior citizens through the HMO. Managed care was the central focus of the Clinton Plan. It was going to control costs through managed care. Of course, over the last few years, the relationship has changed significantly. The reimbursement for Medicare Risk Programs has gone down to the point where lots of HMOs have flooded out of markets, which has left hundreds of thousands of

elderly people without insurance. Patients can now sue HMOs if doctors deny them care. Now we're looking at the potential for some sort of "Patient's Bill of Rights."

But this change in government perspective is really not completely exclusive to health care coverage. It's not just that we had this happy marriage with HMOs, but now the federal government thinks HMOs are bad. The relationship between the governments and insurers hasn't been the only thing deteriorating. The change has occurred in the government perspective in general. This is, of course, just my opinion, but I believe that the government is starting to look at things from a much more emotional, rather than a practical or pragmatic perspective. It is not thinking so much in terms of what's going to be the best in the long run, or what's going to be the best on a global basis. It is thinking about individuals getting hurt. It is thinking about protecting specific people.

There's also a different mindset. Americans love health insurance, as we found out in 1993, but they hate health insurance companies. They hate the health insurance industry. The industry is an easy target and health insurers are thought of as greedy and uncaring. In 1993, Hillary Clinton stood there and talked about how insurance companies just take people's money and make enormous profits. That sentiment still exists today, regardless of what the actual profit margins are for insurance companies. I know the ones we work with aren't making a fortune. The big thing is politicians recognize that it's easy to think of insurance companies as targets. People think of us as a target. There's no real backlash against anti-insurance company legislation. So politicians are more than happy to do things to "protect their constituency." They don't want to be perceived as taking away benefits." They want to be thought of as giving people the opportunity for more benefits and fighting against big insurance companies.

The question is, what's happening as a result of all these changes in legislation and the changes in attitudes? Lots of health insurance companies have left the market either in certain markets or altogether. Others have actually gone out of business. Others, however, have learned to survive by taking advantage of the laws to the fullest extent possible. We get all of these completely unintentional byproducts of all of this legislation. We get these artificial mechanisms, such as what are called air breather associations. You can buy insurance through an association as an individual through some sort of a group mechanism. They're often called air-breather associations because anybody can join, even though the idea behind the association is supposed to be that it's created for something other than the purpose of buying insurance. There are also multiple-employer trusts, where small groups get together and buy large group insurance to avoid the mandated benefits that were supposed to be there to protect them in the first place.

The Employee Retirement Income Security Act (ERISA) says that self-funded plans aren't subject to state-mandated benefits. So what tends to happen is, even small employers will self-insure in order to avoid having to pay for these benefits. What's tending to happen is, as regulations and state mandates become stronger and stronger and more and more restrictive, self-funding has gone down to a smaller and smaller group size, as has the coverage level. You're getting what many people would say isn't really stop-loss coverage; we see attachment points of

$5,000 and $10,000, which really could be thought of as high-deductible plans with some sort of a basic plan underneath. The reason that employers are doing this is because they can't afford to offer care otherwise. It ends up being kind of a spiral going back and forth.

Much animosity begins to be generated as regulations are put into effect and regulations don't have any impact. As regulations become more stringent, employers work harder to get around them. Many of these laws haven't accomplished their objectives. For example, we get lots of states that passed what are called basic or standard plans, which are supposed to be plans that everybody can afford. They're highly restricted in terms of how you can rate them, age and gender, and things like that. Nobody buys them because insurance companies have to rate them up so high. So you've got these plans that are supposed to be there to provide almost universal coverage, but nobody buys them. There's a lot of pressure on the states and the insurance departments. Departments of insurance are stuck with what's really an unpleasant task—enforcing rules that are often unenforceable.

There was a recent court case in Maryland where there was a self-insured plan with a very low stop-loss or excessive loss coverage. The state took the plan to court, saying it was a high-deductible fully insured plan. The court said, "It might look like it's just a $2,500, $5,000 high-deductible plan, but the reality is that the company says that they're self-funding underneath, so it's self-funding." So the insurance departments are really in a bind.

So the question becomes, what's going to happen going forward? These are completely my opinions, and I might be completely incorrect. My guess is that we'll see a continuation of this pro-consumer or anti-insurer public sentiment. Whenever you see public sentiment, it tends to channel into legislation. There will probably be increased legislation and restrictions, but as a result, accessibility is going to continue to decline. Costs are going to continue to go up, small group health is going to become more and more unaffordable, and fewer people are going to have access to care. Of course, this cycle will turn into legislatures and insurance departments being forced to do anything to stem back the tide of what insurance companies are doing. It will, of course, be framed with the mindset that insurance companies are doing this and taking advantage of people, so something has to be done to stop them.

