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DIGEST OF DISCUSSION AT CONCURRENT SESSIONS

HEALTH INSURANCE AND HEALTH CARE

1. Outlook for, and impact of, health maintenance organizations (HMO's) on the delivery of medical care. (The changes occurring in patterns of medical care; the extent and sponsorship of HMO activity; the likelihood of success, or results being observed—impact on medical costs, utilization; status of legislation; insurance company involvement.)
2. Current status of proposals for United States national health care legislation. (The political climate; response to the HIAA proposals; relationship of AMA, AHA, administration, and other proposals and activity; changes in insurance benefits needed and occurring.)
3. Medical care costs. (Trends being observed; impact of stabilization controls; opportunities and methods for insurer monitoring in cost control.)
4. Experience in Canada. (Quality of service, medical costs, cost to the taxpayer, changes occurring in the delivery of care: comparisons with original expectations; comparisons with the United States and other countries; how insurers have responded; the role of actuaries.)

CHAIRMAN WILLIAM W. KEFFER: Our purpose this afternoon is to discuss developments in health insurance and health care. It is important to recognize right at the start that in this field we can no longer confine ourselves to considerations of insurance alone; for those of us who are involved in health insurance, our future is bound up in what happens to the health care delivery system in this country and in Canada in all aspects, not just in its financing.

Health care is a big business, and some say that it may soon represent the biggest major allocation of our national resources or national income. I am not the one to get into a statistical argument of this sort with this group here today, but the numbers as they apply to the insurance industry are impressive.

There are now over 100 million people in the United States with some form of private health insurance, not counting the Blues, and, in case there are any Blue Cross actuaries present, the Blues add another 70 or 80 million. Health insurance benefit payments for health care (not including loss of income benefits) are currently running at $8–$9 billion per year, again without the Blues—and it is interesting to me that this is in the same general range as the level of death payments and matured endowments paid by life insurance companies in the United States last year.

Among the twenty-five largest life insurers (by life insurance in force) in the United States, group accident and health premium last year represented almost 30 per cent of total life company premium income—and for some companies, such as my own, this total ranged up to more than 50 per cent.

Thus, many of us have a considerable stake in what is happening to health care and health insurance these days—and plenty is happening. We must be alert and responsive to these changes.

The *Harvard Business Review* is not exactly a scandal sheet, but I am reminded of one of the scare stories that occasionally appear there. Recently, one of the authors traced the miraculous escapes of the oil industry from obsolescence as the uses of oil progressed from patent medicine to lighting to gasoline engines to oil heating for homes and then to the development of natural gas. Companies which did not keep pace with these changes lost important opportunities or even their whole businesses. The message for us is clear. There is no guarantee against obsolescence of our health insurance products.

There are several ways to prepare ourselves for changes in the health care system. We can (1) learn from the experience of others; (2) analyze our own experience; (3) experiment with new and broader forms of health insurance; and (4) go beyond insurance to become involved in the whole health care process—the political aspects, the delivery of health care itself, and the regulation and control of health care.

ROBERT D. EILERS:* There now is ample support for the assumption that, if private insurers are to have any key role in the financing of health care in the late 1970's, they will have to have demonstrated by the mid-1970's that they have taken a lead position in producing a more rational and efficient health delivery system than now prevails. Until very recent years, insurers did not acknowledge that they had a role in health care delivery, let alone responsibility and accountability for producing an efficient delivery system. Nevertheless, such responsibility and accountability unquestionably form a part of the scene in which significant political decisions will be made within a very few years. This creates an enormous and largely new burden for private health insurers.

It now seems self-evident that the major components of the health delivery system, and physicians in particular, will not produce changes, or even health delivery options—such as health insurance organizations—with sufficient speed to satisfy consumer demands and congressional

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expectations. If private insurers also evidence an unwillingness to use their resources and their leverage to develop widespread options for consumers who prefer to obtain health care in ways other than through the traditional system, this will be further evidence to many in Congress that the private sector is inept. The associated conclusion could well be that private insurers should not have a role in the financing and delivery of health care in a national health insurance program.

Health maintenance organizations (HMO's) offer a major opportunity for insurers to identify themselves in a positive manner with reorganization efforts in the health delivery system. In this regard, the failure of the Ninety-second Congress to pass an HMO bill may be a blessing for insurers, at least in states where HMO's currently are allowed. That is, since extensive developmental funds for HMO's were not passed by Congress, insurers can obtain credit for their HMO activity without sharing plaudits with the government. Indeed, there is some reason to anticipate that private insurers may have very limited, if any, involvement in many governmentally financed HMO's. This possibility follows from the fact that a substantial amount of initial governmental support in HMO development will be directed toward plans for the poor. The consumerism likely to be associated with the development of such HMO's could well preclude private carriers from assuming many roles for which they are competent.

Thus insurance companies and Blue plans will have to move rapidly if they are to gain a substantial foothold in the HMO field—a development that would greatly enhance the reputations of these carriers in many sectors and would add importantly to their political position.

Probably only a small proportion of the total population will be HMO subscribers during the 1970's. Nevertheless, there is growing recognition that if only 10–20 per cent of the inhabitants in a community enroll in HMO's, substantial pressures will be exerted on the traditional delivery system both for cost control and for providing care in a manner that is more congenial to consumer desires. At the same time, the efficiencies of HMO's in financing a substantially greater proportion of consumers' health care expenditures than does traditional coverage at comparable premiums, and the acceptance by HMO's of responsibility for co-ordination and availability of care, weigh heavily in the eventual favoring of HMO's by an increasingly large segment of the population.

As the nation moves inexorably toward the enactment of national health insurance, it appears almost certain that any program of national health insurance (except a plan embodying only catastrophic coverage or one adhering to the proposal of the American Medical Association) will

stress the importance of HMO's, although not mandating protection under this kind of organization for the entire populace. Again, there is reason to believe that the roles available to private insurers under a national health insurance scheme will be dependent to no small extent on the success these insurers have had in establishing and promoting a nationwide network of HMO's. This undoubtedly is one of the factors that has prompted Blue Cross, in co-operation with Blue Shield, to make a commitment to have established 300 HMO's by 1980. At the same time, several major insurance companies reportedly are expecting to be the principal force behind the establishment of HMO's at the rate of two to four organizations each year during the remainder of the decade.

Although private insurers obviously have the capacity to assume several roles in connection with HMO's, no set pattern has emerged, nor is one likely, inasmuch as the extent of insurer involvement in a particular HMO depends on the nature of the financial commitment to the organization, the extensiveness of the population already served by the carrier, and the political conditions in the community, not to mention the carriers' own desires. Blue plans have one-third to one-half or more of the population covered under traditional arrangements in many major cities; hence the Blue plans undoubtedly could support an HMO or a system of HMO's in some areas without co-operation from other carriers. Few insurance companies, however, have a sufficiently large cadre of policyholders in most cities to be able to populate more than a very modest-sized HMO, particularly since HMO protection certainly will be available under a dual-choice arrangement in most cases (and many eligible employees will not opt for the HMO). Even if an insurer could provide sufficient enrollment for an HMO from its current group and individual policyholders, it may be well advised to assume a posture with regard to the HMO which does not involve direct ownership or even the use of the insurer's name in the HMO. In many instances the lower profile will be advantageous to insurers in obtaining the support of provider groups and of other insurers who could make a dual-choice option available for the HMO. Nevertheless, insurers who are willing to provide substantial capital support for the planning and facilities construction required by an HMO, and who will provide operational subsidies or at least minimum enrollment commitments, will be in a position to influence strongly major policy decisions by the HMO.

