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Session 109PD
The Health-Care Financing Crisis

Track: Health

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Panelists: MARK E. LITOW
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Summary: This session explores some of the root causes and possible solutions to the current "crisis" in the availability and financing of health care. Some of the issues to be addressed are affordable health care—cost drivers and recent trends; how the uninsured fit into the picture and how the picture is changing; struggling to stay insured—what everybody is doing; the emerging role of consumer-directed health care; the role of tax policy; and new ideas. Attendees gain a deeper insight into the interrelated issues that affect the cost and availability of health-care coverage in the United States.

MS. VALERIE ANN LENDT: First, we're going to have Mark Litow. He's a consulting actuary with Milliman USA, from its Milwaukee office. He's International Health Steering Director for Milliman Global and a member of the Society of Actuaries' Board of Governors. He has been involved with various projects concerning health-care reform, managed care, disease management and regulatory issues worldwide. A well-respected speaker on health topics, Mark frequently provides testimony on controversial issues and has authored numerous papers. He has done about everything on health that there is to do.

Next, we're going to have Kathy Thomas. Kathy is president of her own firm, K. A. Thomas & Associates. This firm specializes in individual and small group risk management. She spent more than 20 years with what is now Fortis Insurance in various executive positions within information systems, marketing and

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Note: The chart(s) referred to in the text can be found at the end of the manuscript.

underwriting. She left Fortis at the end of 1998 and established her own consulting practice to provide a wide range of services to indemnity, PPO and HMO carriers.

Next, we're going to have John Rink. John has been with the Nebraska Department of Insurance since 1992 where he serves as actuarial assistant. He has participated on many task forces and working groups at the state and national level. These committees and task forces include the Health Insurance Task Force and the Regulatory Framework Task Force, which developed the current models used in most states today.

MR. MARK LITOW: First, I want to go through a little history of the health-care system and how we've gotten into such a mess here in the United States. Canada has its own mess. Then I'll talk about a few ideas that I could talk about for a long time, but I'm going to give you a very brief overview of those ideas.

I would have liked to have given the speech right after Roy Romanow did on Monday, because those types of things usually send the steam through the top of my head. He talked about a couple of myths as you recall, and I think those were pretty accurate. Of course, he created a few myths in the process. The first thing that shocked me was that he talked about how we're going to pick between the U.S. health-care system and the Canadian system. It's not like either one of those systems is working well. They both have massive problems, and they both have a lot of distortions. Why wouldn't you start somewhere else? The problem is that you can go around the world and it's hard to find any health-care system that's working very well.

There's a second item I find very troubling. People say to be reasonable, but be skeptical. Think about these ideas and whether they make sense. He talked about having an "orange and orange" comparison. We're going to compare a single-payer system and the administrative costs under that, versus a private system. So he compares costs under Medicare and Medicaid. As you know, Medicare talks about 2 percent of its costs being for administration, and Medicaid is typically 5 percent to 6 percent. The private system's administrative costs percentage is typically in the teens, most people argue, but it depends obviously on which market you're talking about.

I did a study a number of years ago that I'll talk about just to show you how the actuarial and sometimes the political world don't mix very well. I did a comparison of the administrative costs under Medicare and Medicaid, versus the private markets in the United States. This is almost 10 years ago. I found that Medicare and Medicaid together, on the average, cost 27 percent to administer, versus the private market, which cost 16 percent. You might ask how that can possibly be. If you think about it, how does the government account for its administrative costs? The government takes what it costs to pay the intermediaries to adjudicate. That's it. There's no allocation of overhead in the system, like all the salaries, the benefits and all the time. When we did that study in the United States, we just went through

a functional cost analysis. I gave a little press conference on that—one of my favorite press conferences of all time. There were only two questions from the press. The first question was, "Are you claiming the government is cooking the books?" I gave a great actuarial answer, "Yes." The second question was, "If that's what we were doing in the private market, they'd have to lay people off because they're not efficient enough. Isn't that right?" "Yes." "Since the government will never do that, why are we here?" That was the end of the press conference questions. I had nothing I could say. If you think about that issue, it's come back tenfold. I get more requests to do a re-analysis of that study than I do any other piece.

That's the perspective you're walking into in health-care reform. From an actuarial perspective, it's very frustrating. With that, I want to give a brief overview of our current health-care system, go back a good 50 years and talk about why health-care costs have gotten so out of control.

Everybody knows the number of uninsured is escalating, but when you're talking about health-care reform, talking about people having or not having coverage is not the issue. I do a lot of work in South Africa. South Africa supposedly has this free program for everybody to get health care, but nobody wants it because the care is so poor. It's about access to treatment; it's not about having coverage.

The United States has the best access to treatment; we also have by far the most expensive health-care system in the world. When you're on Medicaid, you can get care pretty fast. You may wait in a queue in Louisiana for a few days and have to come back, but in most other countries you get on a waiting list.

In the United States now we're getting greater and greater shortages of medical personnel. A recent estimate is a shortage of 126,000 nurses throughout the United States.

Of course we talk about the government systems and how financially challenged they are. If you think that's bad, when we pass Medicare legislation here in the next month or two it's going to get much worse. I don't think actuaries would design a stand-alone prescription drug plan unless we wanted a lot of adverse selection.

How did we get here, and what's going on in the system? What is driving all this? Our costs. If you just take a statistical abstract of the United States and look at the costs from 1975 to 2000 alone, the medical CPI has gone up by 8.3 percent, non-medical CPI has gone up 4.3 percent and wages went up during that period about 5.5 percent. That, spread between wages and medical CPI, is well over 2 percent. We all know it's been an even greater gap over the last couple of years. People simply can't afford it, and that's what's driving the problems.

Medicare is projected to be insolvent in 2006. That's never going to happen because they're going to do what Roy Romanow said. Every time they get into

trouble, they shift some from A over to B, Medicare, because the government pays for 75 percent through general revenue. That's an easy solution, so it's going to defer it until the whole system becomes an actual crisis and the public becomes outraged. The public is not happy about some things, but they're not outraged about it.