I'm asking what's going to happen based on my personal thoughts? After all, if you have policies that have been failing over the years and appear to have no chance in sight for any sort of real progress, will some sort of a different approach be tried? My guess is it's not likely. If we look at recent history, we can see what has happened with other failed government programs; for example, the war on drugs is a miserable failure, and the more it fails, the more money gets thrown into it. The same holds true with the embargo against Cuba. The less success they have, the more money that gets pumped into them with hopes that going a little further and doing a little more is going to end up, finally, reaching the solution.

So what are some of the long-term possibilities? One is that there can be some sort of a re-engineering type approach. It would require taking a significant step back and thinking in terms of how we'll make it market-based, and see how things go that way. We'll reduce government intervention and oversight and see if there can be a successful market-based solution. That seems incredibly unlikely, at least to me. The next is that we're going to have a national or government-sponsored program. It will be a Canadian-type, or European-type health care system where the government runs everything. We have to admit that government restrictions on insurance companies aren't going to be the solution so the government needs to take over. It can get economies of scale and significantly reduce the administrative cost, as well as have lots of control over the actual costs of services. I think that's probably as unlikely to happen as the first.

Even though it sounds like a short-term solution, the long-term possibility is going to be a continuation of the status quo. We will continue the self-deception, that increasing regulations and increasing intervention are going to eventually provide a solution. I think it's the most probable of the possibilities, but I think it's the least effective. I'm sure that some of you have your own ideas as to other possible solution.

Mr. John K. Heins: I don't necessarily disagree with your view about the destructive reality of what the NAIC has become, but can you offer some examples of imperfect legislation that has arisen from that?

Mr. Leibowitz: Sure. Let's look at, for example, rating bands. On renewal, the maximum rate increase that a group can get is based on the change in demographic, plus the change in the new business rate, plus 15%. That's an additive 15%. So you've got all these other multiplicative factors and then you add in 15%. That doesn't make any sense mathematically. It's not a real 15% increase. It's just a number that they've added on. Where does the idea of a small group going from two to fifty come from? Why would two be used when two people hardly constitute a group at all? What are some other NAIC-based rules? The differential is between classes of 20%. That sounds like a totally arbitrary figure, as does a plus or minus 25% on rating. Theoretically, if you want to have some sort of a central base rate, then you should have a minus that's significantly smaller than your plus, because you might offer a 10% preferred rate. In theory, you should be able to have your upper bound be double or even triple your standard rate, because that's the way the risks actually go.

Those are my opinions. They might not sound like strong examples, but I'm not saying the NAIC does a terrible job.

Mr. Jay: One could argue that the reason for that is to make health insurance still affordable to those that are a very bad risk. The way of doing that is to have the healthier risk provide some subsidy to the high-risk individuals so that they still can maintain the coverage, which is I think the social motivation behind that.

Mr. Leibowitz: One of the things that I'm always concerned about, though, is when you have these social motivations, it just seems odd that it would be

legislated to have one set of small groups subsidizing another set of small groups. Is your end goal to have all of them covered? Eventually, it becomes unaffordable for all the groups. Everybody's going to do a cost-benefit analysis. You have good groups that have lower risk who are going to look at this and say, "Not only am I paying a rate that is too high for me, but then I'm paying some additional money to support other groups." This is just my opinion, but if the government wants there to be some sort of subsidization, then that subsidization should come from the government. If you're going to say, "These people can't afford it and we, as a government, think that they should get this assistance," why should the health care industry have to sponsor that burden rather than the government sponsor that burden? That's my personal opinion.

Mr. Jay: I think it would probably agree with you. The fact is that the more tax-based solution might seem unattainable to the state regulators.

Mr. Leibowitz: Sure.

Mr. Jay: This might be the only approach that's available to them.

Mr. Leibowitz: I agree 100%. I think that goes to this mindset of how it is easy to do things like put a burden on an insurance company. There's not going to be any sort of backlash, whereas increasing taxes for the general population in order to pay for this will certainly have a significantly larger effect.

Mr. Rob Damler: Tom, I want to make a couple of points of clarification on your comments regarding the small group legislation that came out from the NAIC. I think your 15% differentiation between rating bands is actually multiplicative, not an additive. In addition, your plus or minus 25% is off the midpoint range, so you can't actually go negative 10% off your average rate. It's multiplicative from there, being plus or minus 25%. So you can actually have a factor of one-and-a-half or 1.67 times your average rate. It's plus or minus 25% from your midpoint rate, which is also multiplicative.