In most instances insurers who are associated with HMO's will have much less of a risk-bearing role than has been the case in traditional coverage. The three principal financial risks faced by an HMO are that it will (1) enroll too few subscribers, (2) incur adverse selection on the part

of those who enroll, or (3) be subjected to epidemics, such as widespread disability on account of the flu. The second and third types of risks are those traditionally borne by private insurers in their health insurance contracts. At least new and small HMO's in most instances undoubtedly will want to procure some form of reinsurance against the epidemic type of risk from one or more carriers. The adverse selection risk, however, must be borne largely by the HMO itself, lest the central theme of the HMO and its cost-control potential be impaired. This follows from the assumption that physicians (or physician groups) and possibly hospitals involved in an HMO must share part of the risk pertaining to excessive demands for care, since this is the incentive the providers have for ensuring that unnecessary hospitalization and surgery are reduced if not eliminated. The first type of risk, namely, that an HMO will not have sufficient enrollees to cover its costs, can be met by private insurers without jeopardizing the HMO concept, and enrollment guarantees are a principal vehicle in this regard.

Perhaps no aspect of HMO operations (including physician staffing) is more difficult to carry out than marketing. The options available for the marketing of HMO coverage include independent marketing by an HMO; marketing through a regional co-ordinating agency, or "umbrella"; and the use of one or more private insurers. Independent marketing by HMO's will be extremely difficult in most areas, except possibly in locations where a few major employers account for the bulk of a sizable labor force. Since nine out of ten individuals in the United States labor force now have private health insurance, and the bulk of these have obtained it through group coverage, an HMO which seeks to market independently will have to persuade employers to enter into separate dual-choice arrangements, that is, a dual choice that involves the present insurer and also the HMO. For all but the very smallest employers, this approach necessitates contracts with many HMO's if all employees are to be given the dual-choice option. It seems highly unlikely that most employers will look favorably on the additional administrative burdens that are involved.

Umbrella organizations for HMO's have been planned in several cities, notably Baltimore, Philadelphia, and Minneapolis. In some instances these organizations anticipate being marketing clearinghouses for HMO coverage, whereby employers or carriers desiring to offer dual choice will contract with the umbrella organization. The organization also will have contractual relationships with the HMO's in the area. This marketing approach poses a number of significant problems, particularly since its effectiveness relies heavily on the willingness of most HMO's in the area

to utilize the umbrella as the principal marketing device. In all probability, however, many HMO's will prefer to deal directly with insurers, and possibly employers, for marketing purposes. This preference may hinge in part on the fact that a carrier has provided capital support or is willing to make a commitment of a minimum number of enrollees. Thus the goal of the umbrella organizations seems likely to be thwarted if these organizations see themselves as the principal marketing co-ordinators. This is perhaps the reason that the Minneapolis umbrella group decided not to be involved in direct marketing but rather to provide planning and technical services, as well as to be a co-ordinating agency for other aspects of HMO operations.

When private insurers undertake the marketing of HMO coverage, either exclusive insurer or multiple insurer marketing is possible. Most Blue plans, and perhaps a number of insurance companies, seem to prefer exclusive marketing arrangements whereby they are the sole marketers for the HMO. The trend in emerging HMO's, however, appears to be one in which a number of carriers are allowed to market the coverage. One concern here is that multiple insurer marketing will not produce the firm commitment and aggressive support from individual insurers that would occur under an exclusive insurer marketing arrangement.

Multiple insurer marketing raises questions concerning insurance companies in particular. Most companies, in spite of a formal posture of co-operation with one another, still seem leery of full-fledged co-operation, particularly if one carrier has been the driving force behind an HMO. As yet the insurance companies have not developed a clearinghouse system, and the original idea of a co-ordinating corporation under the auspices of the Health Insurance Association of America has been scrapped. While antitrust possibilities and other considerations are important, one can only conclude that the insurance companies will lose a substantial part of their potential thrust in the HMO arena if they fail to develop both closer co-operation with one another in individual cities and a definitive clearinghouse for claims and other purposes on a national basis. Without such arrangements, it will be impossible for large employers to offer dual choice to all their employees through insurance companies. The Blue plans, on the other hand, appear to be much more willing to co-operate in developing an extensive network for HMO operations and, if successful in doing so, will surely gain a substantial competitive edge with regard to HMO's.

As has been mentioned, the Blue plans already have a competitive advantage in many large cities, because of the large proportion of the population enrolled. If 10–20 per cent of the Blue Cross/Blue Shield

subscribers in such cities opted for HMO coverage, it would be sufficient to support a large HMO with satellite centers or, alternatively, a number of HMO's in the community. One of the potential weaknesses in the Blue plan involvement in HMO's has been the dubious support given to the HMO movement by Blue Shield plans. More of these plans appear, however, to be willing to co-operate with Blue Cross, although Blue Shield generally is less active in the establishment of HMO's.

The Blue plan advantage in developing a nationwide HMO marketing network is offset, on the other hand, by the enormous amount of capital which insurance companies could devote to HMO development if they chose to do so. While Blue plans can utilize part of their reserves for HMO development, in most areas the capital and operational support necessary for HMO's will have to rely on funds beyond those that could be provided by the Blue plans. This is not to say, however, that Blue plans cannot be instrumental in helping to obtain funds from other sources.

The national interest in HMO's and, more importantly, the imminent passage of a national health insurance plan make it almost certain that there will be some federal regulation of health insurance, including HMO's. The recently passed H.R. 1, with its implications for HMO coverage of Medicaid and Medicare populations, perhaps indicates the start of a much more comprehensive HMO regulatory purview at the federal level.

One of the critical issues yet remaining with regard to federal involvement is the extent to which federal laws will pre-empt state laws which prohibit or discourage the formation of HMO's. It appeared for a while that committee compromises in the Ninety-second Congress would foster pre-emption only for federally financed HMO's. Such an illogical approach would have had the effect of precluding the availability of HMO coverage to most of the people in states with restrictive legislation. A much broader pre-emption of obstructive state laws is necessary if all Americans are to have an opportunity to choose to have their health care financed and delivered through an HMO.

Another important issue is the extent to which congressional action will force some form of community rating on HMO's. It seems far better for this issue to be resolved in the context of national health insurance legislation than in statutes pertaining to HMO's. If HMO's are forced to community-rate all, or a large number, of their enrollees, such constraint can only be viewed as a severe hindrance to the development and expansion of HMO's. The attendant increase in HMO premiums will render the organizations unattractive to many persons having a dual-

choice option. Then, too, the comprehensiveness of benefits that might be required for HMO's in any federal legislation is a cause for serious concern. Again, this matter should be resolved in a way that applies to all private coverage and not just to that provided through HMO arrangements. An HMO can be price-competitive and hence attractive to group and individual purchasers only if it is allowed to provide a realistic array of benefits.

Of equal concern is the manner in which federal legislation will handle HMO savings or "profits." The H.R. 1 bill which was passed mandates that savings realized by established HMO's on Medicare subscribers be shared 50-50 with the government down to the point where the HMO costs are 80 per cent of those prevailing for a matched set of HMO subscribers in the area. (H.R. 1 reimburses *new* HMO's on the basis of costs for Medicare subscribers.) Any attempt of federal legislation to pay HMO's generally on a cost basis would be detrimental to HMO development, since at least a large portion of any HMO savings should be shared with subscribers in the form of increased benefits, maintained by the HMO for its own reserves or expansion needs, or shared with the HMO sponsors, physicians, and hospitals.

Finally, it is imperative that federal regulation encourage the development of competing systems of HMO's There should be no territorial monopolies, lest individual HMO's become unresponsive to consumer needs and desires. Private insurers, in their HMO developmental efforts and marketing relationships, can help ensure that there will be competing HMO's at least in urban areas.