Chart 1 gives you an example of where we think health-care costs are today with some of the simulation work we've done. We could spend a lot of time on the chart, but the number in the bottom right-hand corner, 53 percent, means that we think health-care costs would be 53 percent of what they are today, had we not gone through this whole process that I'm going to go through right now to show you how the health-care system, at least in my view, has gotten totally distorted and out-of-whack. Actually, these numbers are a few years old. They're calendar year 2000 numbers. We're saying the other number, utilization, is probably approaching 50 percent too high. We have a system where we have low prices on Medicaid. In Medicare, we get cost shifting to the other segments. Price controls always cause a sort of parabola effect where they have a short-term gain because the prices come down, but what will happen is that utilization always trails it, unless you put on utilization controls. Examples include Oregon Medicaid or what you have here in Canada, where you block people from getting care and then you force them either into a private system which develops in the cracks, or they just wait. Of course, if they die, you don't have any health-care costs for them. In the United States at any rate, you get the sale-price thing where everybody gives bigger and bigger discounts. Then you get the utilization boost and that's how you get to this 1.88. One divided by 1.88 is the 53 percent.

Back in World War II, wage and price controls were put on. Flowing out of that, by 1954, came a law called the "premium tax exclusion," which means that your employer gets to deduct its health-care costs. That encourages employees to get richer and richer benefits because, as they perceive it, somebody else is paying for it. That started this whole problem. Every time in a health-care reform you have an action; you have to figure out what the reaction to it is. If the reaction is nominal or minimal, you're okay. If it's more than that, you'll generally have some bad result long term, even though short term it may seem like a good result. What happened there is that we shifted cost over to the risk-takers. Now the insurers, the employers or whoever was taking the risk on the business had to deal with it and of course, that always comes back. Eventually what happens is, because now we shoot demand up to the ceiling and the price down to the floor effectively, everybody wants to use more. Eventually consumers become unhappy with that.

What happened, before Medicare and Medicaid, when you retired? Suddenly the insurance companies—in testimony before Congress, it was the "greedy" insurance companies—were charging these exorbitant premiums to people who retired when they were paying very little for their health care when they were employed. That was unfair, so they had to come in and ask the government to solve the problem. Of course, poor people who either weren't employed or didn't have coverage were

also paying or being asked to pay unconscionable amounts for health care, so we had to shift the problem over to the government. The government put in those programs to take care of it. Of course that created more demand.

For those of you who don't know, in 1965 the government estimated Medicare would cost $9 billion 25 years later in 1990. Does anybody know what the cost of Medicare was in 1990? It was $102 billion. Today, we're at about $255 billion and growing. Medicaid, by the way, is at $260 billion. Last year, Medicaid beat Medicare. To be fair, there have been a lot of increases in benefits. They never even changed the age. The average life expectancy when Medicare was put in was 66 years. Today it's about 78 years. It's the third rail in politics. Every time somebody talks about increasing the age, that person is going to get killed. Of course, the program goes on, and the costs go up and up and up.

Governments know two ways to control costs, either price controls or utilization controls, and they both cause tremendous distortions. We put diagnostic-related groups (DRGs) in about 1983 and resource-based relative value scale (RBRVS) in 1991. Now we've put in ambulatory patient classifications (APC) on hospital out-patient. That creates tremendous cost shifts to the private market. If you look at Canada, the trends in the private market are 8 percent, 9 percent, or 10 percent, and the government is 0 percent, 1 percent, or 2 percent a year because of all this transfer out. They put price controls over here and utilization controls over there, and everybody starts to leave the system. It puts a lot of emphasis on the other side of the equation.

You go through this process and of course now the providers put it back to the consumers. They do that in a lot of ways. They can stop providing certain types of services where they're losing money, as in Medicaid. There are a lot of physicians that don't see these people. You put in capitations. You don't put any providers in the area to service these people, which discourages use. There are all kinds of things that go on, but the providers eventually have to transfer it back to the consumers. Then the consumers, as these costs go up and more things happen, have to transfer costs. They start asking for more Medicaid coverage. They have to start asking for mandated benefits. This process goes on and on, because when you put in more mandated benefits, it goes back to the risk takers.

You've heard all about access provisions and the various types. You have to provide this kind of treatment, that kind of treatment and so on. All that raises costs. What does it do? It increases anti-selection. All these things basically violate actuarial principles. If you think about it, they violate risk classification principles and they get us in a lot of trouble. But then they always come back and ask the actuaries to give them new solutions to solve it, even though we can't tell them to repeal the old laws in the first place, and so it goes. This process goes on and on. We keep transferring back and forth to one another; the consumers are always going back to the government in this whole process. It just keeps looping around and eventually you get to the point where you can't stop this thing. Now you have

to solve that dilemma. How are we going to solve this health-care dilemma? I can't even tell where those lines interconnect or where they cross (Chart 2).

What does this tell us? The problem with models is that you start to learn things that you shouldn't do—that the interactions won't work—but the models don't tell us what to do. They tell us what not to do. What most of the models tell us not to do is, if you're going to have government insurance—which you're probably going to need for people who are incapable of helping themselves—you can't have government insurance on 50 percent or 60 percent of the population or on 50 percent or 60 percent of the cost. If you have that many people on welfare, you are going to have massive cost shifting, massive problems, and you'll have so much distortion the market can't control it. In the United States, a little less than half of all the costs in the system—it keeps creeping up half a point or a quarter point a year—is paid by the government. If you add in a premium tax exclusion, as Roy Romanow talked about, that number does get up to 55 percent. That was accurate, so it's a big problem.

Guaranteed issue sounds innocuous. People may know that the Academy was involved in this fight back in 1995 and commented on how guaranteed issue leads to rating restrictions, which is a huge problem. The Academy was asked to pull out the comments at that time on rating restrictions and agreed to do so. We have to be very careful as actuaries to not allow them to change our discussion or our debate on these issues. Just like government insurance will ultimately, whether it takes two years or two decades, lead to price controls or utilization controls, guaranteed issue is going to lead to rating bands. As more and more people complain about the rating bands, they'll get tighter. We eventually lose our ability to use actuarial principles to rate. What does that mean? It means we get all kinds of anti-selection and these things spiral out of control.

You need minimum coverages and occasionally there are some mandates that make sense, but you know how it is in the United States. A couple of years ago the state of Texas assembled a list of 93 mandates to put in an individual benefit coverage policy. Each one of those quarter or half percents add up to real money when you take 93 of them.

There are benefit safety nets that encourage entitlement mentality. Again, you're going to have people who are incapable of helping themselves and then that makes sense. What we've tried to do is get them to help themselves and to get off of that, because we can't have that proportion of a population on entitlement at the same time.