With respect to the changing role of the federal government in health care, we need to be sure that our voices are heard in the industry as well as in the public discussion. This is how several years ago we avoided having national health care imposed upon us. We're really actually having it gradually imposed upon us through more and more federal expansions. Al Gore is proposing expanding the Comprehensive Health Insurance Program (CHIP) to include individuals who are all the way up to 250% percent of the federal poverty limit. This would include not only children, but also adults. This is not a political statement against Al Gore, but a statement against the expansion in this situation. Small employers will continue to see this as an opportunity to drop health care for their employees who are below the 250% percent of poverty level. More people will get onto these federal programs, and that 250% of federal poverty limit will slowly be increased and expanded. I think this is really one of our concerns. We can look back at some of the legislation that you mentioned, like HIPAA and the coverage for newborns and mothers. I think we also need to focus on how federally covered health insurance, federal and state programs, and Medicaid from the state side have been expanded

and are slowly gathering more and more people under the umbrella of federal programs. I think there is actually a program that was looked at of allowing people that were early retirees to join the Medicare system. There was a methodology to move more and more people out of the private sector into the federal government sector.

Mr. Leibowitz: Are you opposed to moving more people out of the private and into the public?

Mr. Damler: Yes.

Mr. Leibowitz: Okay.

Mr. Damler: My guess is that, if we do that, we still have to come up with some kind of a solution as to how to provide some kind of coverage for all of those people who don't have coverage today. I think the issue is the private mechanisms aren't providing coverage for those large groups of people. The government feels that it has to do something. Can it do something different?

Mr. Leibowitz: I think that's the question that the actuaries from the health insurance side need to address. How can we price products and design products to make it so that they're not so selective? That's one of the issues that I think health insurance actuaries are concerned about. What about offering pharmaceutical benefits, which I know we've seen growing in the Medicare population, for example? We've obviously seen selection. That was the way that the products were designed. Individuals can select on their pharmaceutical benefits. I think that it would be a better option, for example, to have pharmacy benefits covered under a mandated-type arrangement under the Medicare supplement-type situation than having pharmaceutical benefits covered directly from the federal government side.

What we need to do is come up with solutions, as you've indicated, to avoid selection and offer coverage to more individuals in either the individual marketplace or to the small-employer marketplace, to make sure that we're not pricing small employers out of the market and not making the coverage unaffordable. I think that the health insurance industry as well as the actuarial profession needs to educate consumers about the true cost of health insurance. I think we would be in a significantly worse financial situation, for example, if HMOs did not save a lot of the money that they saved during the 1990s through managed care and reducing health insurance trends. I think a significant driver of the economy was the slowing down of health insurance trends, and I think the HMO industry had something to do with that.

Mr. Damler: This might be an odd perspective to a lot of people, but I think potentially the pharmaceutical industry actually could help slow down a lot of the other health insurance trends through the new medicines that they've brought to the marketplace. It is difficult to quantify how much one reduced the other. Our keynote speaker, speaking to the health actuaries, said bureaucrats at HMOs are ruining the health insurance system or health care system. This is what's being

preached out in the marketplace. I think that's when we need to turn the tide. HMOs have been beneficial. There's some things that the industry might not have done right, but I think what we need to do is create products that are more affordable, and we need to avoid selection and put these products out into the marketplace and take the role away from the federal government.

Mr. Mark Wyneblyth: I always found it odd and ironic that back in the mid-1990s the government was passing all this anti-managed care legislation and simultaneously trying to use managed care to lower the cost of Medicare and health insurance in general. I never could figure out how it could reconcile those two actions. I wanted to make a comment about what you said before as far as having the health insurance industry, rather than taxpayers, be the one forced to subsidize the uninsurable with substandard risks. That kind of feeds into the whole attitude towards insurers because nobody wants to see higher taxes. They prefer making the insurance companies pay. Once their rates go up as a result of the increased costs, then people will be saying how all those insurance companies are so terrible because they're taking all their money. They don't realize that it's the government programs that create the higher costs, not the insurance companies.

Mr. Carl Wright: I work for the largest Blue Cross/Blue Shield plan in the state, and I'd like to comment on our ability to have rates that are affordable. The Blue Cross/Blue Shield plans, at least in the state of Pennsylvania, and there are four of them, have become by insurance department dictum, the dumping ground for everything that no one else will take. A good example is demonstrated when trying to figure out how we were going to implement HIPAA legislation in the state of Pennsylvania. We've always been known as the insurer of last resort. For HIPAA eligibles, we have become the insurer of last resort. So commercial companies can find mechanisms and ways to have rates that the person can't afford to pay, they can always come to the Blue Cross/Blue Shield plan and get coverage. That just creates rates that continually go up. I'm the person filing increases for our individual products. The trends on all that business are just unbelievable. The state has also compounded that by passing the law that if an individual leaves a group and wants to convert to an individual agreement or contract, we're capped at 20% over the corresponding group rate that we can charge that person. It gets back into what you said. You get rating bands or rating caps. You become the dumping ground for everyone else that can't be insured in any other way. It becomes impossible for us to have a decent set of rates. The only place that we can have reasonably good rates is if we can medically underwrite the business, but then that doesn't solve the problem of the vast majority of the people that don't have insurance today.