In spite of optimism concerning the ability of private insurers to assume a dominant role regarding HMO's, most carriers seem to be moving far too cautiously regarding these organizations. Much greater developmental effort is needed, including capital and operational support, technical services, and the establishment of a rational marketing system. The challenge to Blue Cross and Blue Shield is intense, as these plans have no other business to fall back on if they lose their role in health care financing. The challenge to insurance companies extends even beyond their health insurance business. One might postulate that, if private insurer effort in reorienting the health care system is so ineffective that private insurers are given no significant role in a national health insurance scheme, the appropriateness of private insurer effort in fields other than health insurance seems certain also to be questioned. One need not be a prophet of doom to envision that the loss of private insurer involvement in purveying health insurance would almost certainly portend the advent of conditions in which the public sector could absorb part, if not much, of

the private market for group life insurance, disability income coverage, and pensions. Many insurers seem to be finding momentary comfort in putting on blinders relative to this forecast; indeed, those who express it are often assailed as anti-insurance company, anti-Blue Cross/Blue Shield, or anti-private insurers. Quite to the contrary, wise insurers—whether insurance companies or Blue plans—will heed the warning voiced by J. Henry Smith: "Our companies will significantly 'stay in business' only by developing effective participation in the organized delivery of services, essentially HMO's."

MR. DANIEL W. PETTENGILL: I would like to comment first on the current status of the proposals for United States national health care legislation. You may recall that at this time a year ago the House Ways and Means Committee was holding hearings on national health insurance and that many of us expected that the House would pass a national health insurance bill of some sort in the spring of 1972. Fortunately or unfortunately, depending upon your point of view, the House Ways and Means Committee never reported out a national health insurance bill. Consequently, no action on this important issue was ever taken by the Ninety-second Congress. Nevertheless, the Ninety-second Congress did pass two bills which have a bearing on the national health insurance issue.

The first of these is the Comprehensive Health Manpower Training Act of 1971, which provides special grants to schools that try innovative experiments in training manpower for the health care field. The second bill is the omnibus bill, H.R. 1, which, among other things, extends Medicare to social security disability beneficiaries after they have been disabled twenty-four months.

The Manpower Training Act is a definitely desirable piece of legislation and is wholly consistent with the principles, if not the details, of the Health Insurance Association of America's Healthcare program. The extension of Medicare to the social security disability beneficiaries is a mixed blessing. There is no denying that many of these beneficiaries need the coverage. On the other hand, the bill has opened a crack through which more compulsory federal coverage of persons below age 65 may eventually take place. Unfortunately, the bill will discourage the continuation of coverage for the disabled under regular group policies, one of the objectives of the Healthcare program.

So much for the past. Now the question is, What is going to happen to national health insurance in the Ninety-third Congress, which will convene in January, 1973?

The answer appears to be a resounding "nothing," unless the insurance industry shakes off its lethargy and stirs up grass-roots support for its Healthcare program so that Congress is prodded into taking action. Even with such pressure, there is very little likelihood that the House would act before late 1973, with concurrence by the Senate coming in 1974. The reasons for this are, first, that the Ninety-third Congress is expected to be a relatively conservative Congress, and such congresses preserve the status quo unless they are forced to do otherwise by the electorate. Second, there are other problems to which most people assign a higher priority than to health insurance, namely, a revision of the federal income tax law and tariff bills regulating international trade. If these other bills can be successfully disposed of in the first session of the Ninety-third Congress, then, assuming that the insurance industry does make a real effort to get grass-roots support, there is hope that a sound national health insurance bill could be enacted in 1974 or 1975.

It should be realized that many of the principles of the HIAA's Healthcare bill are compatible with those of the respective bills sponsored by the American Medical Association, the American Hospital Association, and the Nixon administration. However, there seems to be little likelihood that a uniform position will be taken by these various diverse interests now that the threat of a federal takeover, such as is contemplated by Senator Kennedy's Health Security Act, has greatly diminished.

Some people feel that the insurance business should sit back, relax, and enjoy this brief respite. I maintain that we can ill afford to do so, because, when the pendulum starts swinging back to the left and a Kennedy-type bill again becomes popular, it may be too late for us to muster adequate support to defeat it. However, if we persuade Congress to take positive action to establish private health insurance as the preferred means of covering the vast majority of people, the adoption of a monopolistic federal program should then be much more difficult to bring about. Thus I urge all of you to consider this matter and, if you are like-minded, to work hard to get the Ninety-third Congress to take such appropriate action.

In addition, those of us who are directly concerned with health insurance should work to broaden the scope of existing health insurance plans, particularly with respect to ambulatory care.

We also need to be certain that all health insurance plans include substantial coverage for medical catastrophes. In this regard, I trust you are aware that a number of insurance companies have already increased the maximum benefit they offer under major medical plans to at least $250,000. If your company has not already done so, you should endeavor

to see that it takes such action promptly, because there still exists very strong support in Congress for a national catastrophe plan. Indeed, some congressmen, who are normally staunch defenders of private enterprise, firmly believe that there should be a federal catastrophe benefit financed by social security payroll taxes. In their view, such a program not only would assure everyone that he would not be financially ruined by a serious illness or accident but also would diminish the likelihood that a Kennedy-type bill would ever be enacted. I do not agree with this view. The nation came close to having Senator Long's catastrophe bill passed this year. One reason it did not pass was that a few insurance companies began offering very high maximum benefits under major medical plans. However, this tactic will not permanently defeat the Long bill unless essentially all companies not only offer high-limit major medical benefits but actually sell them to essentially all their policyholders. In this connection, I am pleased to be able to report to you that the Government-wide Indemnity Benefit Plan, which my company administers on behalf of the insurance industry, will provide a $250,000 lifetime maximum, effective January 1, 1973, for those federal employees who subscribe to it.

I shall now comment on the subject of medical care costs. Insurers need not only to provide the public with broader and better benefits but also to find effective means of controlling medical care costs. This is true despite the fact that in the first six months of 1972 the president's price control program cut the annual rate of increase in hospital semi-private room charges from 12.2 to 7.1 per cent and cut the annual rise in physicians' fees from 7 to 2.6 per cent. These smaller price increases, although important, are nevertheless deceiving. First of all, hospitals have not been able to make a comparable reduction in their actual operating costs. These are still increasing at a rate of about 12 per cent a year. Hence there should be very sharp hospital price increases in 1973 if the hospitals are not to incur heavy deficits. Furthermore, physicians are not likely to accept for very long a rate of increase in their fees that is less than that for the consumer price index as a whole.

As we all know, costs depend not only on price but also on utilization. As far as hospitals are concerned, the incidence of confinement is increasing, but the average duration is decreasing, the resultant utilization being about the same or slightly less. This would be an encouraging sign, were it not for the fact that there has been a slight increase in the total number of hospital beds available and a decrease in the hospitals' occupancy rate. A drop in occupancy rate without any decrease in a hospital's fixed overhead expenses will also force an ultimate increase in the hospi-

tal's charges. Thus, despite the price freeze, the battle to control rising hospital costs remains either unchanged or worsening.

With respect to physicians' services, it should be borne in mind that a physician can keep his fee schedule unchanged but increase his income by providing either more expensive services or additional services. It is too early to tell whether and to what extent such a change or increase in utilization is occurring in this area.

One thing is clear: We do not have to wait until we have a national health insurance program to take action to control health care costs. In the area of physicians' services, we can and should encourage the professionals to establish utilization guidelines which the carriers can then use for purposes of screening claims. Claims which fall within the guidelines can generally be assumed to be medically necessary and hence can be paid promptly, provided that the fee charged for a particular service is within the prevailing range of fees for that service in that community. For those relatively few cases which fall outside the guidelines, insurers need to encourage medical societies to establish effective peer review committees that will give the carriers competent advice as to whether the service was medically necessary and, in the case of unusual procedures, whether the fee charged could be said to be within the prevailing range.