I want to talk briefly about what *can* be considered. High-risk pools can work well. There are about 30 states that have those on the individual side. Some of them have not worked well. Typically you have some basic principles and if the states stay by those, the high-risk pools seem to work pretty well. But massive problems are created in the states if they start to expand eligibility, change the premium

loads, start to get rid of the penalties and not allow rate increases. As in any system, there's a real problem with having reasonable checks and balances.

Tax credits to individuals are something that would replace the premium tax exclusion to give people the incentive to spend the money like they'd spend their own money. In the health-care system overinsurance is a big problem, as is underinsurance. As we know from disability, if you overinsure, people use a lot more. If you underinsure, people don't get care and then later on they need a lot more care. They're sicker and the research shows that they cost society more money. It's not a matter of having too little or too much; it's a matter of finding the reasonable balance.

Medical savings accounts (MSAs) and tax-free accounts have flourished in South Africa. Over half the population has them, and they have exploded. The laws on them, in which I was involved in negotiations back in 1995, are very restrictive and they have not taken off. It's a very different environment. They would not take off as they did in South Africa, in my opinion. If they were allowed to expand, I think they could be more prevalent. They're not a comprehensive solution; just a niche. They do very well with discretionary spending. They're not going to help with severe issues where people are chronically or severely impaired.

What about incentives to purchase catastrophic? Just think about what the definition of insurance is in Webster, which we violate all the time. It says you have to have a contingent situation, and the situation has to be catastrophic in nature. That's the definition of insurance. What do we provide to most of our people today? We don't provide them insurance. A $200 deductible—$100 deductible on medical care—is not insurance. That's just trading dollars and adding administrative costs. It doesn't make a lot of sense. We always have to have reasonable restraints on benefits. We have to protect consumers in certain situations, but it's a balance, just like reasonable limits on rate increases. When people buy policies, they don't have any anticipation of you giving them 40-percent or 50-percent rate increases. It would be good to have something reasonable where they understand that they are probably going to get rate increases in an inflationary environment, but what are the reasonable limits on that? Some of the guidelines we've tried on small group have done that.

Now we get to two ideas. There are papers on both of these. One idea is for the under-age-65 market. The first thing I'd do going back in history is get rid of the premium tax exclusion. That started the whole process. I'd eliminate it and replace it with some form of graded tax credits, which I'd grade by health status and income level. I would replace all of Medicaid, except for long-term care, because Medicaid people can't even get to see physicians in most cases. They end up in the emergency room, where it costs a fortune, because no one takes them. Roll the Medicaid, not Medicare, people to private insurance, get rid of that premium tax exclusion and remove a lot of the mandated benefits. This would wake the public up to the costs of health care, they'd start to become unhappy and they'd start to ask

for more options, but they'd also start asking about costs and they'd start asking for information. It would take a long time, and we'd have a lot of cataclysmic and perhaps catastrophic shocks to the system. Unfortunately, I think that's what we need.

I testified on Medicare reform before the Medicare Commission. In fact, this was the only written paper given to the Medicare Commission when they asked 15 groups to come in and testify how to fix Medicare about four or five years ago. The disturbing thing about all this is that I have been with Congressman Bill Thomas (R-CA) and Senator John Breaux (D-LA) on several occasions after that, and I asked both of them if they'd ever read it. Neither one of them had ever read it. Now, it's a very complex, very actuarial-type piece, but on the other hand, it's pretty discouraging if I can't get them or their staffers to read it.

What we came up with for Medicare, and this has actually been talked about in Social Security, was a proposal to split three groups of people. You have the seniors today. You're not going to kick them out in the streets. You have to continue the system for them, but you give them the option to enroll in the new system. For young people, the problem with health care is that costs go up much faster than their wages. By the time they get to age 65 or higher, health-care costs are way too high compared to what you can afford on a fixed income. It's clear they have to save money early and use investment income to make the system workable, so set up some kind of individual medical accounts for individuals so they can accrue investment income over time. Then for the people in the middle, we had a system where they could be part on the old system and part on the new system.

This whole proposal has a 60- to 70-year gradeout. Why? Because the unfunded liabilities that would come from giving accounts, whether to Social Security or Medicare, are so great that it would put a huge hole in the federal deficit. So we created 100-percent cliff vesting at age 65. We actually had an increase in age over time in the program. We'd get utilization savings making up for the cost by getting these people out of Medicare structure into a system where they have more insurance by definition. It was a huge transition program. It essentially put most of the people in private insurance, left the disabled people on the government insurance, put in a whole series of safety nets and added redistribution systems so that the matching employee part of the payroll tax, which is 1.45 percent today for Medicare, went into a national pool, which is redistributed based on income. We estimated at that time that everybody would get money, as long as we found them and they had a Social Security number—88 percent of the national average. Everybody would have money in his or her account, and that 88 percent was sufficient in the vast majority of the cases.

Those are two ideas, one for people under age 65 and one for Medicare. We haven't worked up one for long-term care yet, but that's on the agenda.

MS. KATHY THOMAS: As Val mentioned, I own a firm that specializes in individual

medical. I'm going to focus on that market and the health-care financing crisis.

Here in the United States, as Mark mentioned, the majority of health care is financed through employers. In Chart 3, 58 percent represents large group, small group and also takes into account local, state and federal government employees. More than 20 percent of people get their health care through the government. That leaves another 20 percent that finance their own health care. Out of that 20 percent, roughly three out of four go uninsured in financing their health care. They're on the hook for their own health care, but as we all know, they don't pay for their own health care because the rest of the system ends up absorbing that cost.

I thought it might be worthwhile to talk a little bit about those who have purchased insurance—at any given point in time that represents roughly 15 million people. They're all types of people, including a lot of self-employed. More and more individual carriers are seeing applicants who are employees (or dependents) from businesses that do not provide health insurance. More and more we're actually seeing just dependents from the small group market, because in a lot of cases that dependent coverage is being priced very high and people can get cheaper coverage in the individual market.

The individually insured population skews older. There are fewer children in this population, and there's a higher rate of older adults. You can see that 10 percent of the employer market is 55 to 64 years old, whereas in the individual market it's almost double that.

Individual carriers offer a number of different plans. Some offer coverage like the old indemnity plan. There still are a few plans out there that are not PPO. Some carriers have gotten into point of service (POS); others offer MSAs. There are not a lot of carriers offering individual HMOs. Personally I think that's good, because it's very difficult to effectively underwrite in an HMO environment. More and more people are getting into the consumer-driven health plans. By the end of this year, the carriers expect to have about 500,000 people in those types of plans. Some of these carriers will go out and actually find a provider network for you. Others, such as South Africa's Destiny, have rewards or points that you can get. There's some innovative product development being done by these carriers.