Mr. Leibowitz: I have worked at a Blue Cross plan, which was also thought of as an insurer of last result. I can empathize because our plan was actually even more restrictive in that people who converted from group to individual got the individual rate, even though there was an eight-month waiting period for people who joined the individual plan. In many states, people in the government think of Blue Cross as kind of an extension of the government. So what we're seeing in Pennsylvania is this notion of people being subsidized by the government, except it's not actually coming from the government, it's coming from this insurance company. So the

thought was Blue Cross can take this hit because it is not here to make money. It is here to protect the people of the state, just as we (the government) are here to protect the people of the state.

Mr. Jay: That has been a situation with the Blues for as long as I can remember, and it continues to survive. I don't understand how it does that, but I think you do a fine job of the role that you play.

Mr. Tomas Wildsmith: I'd like to make a follow-up comment on some of the discussions about the uninsured. I think it's very important to distinguish between the different groups. The way we regulate the health insurance market has a heavy impact on the cost of coverage in that market. Deregulation has the potential to make insurance more affordable for millions of middle income Americans. I think it's important to recognize that there are millions of core uninsured low-income Americans. For these people, tweaking the market rules, or perhaps even completely deregulating the market isn't going to help significantly. Reducing the cost of insurance by 20%, 25%, or 30% isn't going to make it affordable for the many people who lack a significant income of any sort. When we talk about who's uninsured and why, and what the impact of regulation has been, it's important to distinguish between the people who could afford to pay your premium and those that couldn't.

I have a question that I'd like to invite you to comment on. Kentucky recently passed legislation that was at least intended to roll back some of their insurance market reforms that had proved to be quite unsuccessful and had, in fact, led to many insurers leaving the individual market in that state. This might be a complete anomaly, and going completely against the flow, but it might be interesting to contrast that against the general trend that you've outlined for us.

Mr. Leibowitz: When preparing for this presentation, I actually sent out letters to 51 insurance departments and asked them for their opinions on how things have changed. I don't know how this will directly answer your question, but we got a wide variety of opinions. We got many responses where they only replied with, "Here's how many people we have working for us."

We also got back quotes like, "It's becoming more and more difficult for us because there are so many regulations," or "it's now not just state regulations, it's also federal regulations." We got quotes like, "We're being regulated to death." "We're losing lots of carriers." So there is a recognition among a lot of state insurance departments that these regulations and these rules are driving costs up and carriers out. There's also this notion out there that, in many cases, they're working with their state legislatures to talk about legislation more and to talk about the impact more. It might be that this is just the beginning of that sort of thing. In some cases, they think of themselves as pawns going around and doing what they need to do. Others definitely think they're playing an active role and they're hoping that they can help set policy based on the impact of the legislation that they've seen so far.

As far as the first thing that you discussed and the uninsured, I think one thing that I didn't really touch on enough in my presentation is the setting of goals by the government and the objectives of the government. What is the government looking to do? In 1993 the government was looking to give everybody health coverage. I think that was the general idea. I think the idea is more of protecting or setting up regulations to protect the voting constituents. The middle class is who is seeing minor impacts of health care. We still have this third-party-payer system in which people who are getting coverage are almost totally removed from the actual costs. I still hear people, and I'm always astonished by who complains about having to pay $15 as their physician co-pay rather than $10. What they are not recognizing is that every month $50 is coming out of their paychecks, and their employer is paying another $300 to cover each of them and their spouses and their kids. So they're seeing nominal changes in benefits, but that's enough to get them up in arms and to push for change in the system.

Right now I think the goals of the government have become very meek. Obviously, Tom will know more than I, but there doesn't seem to be any sort of reform in terms of changing the entire marketplace and changing the scope of who's covered. It might be a matter of saying, "Well, let's get some more kids covered." We're still looking at 45 million people without coverage, and I think the Band-Aid approach is not going to get us anywhere near, at least from a social perspective, where we need to be.

Mr. Russ Edwards: As long as the press reports the uninsured number in either millions or as a percentage of the population, it is negative press and it is a bit of an indictment against our current insurance system. As long as that's the way the focus is, then insurance companies are going to be under fire. I'm not sure how to do it, but somehow the conversation should be more like that of discussions about unemployment numbers. Everybody recognizes that full unemployment is impractical. Everyone would like to have a wage and not work for it. We could do that in this country, but it's impractical. I think that universal coverage is equally impractical. Everybody would take it if it was free, but that's not what America is about.