As you may have noticed from the press, and as my company has found out firsthand, this matter of peer review is a very sensitive one. Certainly the carriers must make it clear to physicians that the responsibility for determining benefits under an insurance plan rests with the carrier and cannot be delegated to a peer review committee. On the other hand, both the patient and the physician will be better served if the physician's peers are willing to stand up and be counted as to what really constitutes good medicine and what does not. Where physicians are willing to do this, then, in my judgment, health insurers should give very careful consideration, in determining their liabilities, to the advice of such physicians.

With respect to the charges of hospitals and other health care institutions, a denial of benefits based on an after-the-fact review of services rendered is not helpful to either the patient or the institution, because the services and supplies that have already been expended constitute an economic loss to someone. In my judgment, the solution to this problem is the establishment of prospective rate review or, if you prefer, controlled charges. In order for such a system to be effective, each state must establish some sort of a health care institution rate review mechanism to which each health care institution must submit its financial results for

prior years, its proposed budget for the ensuing year, and its proposed scale of charges to raise that budget. The institution would also have to assure the state reviewing agency that all its capital expenditures had had prior approval by the appropriate comprehensive health planning agency and that its utilization was being effectively controlled by its management on the basis of monitoring by a competent utilization review committee. Where the foregoing conditions were met and the proposed scale of charges was reasonable in relation to the budget and the services to be provided, the scale of charges would be approved for use for a period of time such as one year. Furthermore, that scale of rates would have to be used for all patients, regardless of whether they were insured or not and regardless of who their insurer might be. This approach not only eliminates discrimination between various classes of patients but also assures the efficient hospital of an adequate income to meet its expenses and to provide a modest surplus for future improvements.

In addition to the foregoing actions that can be taken to control costs, there is now ample evidence that much of the minor surgery performed on an inpatient basis could be performed equally effectively on an ambulatory basis and at considerably less cost. The same is true with respect to many diagnostic X-rays and laboratory tests. Thus we need to encourage the development of ambulatory health care facilities and the manpower to staff them. Furthermore, insurers need to offer and sell ambulatory care benefits to cover the charges of these ambulatory health care facilities.

Another thing that most of us can do is to serve on comprehensive health planning councils and hence ensure that future facilities and services are so distributed that all Americans will have reasonable access to quality health care. What I have said represents action that can be taken by insurers to control or alleviate rising medical care costs without actually getting into the delivery of health care itself. However, there is a strong possibility that the successful health insurer of the future will be one that is involved in the delivery as well as the insuring of health care. Thus I would close with a quick comment on HMO's. HMO's are not utopia, nor are they the only solution to our health care problems. Nevertheless, they do offer a viable combination of delivery and financing and hence are worthy of careful exploration.

MR. CECIL G. WHITE: Our audience may be interested in a brief résumé of the history of governmental activities in connection with hospital and doctors' care programs in Canada. Although three western

provinces had already instituted government-operated hospital care programs that were available to all residents, the enactment by the federal government in 1957 of legislation under which the federal government offered to share approximately one-half the cost of approved provincial hospital care programs greatly accelerated the establishment of such plans in the other provinces. Generally speaking, the provinces with smaller populations and revenues to match received more than one-half the cost of their respective programs from the federal treasury, and they were very prompt to accept the federal offer. The two major provinces, Ontario and Quebec, were the last to institute hospital care programs and did so in 1959 and 1960, respectively.

All these programs provide unlimited care at the standard ward level and related special services in active treatment and convalescent hospitals, and also outpatient services, for all residents. They also provide stipulated benefits in the event that the resident receives care outside his home province. The methods of funding the provincial share of these programs vary from province to province, the majority being paid from general revenues. One or two provinces have specific personal taxes. One or two other provinces began their funding with specific increases in the rates of sales taxes, corporation taxes, and personal income tax. Some of the provinces have included coverage for the costs of services of other health practitioners, such as optometrists, chiropractors, and podiatrists, although the costs of these services are not shared by the federal government. This means that there are variations in these government programs from province to province. None of the programs covers regular dental care or prescription drugs. All the hospital care programs include necessary nursing services in hospital.

These government programs are now reasonably well accepted by the people of Canada and by the doctors and others involved in providing health care. There are relatively few discussions nowadays about the philosophy of the programs. Although there are long waiting lists for admission to hospital, and some patients wait for months, nevertheless emergency care and care of a high-priority nature are given as required. Increased use of active treatment beds has contributed to increasing costs and has sharpened realization of the need to provide larger facilities for convalescent and chronic care in order to relieve the pressure on active treatment beds. The trend among doctors toward basing their practices in the hospital has been accelerated. This trend has had a serious adverse effect in some rural areas and small towns, where often there are no longer any practicing doctors, although before "Medicare" there may have been several in the same small community.

In connection with doctors' care, the chief items of discussion relate to the levels of the fees for service and the earnings of doctors. As might be expected, in general the introduction of the various doctors' care programs resulted in sizable increases in doctors' incomes. Several provincial governments are looking very carefully at the level of doctors' incomes. Some feeling is developing that the fee-for-service principle should be replaced by some other system for compensating doctors under the government programs.

The costs of the existing programs are high and are increasing by large percentage amounts each year—the annual rate of increase is over 11 per cent. To quote the Canadian minister of national health and welfare: "Personal health expenditures in Canada are among the highest in the world and are continuing to escalate at an alarming rate." In the beginning, the trend of steeply rising costs represented the results of hospital workers' earnings catching up with the rest of the economy. However, the increasing costs and complexity of medical technology, combined with increasing utilization of hospitals and doctors' services, have caused the sharp upward trend in costs to continue. The explosive trend to "machine medicine" has had a large impact on rising costs. For example, in Ontario the patient load in hospitals increased by 16 per cent from 1968 to 1970, but the use of laboratory services increased by more than 300 per cent. Moreover, the existing cost-sharing arrangements are oriented toward high-cost services—they encourage the use of doctors' services instead of the services of qualified but less highly trained personnel. Hospital budgets are centrally controlled in each province by an agency of the provincial government. Although doctors' fees are determined by the profession, they are being more closely scrutinized by provincial governments with every passing year.

There is general agreement that the government programs have removed financial barriers to the receipt of hospital and doctors' care. However, from time to time there is some tendency for attention to be focused on the rising costs of prescription drugs. Also, some suggestions are made with regard to the need for dental care programs, perhaps to begin with children. In all likelihood, the level and trend of costs associated with the existing government programs are the chief factors that act to deter any extension of these programs into the other areas, such as dental care or prescription drugs. Moreover, with the federal government now wishing to change the sharing of costs of existing programs, the provinces face the possibility of having to meet the entire cost on their own. The provinces are already fully responsible for the costs of education at all levels. If the percentage of the gross national product devoted to

health and education costs continues to increase at present rates, this percentage will reach 100 per cent of the Canadian gross national product by the year 2000.

What has been the role of the insurance industry and the actuarial profession in these developments? The spread of private coverage for the costs of hospital and doctors' care varied greatly from province to province during the 1950's and the 1960's. In the more populous industrialized provinces, like Quebec, Ontario, and British Columbia, group insurance combined with individual coverages, underwritten by insurance companies and Blue Cross/Blue Shield-type plans, provided protection for high percentages of the residents. The extent of coverage was greater for doctors' care than for hospital care, partly because of the activities of doctor-sponsored prepaid programs. The benefits in many policies were rather limited in nature.