I usually segment the individual market into three different kinds of carriers. First of all, you have the Blues (BlueCross BlueShield Plans). Whatever amount the Blues are paying to maintain the visibility of that logo is worth every single penny, because most agents say the first question that they get from someone moving out of the group market is usually, "Do you have a Blues plan?" That name recognition is critical to their success. The other thing that's critical is the deep discounts that they get by having their focused population in a particular region. They also typically on the individual side are paying a lower commission than some of the other carriers. The brand, the discounts and the lower commission usually

make these carriers much more successful in the individual market. We're seeing a move of Blues from a not-for-profit to profit status. I'm not sure what the latest activity in Maryland is going to do to that trend, but I would think that it's going to continue.

Besides the Blues, we have indemnity carriers, some of whom specialize in the individual market, such as Golden Rule, Fortis and American Medical Security. Over time, these carriers have been successful because they've been able to underwrite and price more specifically than a lot of the other carriers in the individual market. By nature of provider networks, their discounts are not as good as what other carriers get, and they usually have to pay higher distribution costs. But in general, they need to work harder and do better to make a profit in this market.

The third kind of carrier is the managed-care carriers, such as Aetna, Humana, and Health Net. Some, like Aetna, pulled out of this market 10 years ago and are now getting back into the market, feeling that they can leverage some of the strengths that they have, particularly on the claims side, and be successful. We're probably going to see more of that over the next few years.

Who are the uninsured? That 40 million number gets bantered around. A study recently released by the Congressional Budget Office says that it may not actually be 40 million who go uninsured a full year. That number may actually be closer to 20 to 30 million, but nevertheless, there are a sizable number of people out there who go without insurance. It varies significantly by state. The uninsured population is fortunately under-represented by children, and a lot of the Children's Health Insurance Programs (CHIPs) have helped with that. One in five adults between the ages of 19 and 65 goes uninsured for various reasons. There's no question that you're more likely to be uninsured if you are lower income. Interestingly enough, the states with the lowest uninsured rates are states for the most part that have high-risk pools. The states with the highest uninsured rates are Texas, California, Florida and New York. It's interesting to note that California does not allow exclusion riders in the individual market. New York, I think, is guaranteed issue, so some of the things that we supposedly put in place to make this situation better have served simply to exacerbate the problem.

Chart 4 reflects both company size and pay. You can see that lower line. If you have a small group of fewer than 10 employees and the salary is under $7 an hour, only 46 percent of those employers offer medical insurance. Whereas if you look at the top line, if you have an employer with more than 100 employees and they're making more than $15 an hour, fully 96 percent of those businesses offer health insurance.

I'll discuss some more facts regarding the uninsured. The last one might be particularly timely for people. With the current economic situation, the fastest growing segment of the uninsured is made up of those making more than $75,000 a year. We have yet to see at what point this becomes a critical issue for people.

Over the last couple of days I've heard people use the term "dysfunctional." It certainly does apply to the individual marketplace in particular. But in general, we in the United States are living longer, and we're living longer because of many of the benefits of this health-care system. On the other hand, we're paying more and more. We've always spent a lot on health care and it's increasing. A recent BenefitNews.com poll reported that 85 percent of businesses are going to see annual increases of more than 15 percent. How many years can you absorb that before it does become unaffordable, no matter what the size?

I brought an example of one plan—the plan for the Milwaukee Teachers' Education Association. They offer an HMO and a PPO. Milwaukee teachers do not pay one cent toward their health care. It's a benefit of the plan. Some of the benefits are $0 deductible and $30,000 lifetime infertility benefit. It's a very rich plan and you can only imagine how the cost of this plan increases from year to year.

We're medicating more frequently. There are double-digit increases in medication costs. I don't know how many of you have ever taken a look at *The Dartmouth Atlas of Health Care*. It works primarily off of Medicare data. It gives some excellent insight into regional costs and practices. The people here have come to the conclusion that Americans are "over-treated," and treatment is more closely correlated to the availability of hospital beds and specialists than it is to your health status, your age or any other factor. This is a good resource if you haven't ever taken a look at it.

In spite of everything that we're spending on health care, we have increased rates of diabetes, obesity, asthma, autism and any other number of medical conditions. All of these problems are magnified when it comes to the individual market. First of all, in this market there's a higher base premium for people participating in the market. This is one of the reasons why the uninsured rate is so high. There's less coverage. Your average deductible and your average co-pay are going to be much higher than what they are in the group markets. I mentioned before the lower provider discounts, the higher acquisition and distribution costs and the impacts of anti-selection.

I've worked with indemnity carriers, HMOs, Blues, etc., and have seen offer rates anywhere from 50 percent to 80 percent. The 50 percent is going to be more likely in an HMO environment or in an accept/reject environment. Standard issue rates, of course, would be 100 percent if you were in accept/reject, but usually they range around 45 percent to 75 percent. There's a wide range of underwriting unit costs. There's a lot of disparity in what carriers are willing to invest in the front-end underwriting assessment. Also in the individual market, especially for carriers who don't offer a short-term plan, carriers can see very short durations. Often, the duration is only 18 to 24 months; it's going to be sometimes half of that if the carriers don't offer a short-term plan. We all know that the people who stick around are the ones with claims and medical conditions, where the others move on very quickly.

There are increasing state restrictions. I think in Florida a carrier cannot decline medical insurance or even rider in the case of a woman who has survived breast cancer more than two years. You look at the inability in Indiana and California to use exclusion riders. All of these things are driving up the costs in this market. We're seeing increasing carrier withdrawal and consolidation. We've had some good carriers exit the market in the last five years, including Mutual of Omaha, Principal Group, National Travelers, Conseco and Trustmark. We are seeing some limited re-entry, but there aren't a whole lot of people right now that are interested in getting into this market.