Mr. Leibowitz: That's an interesting final statement. I think we're looking at two very different things here. When we're talking about unemployment, we're talking about rates of 5–8%, and sometimes the rates are even lower. When we're talking about health care coverage, it is 20% of the population. Countries have often been viewed most objectively by how they treat and take care of those most in need. We have a country where we have tens of millions of people who are working who are unable to be covered by insurance for one reason or another. It would be difficult to say that that's what America's about. It's not a question of, "We have lots of lazy slackers out there who are just hanging out and want to have health care coverage". It's a question of how we've had a system in place that has been set up, in a lot of ways, to be very equitable. For instance, let's say that, regardless of salary level, everybody at a large corporation will get the same benefits. So it's something that's, to some extent, very socialized. As a result of the way things have progressed over the last 20 or 30 years, we have reached the point where it's not so much that there are people who can't afford insurance.

Rather, the situation is that there are employers who can't afford to provide it to the people who work for them. That's a very different situation. The question becomes how to address that and what sort of redistribution, if any, needs to be done.

Mr. Frederick Busch: I worked in the Kentucky office, and the State of Kentucky just passed another health care reform bill. It is the fourth one in six years. I agree with your comment, Tom, that when there are a lot of failed programs and policies, there's no recognition that this is not working. Instead, more money is thrown at the program. This health care reform bill was a little different in that at least our feeling was there is some recognition that what we've done in the past is bad, and they tried to undo some of the damage that they had done by driving out carriers. They actually liberalized the small group law, and expanded the rating bands. They can give 20% percent for experience now. It's partial good news, and at least there's some recognition on the legislature's part that we don't know as much as we think we do. I don't know whether that's going to happen.

The other comment I wanted to make is we have been in contact with the NAIC about the 15%. Their interpretation is it's additive. The new business and case characteristics are multiplicative. The 15% is 15 points.

Mr. Leibowitz: Right.

Mr. Busch: We have been operating multiplicatively. That can work for or against the insured, depending on whether you're above or below, or depending upon which direction you're going in terms of giving an increase or decrease.

Mr. Leibowitz: How often do you go down? We haven't done it very often.

Mr. Busch: I think standard operating procedure in our industry dictates that this is multiplicative. It doesn't make a lot of sense to go with two multiplicative factors and then an additive. Even our insurance department, and the actuary that we're working through, said, I think it should be multiplicative. They got in contact with the NAIC and it said, "No, it's additive."

Mr. Leibowitz: As a result of changing the Kentucky laws, did some of the carriers come back into the state yet?

Mr. Busch: Not so far.

Mr. Leibowitz: Maybe there has not been enough time.

Mr. Busch: I think people are always going to be leery, because of what happened before. They wonder, "If we get into a market, are we going to have to pull out again? When is the political climate going to change?" So we'll see.

Mr. Leibowitz: This brings up two important issues. One is legislatures, for the most part, are not health care or health insurance experts. So a lot of what they do they're doing based on the advice of others. Much of what they do they see as

having been well-intentioned, but it ends up being very detrimental. The other is that a major concern is choice. Right now, consumers have it, regulators have it, but if a by-product of passing legislation is a flood of people out of the market, then it's really continuing to defeat the purpose of the legislation.

Ms. Diana Wright: I'm the NAIC health actuary that answered the additive vs. multiplicative question in Kentucky. I wanted to enlighten you a little bit on that. It's not necessarily just a matter of it being an interpretation of what you think is right or the appropriate pricing model. At a certain point, it becomes an appropriate interpretation of the law, whether that is right, wrong or indifferent. So I guess this gets back to whether or not you need to make sure that the legislative language says what you want it to say. The legislative language does not permit the multiplication. It uses the word sum. Any way you look at it, sum means add. So there was no other way to interpret that, given the law. I didn't get to hear the prior discussion.

The NAIC has open forums. Most of the work takes place in what they call working groups. They really are working groups. There are open conference calls. There are open meetings. There's going to be a national meeting in June 2000 that will be open. The industry is always welcome to participate. Comments are received from industry. It is not simply the regulators going into a back room, smoking cigars, and deciding what to do. So there is opportunity. If you like to be on conference calls, you can be an interested party and notified when these conference calls are. We send out literature or the discussion documents that go along with those conference calls. So every attempt has been made to have various aspects of input from all parties concerned. However, I would like to stress that the regulators' perspective, that is their interest, is to protect the consumer. I have run across a variety of regulators, but, by and large, I would say the regulators are interested in industry making a reasonable profit, because they don't feel that it does their consumers any good for insurance companies to go out of business. That doesn't accomplish anything. Then the consumers are left with nothing. So I don't think that their intent is to try and drive people out of the market.

Mr. Jay: Thank you, Diana. I'd like to expand on that a little bit. I have attended some of the NAIC sessions. The extent to which unintended consequences get in the regulations is as much our fault as it is the regulators. We were not involved, and we do have the opportunity to get involved.