The insurance industry preached the gospel of "true insurance" versus budgeting as a reason for its unwillingness to provide complete coverage on a first-dollar basis, especially for doctors' care. However, the gospel of "true insurance" seemed to have a lot of caveats in the form of maximum annual limits, maximum lifetime limits, and numerous "inside" limits. Many of these limits had little effect on price, were a nuisance in claim administration, and were bad for policyholder relations. During the 1950's and the 1960's it was quite evident that Canadians wanted complete coverage on a first-dollar basis. In the area of doctors' care, the prepaid plans provided this kind of coverage. The insurance companies eventually followed suit, but too late, because the government was about to move in. The point is that, when people want a certain kind of coverage, they will take steps to get it—and they will get it from government sources if private sources are not prepared to make it available.

MR. WILLIAM HSIAO: Would Dr. Eilers care to comment on the advantages and disadvantages of the HIAA Healthcare proposal as he sees it?

DR. EILERS: The HIAA's proposal for national health insurance, although meritorious in many regards, contains a critical weakness—the failure to make the purchase of a minimum level of benefits compulsory for the nation's employers. The income tax credits incorporated in the HIAA plan would encourage most large employers to meet the minimum benefits standards, inasmuch as a slight increase in premium, if any, on the part of these employers would entitle them to the tax

credit for the premium paid. On the other hand, smaller employers—the group whose current health coverages tend to be least adequate—would have little incentive for purchasing the minimum level of benefits, because the increased premiums necessary to reach the minimum level would more than outweigh the potential tax credit. Thus the portion of our nation's citizenry currently possessing the least adequate group insurance benefits would continue to be substantially underinsured.

Among the laudable aspects of the HIAA proposal is the realistic phasing-in of benefits. Some national health insurance proposals incorporate such comprehensive benefits that it is highly unlikely that the current health delivery arrangements in the United States could possibly deliver the magnitude of benefits anticipated. The increase in demand for health services that would result from such a comprehensive plan would certainly produce enormous increases in unit costs for health care. While the supply of health services is a function of numbers of health personnel in the system and the procedural arrangements in which they are used, it is not possible to drastically alter aggregate supply in the short term. Although new delivery arrangements, such as the HMO, will help to eliminate waste and make the health system more productive by increasing aggregate supply, such changes can occur only over several, if not many, years. Thus, as we move into a national health insurance program, it is important to establish priorities among the benefits to be provided, incorporating them at the levels that are reasonable relative to the nation's ability to deliver care. It is equally important, of course, to stipulate a phase-in program in order to set timetables and deadlines for changes in the delivery system that will allow the national health insurance program to provide more comprehensive benefits.

MR. PETTENGILL: I believe that one of the major strengths of the HIAA's Healthcare program is the fact that purchase of insurance remains voluntary except in the case of federal welfare beneficiaries, for whom the government must buy coverage. I hold this view because I do not believe that we know at the present moment enough about health care to mandate for all time a given level of health insurance benefits. Medical science is not static, and what may be necessary in the way of health insurance benefits today may not be so tomorrow. It will be far easier to change a voluntary set of health insurance benefits than it would be to change a mandatory set.

This is not to say that the HIAA's program does not encourage people to buy the minimum standard of benefits established by the federal

government. The program establishes that the tax deduction for premiums for health insurance will be 100 per cent if the employer or the individual purchases a qualified plan but only 50 per cent if he does not. Many large employers have told me that they could not afford to carry a nonqualified plan if it provided them with only a 50 per cent tax deduction; hence they consider the HIAA's program to be essentially mandatory. I want you also to bear in mind the fact that under the HIAA program every health insurance carrier is required to offer the minimum standard benefits established by the federal government. Another argument for a voluntary program is the fact that there are some groups in this country whose religion might well dictate against their joining a health insurance plan.

MR. PAUL BARNHART: For almost a decade now I have been a strong advocate of high-limit catastrophe medical insurance—at times a very lonely advocate—and it is most encouraging to hear someone like Dan Pettengill supporting this concept and testifying to its great importance in the political context of national health insurance developments.

Over recent years I have urged a number of clients to consider marketing this type of insurance, and I have encountered three basic hindrances to the suggestion:

1. A fear of the magnitude of the possible risk, which I think is really somewhat irrational. Everyone is aware of the cost problems that have beset major medical insurance, and the assumption is that higher-limit insurance can only lead to even larger problems. But it has never been the *maximum* benefit that has caused the trouble—it is the front end, the first dollars spilling over the deductible. The insurance industry does not tremble at the idea of issuing $1,000,000 life insurance risks, where the entire sum becomes payable in a moment, and there is really no sound reason to be so afraid of a conceivable $250,000 catastrophe medical claim that would probably span five years or so in its development.
2. A concern over start-up costs and new business surplus drain associated with marketing of a product that could be abruptly swept out of existence by de facto federal expropriation if any of several proposed national plans were enacted. Companies are reluctant to invest money in a product that just might not survive long enough to permit recovery of the investment. This is certainly a very real risk, but it seems to me that it is not that great a price to pay if, as Dan has suggested, wide-scale marketing of such coverage could be a powerful factor in heading off a possible federal catastrophe insurance program. Isn't it worth this gamble?
3. Difficulties in finding reinsurance backup for the catastrophe risk, which

naturally leaves a smaller company very hesitant about getting into this field. The major reinsurance companies could help greatly here by providing realistic reinsurance facilities to assist smaller writers in undertaking the risk.

One feature of a truly high-limit plan that I consider essential is to move, at some point, to 100 per cent insurance of continuing expenses. It does not make sense to insure an individual up to a $250,000 limit but expect him to keep paying 20 per cent of catastrophe level expenses. He will still be bankrupted! As an example of one organization that has embraced the catastrophe protection concept, I might cite the Aid Association for Lutherans, which since July, 1970, has been marketing a medical catastrophe plan that pays without *any* maximum limit and provides for 80 per cent insurance of the first $2,500 over the deductible and 100 per cent insurance of any excess.

I would be interested in any further comment Dan would care to offer on these thoughts.

MR. PETTENGILL: Mr. Barnhart is correct in stating that comprehensive and major medical plans need to be concerned about the amounts of copayment required as well as about the amount of maximum benefit provided. In this regard, it should be noted that the HIAA's Healthcare program establishes a maximum copayment of $1,000 per year per family under qualified group plans. Lesser maximums are required under the state plans for the poor and the near-poor. In this latter instance, the maximum amount of copayment per year per family is related to the family's income and is as low as $30 per year for the poor family.

MR. EDWARD G. WENDT: Is Aetna's $250,000 major medical maximum available to both large and small groups, and are there any differences in the program by size of case?

MR. PETTENGILL: In April, 1972, Aetna Life and Casualty began offering a $250,000 lifetime maximum under its major medical plans. Previously, the largest maximum offered was $50,000. The $250,000 maximum is automatic for employers with fewer than fifty employees, existing policies being shifted to the new maximum on their first anniversary following April, 1972. The new maximum is optional for groups with fifty or more employees. Even so, an intensive effort is being made to persuade such policyholders to accept the new, larger, lifetime maximum. It is anticipated that most of Aetna's group cases will have a new maximum by the end of 1973. The major exception will be those

cases where there is an existing collectively bargained plan that does not expire until after that date.

MR. GEROLD W. FREY: Mr. Pettengill, in addition to the $250,000 major medical maximum benefit available to all sizes of group cases, we believe that the $250,000 limit is also available even in individual health insurance policies issued by your company. What kind of underwriting rules does your company use for this high major medical maximum? How do these underwriting rules vary by size of group? Do you underwrite individual lives? Do you use health statements?

MR. PETTENGILL: As far as groups with ten or more covered employees are concerned, Aetna will not use individual underwriting in connection with its new $250,000 lifetime maximum under major medical plans. To avoid adverse selection, this new lifetime maximum is the only maximum being offered groups with from ten to forty-nine employees. Admittedly there are a few types of business enterprises to which my company does not offer major medical benefits at all, but this list has not increased by reason of the adoption of the new higher limit. The group division does not handle groups with fewer than ten employees. These are handled in the individual department on either an individual or a franchise basis. Here there can be and often will be individual underwriting.