Another important issue in the individual market is the lack of standardization. I was co-author of a report that was done about two years ago. I worked with Georgetown University on a study that was funded by the Kaiser Family Foundation. We put together seven hypothetical applicants. These applicants were very representative of the types of risks that an individual underwriter sees every day—things like a knee problem, asthma allergies and so on. We contacted 20 different carriers who did business in eight states, and then we analyzed what these carriers would do from an underwriting perspective. There was absolutely no commonality here. Every single applicant was declined by at least one carrier. By the same token, every single applicant was issued standard by at least one carrier. Now, most of the actions were somewhere in between, but what this showed is that underwriting guidelines are unique and differ greatly among carriers. By the same token, premiums differed greatly. We had a 24-year-old with allergies in San Diego and she was actually rated up 25 percent. Even with the rate-up, her monthly premium was $34. At the same time, a different carrier in that same market offered coverage to that person for well over $300. There's very little commonality in this market. We did see that commercial and multi-state carriers tended to be able to make offers more frequently. I think this is because they typically rate, rider, adjust benefits and things of that sort.

States like California and Indiana, where you can't use an exclusion rider, had lower offer rates than those states where carriers were allowed to use exclusion riders.

Today we are seeing increased consolidation and carrier withdrawal from the market. For the most part, carriers are staying ahead of the curve. Carriers are out there making the rate increases that they need to make. In 2001, Weiss Ratings did a short little blurb and said 70 percent of the profits in health insurance came from the Blues. Considering that a minority of those Blues are actually for profit, that's not bad. There's a slowing of some reform at this point, but there are some things out there that are certainly likely to come to pass. Medicare reform, tax credits and association health plans, in spite of the best efforts of any number of organizations, will pass this year. This could have some very dramatic and perhaps devastating effects on both the individual and small group markets. Increasingly, we're seeing CEOs actually talking about mandating coverage and providing universal coverage. Again, though, usually that talk is about mandating the

coverage through the employer vehicle.

What do I think is going to happen? It appears that we are going to continue to have premium increases and probably continue to have increasing backlash. For any of you that have done any work in the California market, you know that providers there are very hostile right now toward insurance carriers. I was at the Health Insurance Association of America (HIAA) conference a few weeks ago. Four CEOs said that 2003 looks pretty good, in 2004 they're probably going to run into problems, but all four of them were extremely apprehensive about the industry by the year 2005 and what's going to be happening then. I talked about accountable health plans (AHPs) and increasing discussion of universal coverage. We're probably going to see more consolidation out there (carriers purchasing other carriers).

I agree with Mark. Any solution that we come up with is going to be bad. In some cases it's going to be perhaps like some of the Eastern European countries that needed to move from communism to a free market. It will be extremely painful, and we're going to have to decide which set of problems we want to address. It kind of blows my mind that we're all out there every year making payments on cars, making payments for insurance, and it's not unusual for that to add up to $3,600 a year, but people are insulted when they have to put the same amount toward their own health care. This is a paradigm shift that's going to have to take place, and that will be extremely painful. We're going to have bitter medicine that we're just going to have to take. We have to increase the end consumer's stake in this paradigm. People just have to be more responsible. The $0 deductibles and things of that sort just have to go away. Tax incentives could certainly help; high-risk pools have been extremely helpful in many states. And if none of those things work, my guess is over the next few years we will be moving to some sort of universal-coverage mandate.

MR. JOHN RINK: I'm the actuarial assistant with the Nebraska Insurance Department. First I'm going to give you a brief review of what's currently going on in the health-insurance industry from my perspective, and then I'll give you a list of things that have been tried in each of the states. It won't be a complete list; it will be a pretty generic list. Some of these have helped slow the amount of growth in premium rates and others have not helped much at all. What you'll find is that some of the things that some of the states have done have not been as helpful as we would have liked. After that, I'll try to give you a laundry list of things that we might look at to change and see what we can do to make things a little bit better.

As many of you know, there are significant issues that are causing many problems for all of the states. The first major one that concerns most of the states is the budget crisis. The financial crisis in most states is presenting major problems for us. As an example, this year Nebraska has had at least two and potentially three special sessions of the legislature. We're a unique legislature in that we only have one body. We do not have a House and a Senate; it's unicameral. We are experiencing extremely large budget deficits. We are looking at both increasing

taxes and reducing spending. I'm sure most of the other states are just like ours. This is causing increased burdens on the marketplaces in our states. As an example, right now we have to look at potentially making some cuts to our Medicaid budget. I can tell you that we are anticipating by the year 2010, the largest piece of our Medicaid budget will be long-term care and that's a significant problem. The amount of growth is overwhelming.

We have heard from many physicians who would like to add additional doctors. Many states are having problems with medical malpractice. We did have a cap on punitive damages, and it was found unconstitutional by the Nebraska Supreme Court. We're looking at issues to try to solve that problem. I did have the opportunity a little over a year ago to speak to a group of physicians. The overriding theme from that whole discussion was that their medical malpractice rates are getting prohibitive in the sense that it's getting more and more difficult for doctors to pay their medical malpractice insurance premiums. In our state and others, provider problems are an issue. I was out in western Nebraska a couple of weeks ago, and a friend of mine had to be taken to the emergency room. The nearest emergency room was an hour away. There are a lot of counties in our state that don't have ample physicians and other things like that.

It's been difficult to encourage doctors, whether they are doctors in general practice or specialists, to practice in the rural areas. As I stated, there are several counties in Nebraska where there are no doctors or a very limited number of doctors for large areas. Our state legislature has proposed paying loans for individuals who practice in the rural areas. This might help increase some of the availability of doctors in rural communities.

Another issue we've seen contributing to the health-care financing crisis is that most physicians' offices and hospitals would like to be able to offer a lot of different services, which may require them to buy duplicate things among offices, if you compare doctors' offices. They would like, in some cases, the biggest and best equipment, which is in many cases very expensive. Most of the equipment is expensive. There needs to be some process in place to monitor the size of facilities and numbers around the country. Providers need to find a better way to control their costs. They need to take a closer look at their expenses and try to cut costs where they can. I know this is a generic statement, but when you look at the problems out there right now, obviously all the providers, the insurance companies and also the consumers, have to become aware of how much things cost. Right now they don't have that awareness. They may not be able to cut costs, but they still should take a close look at all of this to see if some good could be done.

Some states have an approval process to determine if there's a real need for new facilities. The program in Nebraska is called the Certificate of Need program and is run through the state health department. You have to obtain approval before you can develop new facilities. Some people think that this has been a very good program; others think that it's a burden and a waste of money. The cost-benefit

analysis isn't worth it based on the fact that 99 percent to 100 percent of all facilities that apply for a Certificate of Need obtain it.