Mr. Leibowitz: I wanted to ask Diana a follow-up question on the sum. The interpretation that we got from them was that the first two factors, case characteristics and new business, are multiplicative. The third one, health status, is additive. So if sum means multiplicative in the first two, why does it not mean multiplicative in the third one? It seems to me like you're mixing definitions of sum.

Ms. Wright: I'm at a slight disadvantage. I don't have the language in front of me. Do you have it?

Mr. Leibowitz: I don't, but I can give my theory on why it's additive. My guess as to why it's additive and the other pieces are multiplicative is because not everybody is renewing annually. There are all sorts of semi-annual renewals taking place. If you make your changes to demographics and the new business rates twice within a year, you're going to end up in the same place as if you did it once at the end of the year. If you add 7.5% twice, you're going to end up at the same place. If you multiply by 1.075 twice, you're going to get a higher number. Whether or not it was intentional, there is actually some sort of logic to it. I'm not saying that I think it's great, I'm just saying that there is some sort of rationale to it. I still don't like the idea of having any sort of factors that are applied to each other adaptively.

Ms. Wright: Right.

Mr. Leibowitz: There is some sort of a justification to it. I don't know if that was the actual justification or if the language just came out that way.

Ms. Wright: I liked what you said, but the actual language, says it takes the change in the new business rate and then 15% plus these other things. So that's what makes the new business rate change be multiplicative. It would be 4% more, 10% more, or whatever. It says 15% plus these other things. That's why it's additive.

Mr. Joseph Rolling: Regarding the idea of the small group rating bands you had mentioned, why it is plus or minus 25%? Why is it plus 15%? In my opinion, I've worked with that a lot. I think it was done so as to put some limits on it. Obviously, different states did different things. There is no magic number, but you try to limit it. It didn't matter much what the numbers were, as long as there were some types of limits. But that's not the reason I came up here.

Mr. Leibowitz: Oh, good. No more questions on the rating bands, please.

Mr. Rolling: Let's get back to the changing roles of the federal and state governments. Governments are trying to have both access and affordability, and obviously everyone knows that if you have more in one, you're gonna have less of the other. The more access, the more the rates go up. You can't have both. Obviously, there's no great solution, because we haven't heard any great solutions yet. I just wanted to throw out an idea and get different opinions. The idea is, can the federal government basically require everyone to have health insurance? Obviously that's not an easy thing to do; otherwise, it would already do it. You get everybody having health insurance. Anti-selection would still be a problem because if you switch insurers, it'd be a lot less of a problem. Is that something that's desirable? If so, what are some methods that could happen?

Mr. Leibowitz: Does it have to be health insurance? Or can it just be health care coverage? I think the two are very different. Addressing the issue of coverage, here is my perspective. There's a certain amount of money that's being spent on health care, and it's not being spent by the people who are getting it. Except for the small exception of the individual or non-group market, people aren't paying for their own coverage. Most of it is being paid for either by the federal government or

by employers. Given that it's by employers, just as Social Security taxes are paid by employers, it might as well all be coming out of the government. It's all coming from someone other than the person who's getting the care. Given that, and given that you have this big pot of money, the question is how do you want to allocate it?

Traditionally, the way it has been allocated is as follows. The elderly are going to get coverage from the government. People who are working for employers are going to get coverage that's paid for by their employer. People who are self-employed are going to get coverage on their own, and lots of people are going to go without it. It becomes incredibly clear when you look at the differences in who's getting how much coverage and how dissatisfied the public appears to be with the whole system, even though lots of people are very happy with their coverage, although they have legislatures telling them that they're getting really abused and taken advantage of. You have all this money, and you need to find the optimal way to distribute it. Does that require giving everybody coverage? Maybe. One advantage to having the government do it is that it ends up being done much more efficiently than if we were to do it (as crazy as that sounds). In Medicare, the administration costs are low, and there are no sales and no commissions. The only real costs are the claims costs plus 3% or 4% for administration, which is very different from our retention schedules. I know some of the Blue Crosses are more than 15%, but ours are easily 20% or more. There has to be a more efficient system than that.

Mr. Rolling: Let me make the question more specific, then. I like my job so I want to keep health insurance alive and well. So how can we get the government to mandate that everyone have health insurance? It has been a few years since I've heard the term pay or play, which means that employers would be forced either to cover everybody, or if they don't cover them, to pay something into some pool that does something. Those are the types of ideas I was trying to generate here so that I'll have more job security in the future.

Mr. Jay: I can't see how you can require an individual to cover himself if he isn't able to afford the cost of health insurance. There are some states that require automobile insurance, but no state requires collision. It's only liability that affects other people. You can tell a person that he has to buy health insurance, but if he can't afford it, you can't change that. Most of the people that are uninsured get some health care. The care is not as good, but most of them finally get some health care provided gratuitously by hospitals and doctors.