MR. FREY: You have indicated that upward cost pressures on hospitals of providing a day of care have been at least as great since August 15, 1971, as ever before and that the reduction recently brought about in the inflationary increases of hospital charges for providing services is therefore deceptive. Our findings agree with yours. We also feel very strongly that upward cost pressures on physicians and dentists have continued through the economic stabilization program period without letup; however, we find it difficult to make meaningful studies substantiating the validity of our feelings. Have you asked yourself the same question, and have you been able to develop factual support demonstrating continued cost pressures on doctors through the past year?

MR. PETTENGILL: We have considered the question but have no answer.

MR. JOHN ANGLE: Dr. Eilers, in urging insurers to sponsor a hundred new HMO's, said that the United States was still in the process of

determining what part of the nation's health care should be financed or organized in the private sector. Dr. Eilers believes that the outcome will be importantly determined by the extent to which insurers use their resources and "leverage" to constructively change our nation's health care delivery system. Dr. Eilers believes that, unless insurers act to substantially improve access to adequate health care services by the mid-1970's, the financing of health care will move to the public sector in the United States.

Let me respond by first agreeing with Dr. Eilers that insurers should aggressively involve themselves in HMO's and in other endeavors that could improve the effectiveness of our health care delivery system. I wonder, however, whether Dr. Eilers does not overstate the extent to which the burden or responsibility for improvement falls to insurers and others in the private sector. Is the public sector really that efficient and responsive to human needs? From where I sit, the nation's medical schools have both the means and the opportunity of bringing about constructive changes in the delivery of health care. I would like to know what comments Dr. Eilers would make on the performance of medical schools as a responsible example of the public sector at work in rationalizing our health care delivery system.

DR. EILERS: It is appropriate to look to medical schools to educate potential physicians about the latest types of health care delivery systems as well as about the latest advances in medical science. There are not within the medical schools, however, sufficient financial or medical resources, nor indeed is there the leverage, to make them the principal factor in producing changes in our health care delivery system. For example, the problems of developing an HMO within the setting of a medical school can be formidable. Such problems include the fact that the daily cost of care in teaching hospitals is far greater than that in most community hospitals, and incorporating the high cost of medical school hospitals could render premiums for HMO coverage noncompetitive. For this reason, medical schools involved in HMO's often have virtually to preclude a teaching relationship in the HMO and its facilities, at least during the initial establishment period. Furthermore, the politics within the medical school can make the establishment of an HMO very difficult. Then, too, marketing is a significant obstacle for an HMO associated with a medical school, and the use of existing carriers generally is necessary for the marketing function. In short, while medical schools need to be involved in HMO's—and, in the process, can have a salient influence on the new generation of physicians—it is unrealistic to expect

that a principal driving force will emanate from most medical schools as we seek to develop alternative systems to additional health care delivery arrangements.

MR. BARNHART: It seems to me that there is much to commend an HMO program developed around individual practice participating providers, as distinct from group practice organizations. Some of the potential advantages of this form of HMO program would seem to be the following:

1. There is less resistance from doctors themselves, since it would be possible to retain most of the individual private practice concept, while still applying effective cost and utilization control, minimizing of unnecessary hospitalization and surgery, and the like.
2. Far less initial capital investment is needed to start up the program, since the manpower and facilities are already there and operating, and all that is necessary is to set up the administrative organization and the rules and standards of participation.
3. There is decentralized, local availability of care, in contrast to the case of a central clinic or health care facility. This feature should make the approach particularly feasible for small town or rural HMO development.
4. There is a reduction in minimum enrollment requirements to enable an HMO program to get off the ground. I would appreciate any comments Dr. Eilers might wish to offer on this.

DR. EILERS: Mr. Barnhart suggests appropriately that organizations and individuals who are involved in the planning of HMO's should be willing to consider physicians' staffing arrangements that may differ from the classical HMO approach in this regard, namely, closed-panel, salary- or capitation-paid physicians. There are indications that an open-panel approach may be workable in certain settings. Moreover, the fee-for-service approach for the payment of individual physicians working in an HMO can be used with some modifications. The principal modification necessary if fee-for-service payment is to be used is the obtaining of a commitment on the part of co-operating physicians to accept less than full fees in the event that the utilization of services exceeds that anticipated. Several of my colleagues and I at the University of Pennsylvania have developed a fee-for-service system of this sort for compensating physicians who are providing primary care in an HMO.

Compensation arrangements for physicians delivering primary care need to be carefully integrated with the compensation of specialists in

any open-panel or modified closed-panel arrangement, lest there be a financial incentive for patients to be shunted between these two general groups of providers.

Regardless of the basic method of compensation of physicians, there are strong arguments for sharing with participating physicians some of the savings that an HMO realizes through a reduction in hospitalization and surgical procedures.

MR. GEORGE B. TROTTA: I would like to comment on the position in which the insurance industry finds itself as a result of the numerous national health insurance proposals which have been made.

Have any of you sensed recently that our industry may be adopting an overly defensive posture whenever the question of inadequate medical care comes up? Do you feel, as I sometimes do, that we may be beginning to develop a subconscious guilt complex on this over-all question? While many outside the industry go about advocating panacea health care plans at unrealistic bargain-basement rates, industry actuaries reply in terms of the Society's motto. But health care has become a choice political topic, and I am afraid that its ultimate form will be forged more by the rhetoric of "appearances and impressions" than by the logic of "facts and demonstrations." In a political arena the actuary may come out a poor second.

Let us examine more closely some of the charges being made against the insurance industry.

1. "The industry doesn't provide adequate health insurance coverage; too often, policies leave the insured with distressingly large unpaid medical bills."

We don't provide? Can you imagine telling a large group policyholder that your company has just made an analysis of his medical care plan and determined it to be inadequate and that unilaterally we are going to liberalize it? The monthly premium which he is now paying will have to be doubled starting two months hence. We are sorry about this problem, but it is simply one that he will have to live with. We admit that he closed down some of his plants recently in an attempt to keep the corporation solvent; we are also aware that the company is deferring capital projects because of lack of funds, but we will not be able to accept these as excuses. The billing rate will simply have to be doubled, starting immediately. The policyholder's answer would probably be, "Thank you very much for your information. We will bring it to the attention of our

next group insurance carrier, which we expect will replace you in about 60 days."

Those who attack most vociferously the insurance industry's allegedly poor production record in the health care area never have to worry about such practical things as operating within the limitations of the premiums which a policyholder is willing or able to expend for health insurance. As an actuary, it is often frustrating to have to worry about such things as adequacy and equity in premium structure. If we could make up any deficit resulting from our health insurance experience, regardless of the magnitude, through the magic of taxing powers as exercised at the various governmental levels, we, too, could devise health care packages for our policyholders which would be as grandiose and creative as any of those publicized in the mass media. If any policyholder commented that he couldn't afford them, our answer would be simple: "Don't worry about it; contribute what you can, and we'll get the rest from a special tax on tissue paper, underwear, and Easter eggs."

2. "Health insurance plans encourage inferior-quality medical service; they also encourage wasteful and expensive medical care."