Prescription drug costs are a real problem. Drug costs are skyrocketing, and there seems to be no relief in sight. There are several proposals in Congress to provide for a prescription drug benefit. This has been debated for a long time. It will be interesting to see if they do add it as a benefit. We did receive a briefing last week at the National Association of Insurance Commissioners (NAIC) meeting, and it does look like a prescription drug benefit will be passed this year.

There's a reluctance of legislatures to try new things this year due to the cost of some of the items. We had a bill within the Nebraska legislature that would have provided an unlimited, fully mandated benefit for mental illness on health insurance policies. We'd developed what we figured the cost would be for the program, and once the legislature saw what the cost would be, the legislature instantly put it on indefinite track. It basically was stopped in its tracks. The price tag on changes in the mental health parity was several million dollars. Several other bills concerning mandated benefits saw similar fates this year. In Nebraska we do have several mandated benefits, but we're not as extensive as some of the other states. In my opinion, mandated benefits are a real problem and are causing some major increases in costs for some of the plans, particularly on the small group side.

One other thing is that states may want some changes, but if changes are made, states have to obtain approval from the federal government in many cases. Right now, as was stated earlier, AHPs and other things could be a reality by the end of the year. I would like to make some changes to our small group legislation, but our hands are tied by the federal government in the sense that if we made some changes, my guess is that most of the changes I would like to make probably wouldn't be approvable. Mark made some comments about guaranteed issue leading to restrictions. He's absolutely right, in my opinion. I think that something needs to be done to reduce the guaranteed issue. Guaranteed issue is causing major problems in the small group market in our state in the sense that costs are skyrocketing.

Let's look at some of the things that states have done in order to try to answer some of these questions. As I stated earlier, a lot of these have not worked to reduce costs. Actually from 1994, when the debate got really heated with Hillary Clinton's health-care reform proposals, until now, we have seen an increase in the uninsured population. I think that's a problem. Maybe we need to step back and look at what some of the states are doing to see if we can make corrections and make things better.

Several states have tried to implement laws they hope will control health-care costs. A few things have helped to reduce the costs; others have not. Purchasing alliances have been tried in several states, and I'm not sure that they've worked very well. We did pass a law in 1994 that allowed individuals to form groups of 25

or greater for the sole purpose of purchasing insurance. We had three associations that were set up. The restriction on the association was that you had to live in the particular county. The associations lasted one year. Many of the farmers in those communities were signing up for the coverage. They were being underwritten and all that. The problem was that they were using it as workers' compensation coverage as well. They saw large rate increases, and that was discontinued. We've since gone back and repealed the law.

Some states have had multiple alliances; some have had only one. I think there are only a few states that have tried them, and I don't think they've worked with very much success. In order to appease the different views, the NAIC has developed three separate models, which will hopefully alleviate some of the concerns many of the states had. But in doing that, I don't think many of the states have implemented, as I stated. Several groups are set up, as I stated, in Nebraska.

Community rating has been tried in many areas and has not really worked. As I understand it, New York has community rating and I think that's caused some severe adverse selection. I don't think it's really worked, and I think it has caused an increase in the uninsured population.

Several states have bare-bones policies out there. We're a state that would allow companies to sell bare-bones policies. The problem with them is nobody wants to buy them. What's the sense in putting out any form of legislation that would dictate or tell companies they can offer it, if nobody wants to buy it?

Obviously, most, if not all, companies go through a pre-certification process, which for the most part has been pretty good. As far as multiple-employer welfare arrangements, several states in the past couple of years have developed legislation that would allow for regulatory approval for your multiple-employer welfare arrangements. We had a bill in the legislature this year that would allow professional employer organizations (PEOs) to register as PEOs and allow them to insure their members without state insurance department regulatory oversight. We have a couple of PEOs currently that are doing that regardless of the bill, and it's causing major problems. There are several that are technically insolvent and we're trying to get some cease-and-desist orders put out about them.

Coordination of benefits is currently being discussed at the NAIC, as far as potential changes to include coordination of benefits with individual policies. Initially the task force was leaning toward including that. I think after this last meeting they're leaning toward leaving things close to the way they are. My opinion is that including individual policies would increase some of the problems by making things a lot more confusing. It might open some cans of worms that we don't want to open.

Utilization reviews have been used, and I also listed standard policy provisions. I want to talk about standardized claim forms. All the insurers that I'm aware of are using the same claim forms. I was asked to chair a committee in Nebraska to try

to develop a standardized claim form. We found out the problem wasn't with the insurers, the state health department, the physicians, the dentists or other types of providers. We found that many of the state Medicaid programs and claim forms that were required there were far different than what the insurers were requiring. It turned out that Medicaid was causing an increased burden on the administrative costs. In trying to get some changes made, I found out that it would take many millions of dollars to get it changed on our outdated computer system. We were looking at well in excess of $10 million to $15 million to make some minor changes.

I'll go into some of my solutions. They mirror a lot of what Mark and Kathy stated. We are a state that has a high-risk pool that has worked very well. The cost of the program is running anywhere from $12 million to $15 million. For a state with 1.7 million people, that seems like a lot. We have made some significant changes. We used to take the losses, assess the companies and allow them to write it off on their premium tax. We've done away with that program because our largest carrier in Nebraska, which happens to be BlueCross BlueShield, was actually getting refunds at the end of the year. If we wanted $3 million in funding, we had to ask for $7 million in order to get what we needed.

Tax credits and refundable tax credits are great ideas. There are individuals in our state that have brought forth some individual refundable tax credits based on health status and on income. I think that has some potential to be beneficial. Medical malpractice obviously needs to be looked at and changes made. There's a lot of debate among a lot of people as to how that should be done. I'm one of those that probably would propose some sort of limit. We should consider loosening rate restrictions in the small group market and finding ways to alleviate some of the issues surrounding guaranteed issue. Guaranteed issue in a lot of states has driven a lot of companies out of the marketplace. Nebraska is fortunate because we are not down to two or three small group carriers, but we have seen an exodus of small group carriers.

We need to find ways in all states to provide incentives to get doctors into the rural areas. As is the case in other rural states, there are many areas of Nebraska that don't have any physicians for miles around. It would be nice to provide a payment program to help pay for some of the doctors' medical schooling if they work in a rural area.