Mr. Wildsmith: I'd like to speak to that from a little different perspective? I think the short answer is, that the government could put a coverage mandate in place. It could mandate either the employers provide health benefits or that individuals purchase it. There are three problems, and I think you, Bert, touched on two of them. The first is you may not be able to administrate. You mentioned the automobile insurance. In theory, everyone is supposed to have automobile insurance. You can't get a car loan without proving that you have uninsured motorist coverage. But, in practice, not everybody has that auto insurance. It just isn't enforceable. The second issue is you can have a mandate, but if people don't

have the cash to pay the premium, again it's unenforceable so you have to do something else on top of it.

Beyond the technical issues, I think nothing is going to happen on the political front. It's very difficult to get voters or interest groups interested in getting the government to force them to do something. It's just not an easy political sell. Making health insurance coverage mandatory instead of voluntary would change the market dynamics and make many of the things that regulators want to do perhaps more practical. From a political standpoint, I think it's a complete nonstarter. We're just going to have to find a different approach to solve these problems.

From the Floor: Let me give you a little different perspective, because I work for an indemnity insurer. I know a lot of you work for managed care. I'm in a managed care plan myself with my own employer. One of the perspectives that a lot of consumers have is that they have taken lower cost and they have given up choice. Choice can mean a lot of different things. For a lot of people, the way that managed care plans were presented to them originally seems misleading. I've been under a bunch of different plans. I used to be under the Air Force plan, so I got free government health care, and I'm definitely against that. It doesn't matter how efficiently it claims to deliver it, or not deliver it, as the case may be. I've gone through a bunch of different plans. One of the things I discovered is that I now have 100% coverage of things I previously couldn't get approved under a managed care plan. That saves me money.

To a lot of people, the whole paradigm of health services needs to be addressed. As a consumer, if I want health care, I can just get it. I think there's a mistaken idea here, to a certain degree. I'm not saying it's entirely mistaken. People don't realize that all this money is eventually coming out of our pocket. Whether our employer pays it or whether the government pays it, it's money I don't get. I don't believe the government has money. It has my money. It doesn't have any money of its own. It has mine. One of the reasons why I wouldn't favor the government getting the money for uninsurables is because once the government has it, you have no recourse. With my insurer, I can complain to my employer, and I might get some action. Once the government has it, it is going to do what it wants. You can complain about Medicare all you want and right now the older voting block is able to get some things done with Medicare. We don't do major medical, so I feel safe saying this. If we offered a plan for people under 65, and all we paid were the benefits Medicare pays. I'm not sure states would approve it. It's not that great a plan. So much more has to be supplemented on the outside. The government can do it because it can get away with it. It can just say, "This is all we'll pay."

There are things I would say for people who are in the managed care industry, which I don't have a problem with. You mentioned early on that you feel like governments are more emotional now than they used to be. I totally disagree with that. I think they've always been completely responsive to emotional arguments. The original arguments in favor of HMOs said that indemnity-paid doctors were under a financial or economic incentive to overdo services. The economic incentive was too strong, no matter how much the doctors cared. Now the doctors are under

an economic incentive to under perform. It's a reality, and people are encountering it. You can't have it both ways—on one hand saying the economic incentive overcomes the doctors' desire to do right, but, on the other hand, we have quality programs that make up for it all.

There's a very real problem that surrounds all of this, and I don't know that there's an easy solution. I just wanted to give you a different perspective from someone who's not in the managed care industry.

Mr. Leibowitz: You've certainly given us the perspective that has been given to legislatures, which is that managed care is just a bunch of bureaucrats sitting behind a desk somewhere and making decisions about who gets care and who doesn't. I have worked at managed care companies before. I've reviewed statistics like 85,000 outpatient surgical claims have been reviewed and five have been rejected. I can tell you, based on the numbers, that the extent to which care is restricted has been over exaggerated.

Managed care has done some fantastic things for the industry as a whole. Standards of practice have become significantly more aligned than they used to be. Protocols are now in place. Care is much more consistent and at a higher level than it was several years ago. You need look no further than the dental industry, on which we don't have any controls, to see how wide the patterns of practice and how disparate utilization levels can be in this sort of environment where you have a third-party payer system that's paying for service.

An added benefit is that all of these advantages have transferred not only out of HMOs, but to PPO plans and even indemnity plans because providers have changed their patterns of practice and new doctors coming out are just used to it. So it has done fantastic things. At this point, a lot of HMOs are starting to believe this idea of going out and pushing for more savings is not worth the benefit that they can gain, because all the squeezing of the lemon has already taken place. So you're in a situation now where the doctors know the rules and are going to follow the rules, at least to the extent the cost-benefit analysis says that there's no reason to have the rules on them anymore.