In the insurance companies' interaction with physician or hospital and patient, we play many parts—for example, risk-bearing underwriter, claims administrator, actuary, and consultant. One thing that we do not do is to actually provide medical care. I know of no Metropolitan Life General Hospital, nor have I heard of any Prudential Insurance Medical Society. We do an extensive amount of claims control work, attempting to determine what medical charges and services are reasonable, customary, and necessary. However, listening to our critics, one gets the idea that we should actually be policing the medical profession, waiving the practical fact that we have no authority to do so. Can you imagine saying to a hospital administrator, "We have just made a medical and statistical analysis of the hysterectomies performed in this hospital in the last two years, and we are sorry to say that we find that too many of them were unnecessary. As a matter of fact, you didn't fare too well with tonsillectomies or gallbladders, either. Result? As probationary punishment, you must close this hospital for six months. We will allow you to keep the outpatient department open, but you should be warned that we are currently making a study of that department."

Absurd as this hypothetical case may be, it seems to me that the logic of the charges against us assumes that we are capable of performing the farcical acts to which I just alluded.

3. "The industry has lost the capacity to experiment and create unless assured of a favorable financial return."

Obviously, those who talk about our reluctance to experiment unless we are assured of a winner know very little of the far-from-favorable experience on significant amounts of long-term disability business which has been underwritten in the last five years. (To those on the "in," LTD often stands for "long-term debacle.") Nonetheless, the industry continues almost daily to experiment with such coverages as dental insurance, prescription drugs, vision care, major medical catastrophe provisions, and the like. The comprehensive range of medical protection which we offer today reflects our continuation of past experiments.

4. "Support of the fee-for-service approach to medical payments is contributing greatly to the over-all national health problem."

Without arguing the pros and cons of the fee-for-service concept, it should be realized that this system was extant long before our industry began to insure health care on a large scale. We did not create the concept, and we hardly have the means to change it by ourselves, regardless of the merits of the case. However, as most of you probably know, many companies are expending large amounts of both money and manpower in experimenting with new vehicles for the delivery of medical care, for example, the Columbia and Harvard medical care plans. We are doing this with the realization that, if successful, we will probably have created competitors which will reduce the premium income that would otherwise have flowed into insurance companies.

PENSION PLANS IN PERSPECTIVE

The impact of pensions as they relate to

1. The investment community
   a) What effect do pension funds have on the capital markets?
   b) Is it likely that pension funds will become an even greater force in the capital markets?
   c) What is the role of the actuary in pension fund management?
2. Corporate profits
   a) Is the cost of pensions a material factor in doing business?
   b) How do such costs affect the earnings-per-share figures?
   c) Can the actuary ignore the effect of his results on the business for which he does pension work?
3. Social security and individual savings
   a) Are private pensions building an adequate structure over the "floor of protection" offered by social security?
   b) Is it likely that expanding social security will take over the pension business completely?
   c) How valid is the concept that the "three-legged stool" will provide for retirement needs? The three legs are
      (1) Individual savings
      (2) Private pensions (including governmental unit plans for government employees)
      (3) Social security
4. Personnel policies
   a) Do pension plan provisions conflict with good personnel policies and practice?
   b) Is a mandatory retirement age beneficial to companies and to society in general?
5. The Canada Pension Plan
   a) How does the Canada Pension Plan differ from private pensions?
   b) What should be done with the Canada Pension Plan in the future, and how would this affect private pensions?

MR. HOWARD H. HENNINGTON: On March 20, 1972, at the Society meeting in New Orleans, Mr. E. Allen Arnold spoke on the subject "Pensions and Future Change." Mr. Arnold's conclusions as reported in the press were made to look like predictions and were quite alarming to many people. The newspaper reports indicated that pension growth would be such that in seventy years these funds would completely dominate the investment market.

In my opinion, the newspaper reporting was unfortunate, because Mr. Arnold's results were probably not intended to be predictions. He made some interesting calculations in which he took the present population, converted it to a mature age distribution (for a stable population), and assumed that essentially all workers were covered by private pensions of $3,000 a year and that these pensions were fully funded under an entry age normal cost funding method. On this basis of full funding, full coverage, and a mature population, he calculated private pension funds of about $2 trillion. It was this result that caused the alarm and concern about the domination of investment markets. Mr. Arnold's purpose was to direct attention to private pension plans. Perhaps it was partly the stimulation provided by him that led to our discussion.

Pension fund projections have been prepared by two economists—Professor Daniel M. Holland[1] and Professor John O. Blackburn[2].

Professor Holland's estimates, which were derived from projections of covered employees and beneficiaries, reflected the rapid growth in the past of coverage of employees and increases in existing benefits. These projections assumed diminishing rates of growth in the future. His annual rates of growth were 7.3 per cent in the period 1966–71, 5.5 per cent in the period 1971–76, and 4.2 per cent in the period 1976–81. Professor Holland projected total private pension plan funds of $320 billion in 1981, including both private plans and state and local government plans. Actual results have been running ahead of Professor Holland's projections. For example, the annual rate of growth in the period 1966–71 turned out to be 9.6 per cent instead of the 7.3 per cent used in the projections, and the actual total of private, state, and local government pension funds was $216.5 billion at the end of 1971 instead of the projected $177.4 billion.

Professor Blackburn in 1967 noted the fact that Professor Holland's results appeared low. He reasoned that pension funds should increase not only from a growing population but also from rising wage rates and benefits. Professor Blackburn also used diminishing future growth rates, but he projected private, state, and local government plans reaching a level in excess of $400 billion in 1981—in fact, $450–$470 billion in 1981 if federal civil service plans are also included. Professor Blackburn's rates of growth were 10.5 per cent in 1965 graded down to 6 per cent in 1980.

[1] Daniel M. Holland, *Private Pension Funds: Projected Growth* (Occasional Paper 97, National Bureau of Economic Research [New York, 1966]).

[2] John O. Blackburn, "The Macroeconomics of Pension Funds," in *Financial Aspects of Pension Plans: Compendium of Papers on Old Age Income Assurance Submitted to the Joint Economic Committee, Congress of the United States*, Part V (Washington: Government Printing Office, 1967).

It is my guess that these estimates probably also will be exceeded, because the rate of growth in the five-year period ending in 1971 was almost the same as that experienced in the preceding five-year period—10.3 per cent in 1966–71 compared with 10.7 per cent in 1961–66. These fairly level results combine a decrease in the five-year annual growth rates from 10.6 to 9.6 per cent for private plans and an increase from 11.0 to 11.8 per cent for state and local government plans.

The question before us is, "What effect do pension funds have on the capital markets?" The Federal Reserve System publishes regular figures on the holdings of different types of assets by private pension funds, insurance companies, and state and local government pension funds. I have prorated the insurance company assets in the ratio of pension liabilities to total liabilities in order to derive assets for insured pension plans. This permits compilation of the asset holdings of all private, state, and local pension funds. On this basis, pension funds at the end of 1971 held about 30 per cent of total corporate bonds outstanding, about 10 per cent of the total corporate shares outstanding (other than open-end investment company shares), and about 9 per cent of total financial assets in capital markets. (For this purpose I have taken total financial assets in capital markets to be the total credit market debt as reported by the Federal Reserve System plus corporate shares other than open-end investment company shares.) It is clear that these figures, although large in relation to the capital markets, do not suggest domination of these markets. Although the rate of growth of pension funds is substantial, total financial assets are also growing at a significant pace—8.4 per cent in the period 1966–71. Thus there will be no sudden changes in the relationship of pension funds to total financial assets, although the figures do suggest a further growth in the ratio of pension assets to total financial assets in capital markets. Such ratios were 6.5 per cent in 1961, 7.8 per cent in 1966, and 8.6 per cent in 1971. But note the likelihood of previously discussed diminishing future rates of growth of pension funds and stable or increasing rates of growth of total financial assets.

Pension funds can have a significant effect on capital markets, even though they do not dominate the market, if pension fund investors act differently from other investors or if pension funds cause a situation where the amount of total savings available for investment is significantly increased. Economists have addressed themselves to both of these questions. I will give you some of their conclusions.