We need to reduce or eliminate the amount of mandated benefits. Mandated benefits, as Mark and Kathy both stated, have been a significant problem. States need to go back and see whether they're actually increasing the problem by passing mandated benefits. I think the more mandated benefits that we have, the more we are increasing the problem. Those individuals with flexible spending accounts should be allowed to keep the money left over from year to year. Currently your Section 125 plans require you to either use it or lose it. If we allowed individuals to keep that money and use it to purchase either long-term-care insurance, a Medicare

supplement or something along those lines, that would alleviate some of the problems that we're having. I suggested long-term-care insurance might be included because of the budget issue I talked about earlier. That would go a long way to reducing some of the problems in some of the states. I don't think it's a full-blown solution, but I do think that it would help.

As I stated, unused money from flexible spending accounts should be used to purchase either long-term care or Medicare supplement plans. A cap on punitive damages for medical malpractice claims should be reinstituted. I do think that it was a good idea, and it helped reduce and keep low some of our costs within the state. States need to go back and look at what they've done in their states. They have to be receptive to some of the ideas from both the industry and the provider groups. States should show greater flexibility in listening to some of their concerns. You're always welcome to call me, because I'm always willing to listen to what people have to say. I do think that the federal government is going to take over more and more of the decision process, leaving the states holding the bag, which could create some problems for us. The federal government may want something to be implemented, but not give us the jurisdiction that we may need. We may have to go in and do some of the clean-up afterward.

MS. GAIL LAWRENCE: I have a question for Mark. You commented that Senator Breaux had not read your plan. I believe Senator Breaux floated a plan earlier this year. I was wondering if you've read it. I'd like to give you an opportunity to comment on some of his ideas, where he's focusing on both pooling—everybody's in the same pool, so everybody's entitled to a group rate—and participation. I think he solves the participation problem with mandates. A number of you mentioned high-risk pools as part of a solution. How do we defend that as a solution for people who have had coverage their whole life? They've worked hard. They have employer group coverage. They get sick. They lose their job because they're sick. They go on COBRA, and then they have to find coverage in an individual market that's probably going to decline them or waiver their condition. Then what's left? A high-risk pool, at a time when they need their coverage the most.

MR. LITOW: I did read it a long time ago, so I don't know that I can remember all of the aspects. There are some good things in there, but I think there are some real problems. Tax credits, for instance, could be considered part of a premium support plan. That works as far as affordability, to be able to cover the premium, but it doesn't necessarily do anything to encourage people to spend the money like they would spend their own. A prepaid health plan may sound nice, but part of the problem with it is that once you've spent the money, you can go and buy anything you want. So it has to be on both sides. That was one issue.

The participation issue was always a real problem. I did a plan in Jamaica many years ago. I don't remember that much about the plan, but I remember that they wanted us to assume that 100 percent of the people would join the plan, which reminds me of John's comments on the bare bones. The problem with bare-bones

plans is, if you don't give the people the ability to pay for the coverage in the first place, even if it's bare bones, and you're going to give them a high deductible, they can't afford it. It's the same thing. If you mandate all these people to join and they don't have the ability to pay for it, and Jamaica has a lot of poverty and so they don't give people the ability for participation, then it doesn't matter; they're just not going to follow the law. It's like the babysitter law for Social Security, where you have to declare it at some point on your taxes. The law just never made much sense.

I think there are some good ideas. Senator Breaux is certainly one that I consider very moderate and open to ideas, but it's a very complicated problem. I think they need a lot of actuarial input, and they don't consider actuaries very good communicators. They're looking hard for political solutions that somebody will listen to rather than sitting down and putting everything on the table and what really has a chance to work for their constituents. I think that's the big problem for the profession.

You were talking about the high-risk pools. It's not just one silver bullet that solves the problem. If you're asking the high-risk pools to solve the problem of the fact that people are in job lock because they can't get out and you've created an employer-based system where they don't have continuation of coverage, the high-risk pool isn't set up to handle the issue. It's only set up to handle the situation for people who fall through the cracks, in my view. I think that's a fundamental part. If people bought policies like a life insurance policy, they would have guaranteed renewability and from that problems may result.

MS. THOMAS: I'm a member of the high-risk pool in Wisconsin because I have a knee condition. As a result of that, I wasn't insurable. It's not the end of the world. You do get coverage, and it's needed coverage. It's a benefit to be able to take advantage of the pool, so I have a little different perspective on that.

MR. RINK: One of the reasons we decided on the high-risk pool as our alternative mechanism was that it does provide coverage to people who need it, and it takes away some of the burden on the individual market. If you look at some of those states that currently have guaranteed issue in the individual market, it's causing high rates. This has been one outlet that keeps those rates down much further than they would otherwise be if we went to guaranteed issue.

MS. LENDT: I'm going to pose one question to the panel here. As a carrier actuary, I've seen a slight slowing of the mandated benefits. But I have seen a lot of regulation coming out of places like Texas and Colorado on clean claims and prompt pay and regulation in Virginia on restricting your renewal rating. Are more and more states going to be adopting this, and how much of a burden is that going to place on the market?

MR. LITOW: I always say a direction on health-care reform is not hard to predict

typically. The speed and the magnitude are extremely difficult to predict. Certainly if we keep going the direction that we're going, at some point we'll reach a crisis and the markets will collapse. I think everybody is desperate. The regulators, legislators and actuaries all know there are serious problems. We actuaries tend to be deliberate. We take our time. We haven't been that actively involved, but more and more the Society of Actuaries is becoming very involved. We have a lot of trouble dealing with the political elements. The politicians generally aim and shoot, and then they analyze later. That's why you get a lot of these things. We're seeing more positive ideas, like a lot of the things Kathy, John and I talked about. Will they all work? No. We'll have to monitor them and tweak them. The only thing that I find troublesome is that we keep passing laws that have for the most part been tried.

Certainly most of these mandates and the rating bands have been tried, not just in the United States. Guaranteed issue and community rating were used in Australia, and that government actually wrote a report five years ago that said don't do it in individual markets because it's an absolute disaster, and it will wipe out your market. Clean claims is another area now that's coming down the pike. Texas is very active in that area. They're trying to solve a problem, but what they're going to do, of course, is create a situation that gives the risk-takers no ability to fairly adjudicate because it's not a one-sided issue. As people that are insurers in this room know, there are fraud and abuse. Until we solve the long-term problems, there are going to be people that just keep shooting at something because they have to show their constituents that they're doing something. The only thing we can do as actuaries is keep throwing intelligence at them and try to force a debate.

