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EDITORIAL

Health care reform: Take 2

by Bob Dobson

Here we go again — another issue with feature articles about health care reform. Won't this topic go away? I, for one, don't think so. Medicare and Medicaid in the United States and the provincial health care plans in Canada are simply too important to the budgets and national economies of our countries. While I am not an advocate of the particular vehicle Canada has used to deal with its health care problems, the Canadians have managed to avoid what I see as the largest problem in the U.S. system — generational inequity. The reason we don't address it in the United States, or even acknowledge it, is the form of democracy we practice and the strong voting bloc of the retirees in this country.

It is interesting and, in a way, refreshing to see that we are now arguing about such things as medical savings accounts (see the article by Ed Hustead in this issue) and the length of stay for maternity cases under managed care (see the daily argument that can be found at our house on this topic). Consider this in contrast to the debates that emerged over the grandiose Clinton plan just over two years ago. A gentleman in California is reported as saying we ought to keep the government out of our health care, because he was perfectly happy with his CHAMPUS (coverage for military dependents and retirees) and his Medicare. I am glad the government was not involved in his health care.

While the Clinton plan would have changed virtually everything at once, what is occurring is an incremental change that is incredibly fast to those of us involved in health care on a daily basis but may seem very slow to those who are not. I have to give credit to Dan McCarthy who, when debating me on the speed and direction of change in 1992, predicted incremental change because, as he said, it is the American way. Of course, he was right. (For you skeptics, I say this in spite of, rather than because of, his being chairman of the board of my employer.)

The drivers of our political system are many and varied. Special interest groups, the media, PACs, and lobbyists — all have a major impact on what becomes law in this country and tend to lower the chances of rapid sweeping reform.

One of the strongest forces is the retiree contingent. One need only remember Medicare catastrophic coverage offered in the late 1980s. The law needed repealing; it promised prescription drug benefits that were far too expensive for the available funding. But, that is not why it was repealed. It was repealed because an income-related element was going to be added to the premium structure for the beneficiaries of Medicare. This was deemed totally unacceptable. Therein lies the real problem.

Actuaries are often quite successful financially and appear very comfortable in retirement. Should they get the same benefits at the same price as less financially fortunate retirees? The fact is that the level of payout they enjoy relative to taxes paid in during their working lifetimes will never be equaled by any future generation. I would love to hear from some retired actuaries on this topic.

MSAs are an interesting area for debate. Are they a great idea that can save the health care system or a vehicle that will drive the system down? Do not, however, believe that a politician is serious about dealing with U.S. health care issues until somebody comes along who proposes to deal with (or even talk about) the generational problem.

(continued on page 5)

Health care financing problems
(continued from page 3)

procedures are usually a bone of contention with managed care plans.

Following are two examples of the difficulties encountered.

Laparoscopic hernia repair. Adult hernia repair can be done either as an open procedure or by a laparoscope. The open procedure requires a large incision by the surgeon, which results in a much longer recuperation period. The ASC charge for this method is approximately $1,000, and the Medicare-approved reimbursement is $570. "Lap" hernia repair is done through two small incisions, with a recovery time of three days or less. Medicare has approved the procedure but allows for only the same reimbursement as an open procedure. The equipment required to do the procedure laparoscopically costs more than $80,000, and the disposable supplies cost more than $500 per case. Because money is lost on Medicare cases, surgeons are urged to do Medicare cases as an open procedure. A base charge of $2,400 has been established for a lap hernia repair for all other insurance carriers. Managed care plans are given the option of accepting that price or having only the open procedure for their subscribers. This is unacceptable. It allows a managed care plan to dictate the type of procedure over the surgeon's knowledge of what is best for the patient. The issue has not been resolved with some managed care plans, because they will only reimburse at whatever rate is established in the contract, normally a group 4 rate or roughly $600. In those cases, the surgeons are told to schedule their cases elsewhere.

Laparoscopic cholecystectomy. A "lap choly" permits the removal of the gall bladder using a laparoscope through two small incisions. The same equipment is used for this procedure as for the lap hernia repair, but the disposable supplies are more expensive. Because Medicare does not approve this procedure, the same problems have been encountered with managed care plans. A base charge of $2,500 has been established by the ASC for all plans. Medicare patients are refused. Again, several managed care plans have wanted to reimburse at the unlisted procedure fee (roughly, $600). This would not even cover the cost of the supplies. Patients from these plans have not been accepted. The last surgery refused on this basis was done at a hospital, and the charges were more than $7,000.

It may be naivete and wishful thinking on my part, but a new start and reconciliation among insurers, providers of services, and patients is long overdue. All parties involved should cooperate with each other, neither seeking excessive gains for themselves nor demanding a "pound of flesh" from their colleagues, clients, and suppliers. Within the recesses of my actuarial heart and mind, I devoutly hope that this can be accomplished.

Robert J. Myers was chief actuary at the Social Security Administration during 1947-1970 and deputy commissioner during 1981-1982. During 1982-1983, he served as executive director of the National Commission on Social Security Reform. Since 1993, he has been a member of the Prospective Payment Assessment Commission. He is a past president of the Society of Actuaries and lives in Silver Spring, Maryland.

AERF establishes Wooddy Scholarships

Four scholarships worth $2,000 each will be awarded for the first time in July 1996 from the new John Culver Wooddy Scholarship Fund. Administered by the Actuarial Education and Research Fund (AERF), this fund was established when Wooddy, who died in 1987, left nearly one-third of his estate to AERF to provide "scholarship aid for worthy students pursuing an actuarial education." Wooddy was active in the profession, serving two terms on the SOA Board of Governors and founding the Reinsurance Section in 1982.

Eligible undergraduate students are those who will be seniors in the semester after receiving the scholarship, are ranked in the top quartile of their class, have successfully completed at least one actuarial exam, and are nominated by a professor at their schools.

Applications are limited to one a school, and financial need is not a factor in selection. Students may obtain applications from their professors or from Paulette Haberstroh at the Society of Actuaries, 708/706-3584. Deadline for application submissions is March 31, 1996.

Editorial
(continued from page 2)

Canada has solved the generational problem by providing the same coverage for every citizen, regardless of age. Their workers today do not have to bear the burden of demands for more care by the retired population. Maybe Canada's system would work in the United States. Or, maybe Americans will be driven to it through cost increases that cannot be controlled because of the demands of the generation that votes.