From the Floor: I think the reason that we have the Patient's Bill of Rights before Congress right now is because of the outcry of people like the last speaker. I wonder if there have been that many people that have had their own care denied. Many thought that someone reviewed it and made a decision. They're fearful that it might be denied, even though it wasn't. Many more of them have the fear without the personal experience of something that they thought should be done to them that was refused. I don't know. My perception is that maybe that might be the case.

Mr. Leibowitz: I live with a doctor who works at Kaiser and she comes home every day with stories like "I have a patient who doesn't understand anything but insists upon getting an MRI even though she doesn't need it." In the spectrum of the government, we're seeing a lot of this notion that doctors are now siding with patients against HMOs. The reality is, there are still a lot of patients who are very

suspicious of doctors and think that they're being denied care or that somehow everything is financially motivated when, in fact, their best interests are in the hearts and the minds of the providers.

From the Floor: They just lost the trust.

Mr. Leibowitz: Right. I'm certainly not saying it's unjustifiable, especially in the case of Kaiser. The HMOs have done a lot to bring this on themselves. It takes a lot of work to get legislatures to side with doctors because, for years, legislatures hated doctors even more than they hated lawyers. But the tide has changed and there has been a shift. It's the HMO's own fault to a great extent.

Mr. David Dixon: First I want to congratulate Tom on creating quite a bit of controversy today.

Mr. Leibowitz: I do it every day at work.

Mr. Dixon: I want to go back to what my esteemed colleague from the NAIC suggested. There's a lot of opportunity for us to get involved and help shape this legislation, both at the state and federal level. I've been at three Blues plans and several different commercial companies. I have been involved in legislative liaison work. There is a special trust, especially at the Blues plans, since you have such an influence in your particular states or area. Somebody in every actuarial department needs to be involved. You need to know the chairman of the insurance committee. You need to be involved with the insurance commissioner. You need to know who reports to the insurance commissioner that works with health insurance. If you're working at a commercial company, the HIAA is a very good organization to help influence both state and federal. There's no excuse. Every actuarial department at every company needs to have some actuary who is involved with your legislative liaison working with the NAIC. Go to the NAIC meetings; they're very informative and very helpful. I will go back to 1991. I was involved with the joint Blue Cross/HIAA committee that helped the NAIC come up with the original small group legislation. The intent was it was multiplicative.

Mr. Steele Stewart: I have a general comment. As an actuary, I've worked with consulting firms on the managed care side. The experience that I've had myself and I've seen colleagues have is that we tend to look at conversion policies and we say, "My gosh, these guys are getting such a deal. I lost 300% percent and the premiums are only $300 per person. This is such a deal." Of course, that individual is fuming. This person has been working for the large employer, went through whatever personal incidents took place, and lost his or her COBRA. Now he or she is really paying through the roof for it. One perspective from the investment side of things is the idea of tranches. There's the individual in the conversion policy, which is kind of like one tranche. There's COBRA. And there's the large and small group coverages. Each one of these are different tranches that we all potentially can go through. The question or the challenge I have is that there isn't anything in the market right now that I know of. I've talked to a lot of people about protecting individuals when they go from one tranche to the next tranche.

Whenever I've brought up the idea to people they say, "that's administratively too expensive." To track an individual going from a large group to a small group to individual is just too administratively expensive. As for the job security issue, I would challenge everyone to try to think about products that we can have to help the people that are healthy today that potentially will move into the unhealthy insurance status in the future. Recognize there might be up-front economic costs to do that, but the political savings might have real a benefit. So it's more of a statement than a question. Does anybody have a product on the market that I can buy at a reasonable price and then get individual insurance later on when I need it? Maybe I want to retire early, and my employer doesn't have health insurance.

Mr. Leibowitz: I think that's part of what HIPAA is really designed to do in terms of the portability perspective. It is not so much from one tranche to the other, but from one employer to the other. But it's just a very meager way to try to address a much greater, much more significant issue. If you have insurance that's tied to your employer, then it becomes significantly more restrictive than if somehow coverage is tied to the person.

Ms. Valerie Lent: You kind of segued into what I wanted to talk about. You focused on HIPAA a little bit as far as the aspect of the employer insurance. One aspect of HIPAA was the group to individual portability. I think that has failed miserably. We have individual products, and we have issued some HIPAA. We don't issue it at a real low rate. Hardly anybody takes it. I think that that aspect could have been more successful if they had required the group carriers to issue that individual policy. The individual carriers are 10% of the major medical market, if that. We can't possibly spread the premium enough to subsidize those people without having a huge impact on that 10% of the population we already had.