MR. JOHN RAGAN: One issue that caught my attention says any solution brings its own set of problems. What I think is a big issue in this health-care crisis, if you want to call it that, is the inability of the consumer to understand what the heck's going on right now. As actuaries, we think detailed and complicated, but my colleagues that I work with have no clue what's going on, and they're just waiting for the dust to settle. I was wondering how you would address that situation.

MS. THOMAS: I agree. After 25 years in the business, it's still very difficult to compare plans. In a session earlier this week, a gentleman brought up the fact that you go to the doctor, you leave the doctor's office, and you don't get a bill. You don't get an itemization of exactly what the doctor is charging you for. There are so many things in this industry that are either ignored or are confusing. I don't have any solution for it.

MR. RINK: I'm hearing the same thing from a lot of other people. The interesting part is, as you stated, going to the doctor's office and not receiving an itemized bill. In my case, I only receive a receipt for the $10 that I paid as my office visit co-pay. It looks as if my bill was $10. If it's only costing $10, what's the problem here? When we were putting together the standard and basic plans, it was interesting to see the mentality of the different people that came to the table. They all wanted the Cadillac of plans, until we had a meeting where we actually added each of the

benefits to see what effect it would have on their costs. Then they weren't so sure they wanted that benefit any more because they weren't so sure they could afford it. People do have to come to the realization that they can ask for the Cadillac of plans, but they're going to have to pay for it as well. That goes along with the mandates as well. States are struggling because they want to provide those benefits, but it's becoming more and more difficult because costs are going way up, and they can't afford to pay for those benefits.

MR. LITOW: That's why I went back to the history. You built the culture in this country over 50 years, and when you build a culture it's tough to change. I'd get rid of the premium tax exclusion and replace it with different types of safety nets, or some of the other ideas I talked about. The key is to get the consumer back involved and create a market. Health care is not food, clothing and shelter, which are the three human basic needs. If we did this for food, what do you think our market would look like for food? We wouldn't have a market. We've done the same thing in health care. We need to get rid of the premium tax exclusion, which is a federal issue.

MR. HOBSON CARROLL: I think that the media in particular continues to confuse the issues of health-care financing with health-care provisions, and sometimes we forget as well. It seems to me that the thing that links a lot of these issues is high-risk pools being the current semi-working solution. The reason you have to have a high-risk pool is because of all the people who aren't high risk who don't buy coverage when they could. I say many of them can. The fastest growing segment was all the people making over $75,000. It seems to me that the only way you get to that, and then maybe we'd have a fundamental basis for allowing the actuarial method to work, is to get everybody in the pool. That requires a mandated coverage, but the mandated coverage I'm talking about is that everybody must have a certain minimum level of health insurance and demonstrate that they have it, sort of like the German model. As for people who don't have the funds to get that, we can give them the vehicles to do that through tax vouchers or mandating employers to provide a minimum amount of coverage, etc. If you got all those people in there, you wouldn't have the need for the high-risk pool.

MS. LENDT: Absolutely.

Chart 1

How High are Health Care Costs versus Appropriate National Level?

Comparison	Today's Price	Adjusted Price	Utilization	Total (-) +	Reasonable Target Level
Usual & Customary	1.00	2.20			
Government (48%)	0.50	1.10	1.65	1.82	55%
Private (48%)	0.75	1.65	1.20	1.98	51%
Uninsured (4%)	0.85	1.87	0.75	1.40	71%
Composite	**0.59**	**1.29**	**1.46**	**1.88**	**53%**

June 25, 2003 Milliman USA

Chart 2

Model of Cost Shift in USA – 1954 on

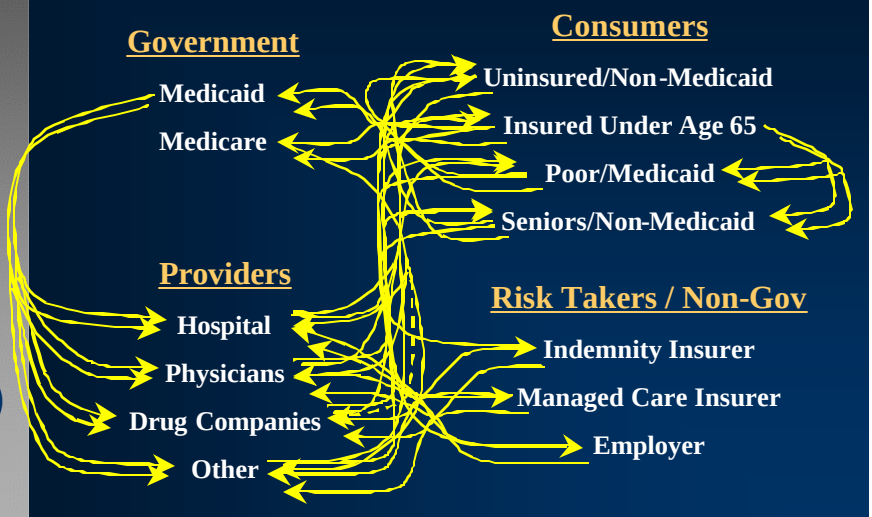

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Chart 3

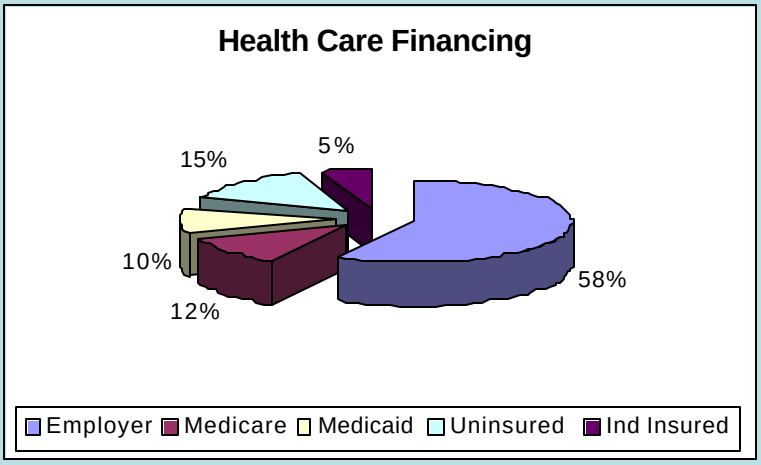

Chart 4

Source: BCBSA/Consumer Education Council/Employee Benefits Research Institute, 2002 Small Employer Health Benefit Survey