Professor Roger Murray states:[3]

[3] Roger F. Murray, *Economic Aspects of Pensions* (New York: National Bureau of Economic Research, 1968), pp. 83, 90.

Little or no support is found for the view sometimes expressed that the concentration of pension fund investing in a small number of leading company shares is tending to create scarcity premiums on institutional favorites. . . . Neither the proposition that pension funds bid up the share prices for a limited group of "institutional favorites" nor the proposition that they are contributing to price volatility in selected shares can be supported by available evidence. On the contrary, it appears that portfolio managers are broadening their range of investment alternatives and taking advantage of the long time horizon implicit in their decisions.

Professor Holland, in a paper[4] for the Tax Institute of America in 1968, refers to Professor Murray's statements as follows:

The "long time horizon" however, does suggest the possibility that institutionalization could raise the general level of stock prices. For the investment decision involves a trade-off between risk (variability) and return. If the long-time investor (the institution) does not see as much risk in connection with the variability of a given stock as does the individual whose period of holding may be less predictable, then the institution would be willing to pay more than the individual for a claim to a given income stream.

Since many pension fund investors today operate in a very competitive environment in which results are compared at short intervals on a market-value basis, I am not sure that pension fund investors can afford the luxury of dealing coolly with the long-time horizon as suggested by Professor Holland. Professor Holland may be alluding to the way a pension fund investor ought to operate, but it remains to be seen whether the institutional investor does operate that way in order to maximize long-term results or whether he maximizes short-term results in order to try to beat the competition.

The most significant effect of pension funds on capital markets seems to come from the fact that pension funds add to the total amount of savings available for investment. Economists have devoted a good deal of attention to this question of whether pension fund savings add to the total of personal savings or whether there is a substitution effect and other savings are correspondingly reduced. Professor Holland sums up the research on this point with the following statement:

It seems, therefore, that with more assurance than is generally possible about complex economic processes we may consider the annual growth in pension funds to represent net additions to the flow of personal saving and, after due allowance for possible offsets in corporate and government saving (or personal saving induced by government's attempt to maintain its revenues), to

[4] Daniel M. Holland, "Pension Fund Growth and Its Economic Implications," in *Tax Impacts on Compensation* (Princeton, N.J.: Tax Institute of America, 1969), p. 33.

be net additions to the annual flow of total saving to something like 80 to 90 per cent of the addition to pension fund assets.

One would expect that a net addition to savings available for an investment, regardless of the source, would imply a bidding up of prices in the capital markets and in the stock market in particular. It is impossible to measure the effect, but most economists would agree that the effect is there.

We now turn to the role of the actuary in pension fund management. It is clear that the actuary should assist the investment managers of the pension fund by providing cash-flow projections that will indicate liquidity needs. The actuary should also make clear to the investment managers any implications of the benefit structure for the investment management. Some investment managers might select investments differently for a plan involving a cost-of-living adjustment as compared with a plan involving fixed benefits. Some investment managers might also treat a final pay plan differently from a career average plan.

Another role of the actuary in pension fund management is evolving in the area of measurement of investment performance. Some actuaries have already devoted considerable attention to this subject and not only have developed expertise in the area but also have acquired a knowledge of the investment performance of other funds for comparison purposes. The measurement of investment performance is a complicated subject that can be quite challenging to pension actuaries.

Mr. Arnold closed his remarks with a plea for long-range, in-depth pension research with the help of economists, sociologists, demographers, actuaries, and other experts. He advocated an open-minded study of pensions in the context of society as a whole.

I endorse Mr. Arnold's plea. This is a time of change for pensions. Now is the time to find the right directions. Often it is virtually impossible to make radical changes if events reveal that a different direction would have been better. The Pension Research Council has made a fine contribution, but more is needed. Examples of some fundamental questions still in need of study are the following:

1. Can a sound plan termination protection insurance, that is, "reinsurance," system be developed?
2. Would reinsurance provide a desirable substitute for full funding if pension funds became much larger in relation to total assets?
3. Should an employer make his own guarantee of pension promises, so that the employer's assets as well as the pension fund stand behind these promises?
4. How can we preserve the private pension system so that we can continue to have innovation and imaginative development?
5. Most fundamental of all, can we help the private pension system withstand

> the encroachment of social security? After the social security changes this year, it seems that some of our concerns about private pension plans could become almost academic.

We must mobilize our talents to encourage better research in order to help build a better private pension plan system.

Pension costs have reached a magnitude that is clearly substantial in comparison with corporate profits. In the last ten years pension costs have ranged from approximately 15 per cent to 25 per cent of corporate profits before tax. Moreover, the relationship of pension costs to profits has been significantly higher in the latter part of the ten-year period. These figures seem to demonstrate that the cost of pensions is generally a material factor in doing business.

The outline for our discussion asks how such costs affect earnings per share. This is a much more difficult question, and I believe that economists differ in their answers. I discussed this question with Professor Holland, and he suggested that pension contributions are not net additions to cost but are transformations from current pay to deferred pay. Under that theory, pension plan costs would have no effect on profits in the longer run, since, in the absence of pensions, higher current wages (or their equivalent) would have been paid. Another possibility is the view that pensions do represent net additions to labor cost. Under this hypothesis there would still be the question of the degree to which net additions to labor costs are absorbed by the company and reduce earnings per share or are passed on to the customer in terms of higher prices and do not reduce earnings per share.

Without trying to deal further with the question of whether or not pensions decrease earnings per share, one can say with more confidence that pension costs have a disturbing effect on earnings per share merely because of their uncertainty. Actuaries are keenly aware of the fact that pension costs are based on long-term estimates involving mortality, interest, and other assumptions. If the actuary handles the uncertainty by a conservative approach, this conservatism will lead to an understatement of current earnings, with the likelihood that future gains will contribute to increased earnings in later years. Conversely, if the actuary's costs are too low as events later develop, they will have contributed to an overstatement of current earnings, and subsequent experience losses will reduce future earnings.

It is clear that the actuary must not only be conscious of the effects of his results on the financial statement but must also be concerned about the conflicting interests of some of those involved in the financial statement. I am thinking of the corporation management, the stockholders,

the investors, and the employees covered by the pension plan. In many instances the interests of these several groups are diametrically opposed. The only way the actuary can act responsibly in the face of opposing interests is to disclose the facts with respect to his calculations and his assumptions as clearly as possible so that those involved can be better equipped to judge the implications of the actuary's decisions. This responsibility is a challenge not only to the actuary's judgment as to the assumptions to use but also to the actuary's ability to describe clearly the nature of his work and the implications for the public at large.

MR. C. L. TROWBRIDGE: Before we attempt to answer the question whether or not private pensions are building an adequate structure over the "floor of protection" offered by social security, it might be worthwhile to examine whether social security is indeed providing a "floor of protection" as most of us believe. Of the roughly twenty-one million people now over age 65, more than 9 per cent are on old age assistance. Four per cent of those over age 65 are on welfare having no OASDI benefits, and another 5 per cent are on welfare despite OASDI benefits. This indicates that the social security floor has a hole or two in it. For some two million of our older people social security is not enough to keep them off the welfare rolls. There are also an additional 1.8 million aged people who, while not on old age assistance, have incomes below the generally accepted poverty level. About 80 per cent of these are OASDI recipients.

Responding to the question, "What proportion of aged persons have a second pension, private or governmental, in addition to social security?" I would say that it is difficult to obtain an accurate answer. Presumably the proportion is slowly increasing as the private pension movement becomes more mature. The Social Security Administration has recently completed what is known as the Survey of Newly Entitled Beneficiaries. This survey covered those who became entitled to old age benefits under social security in an eighteen-month period in the recent past. Among males who became entitled to social security at age 65 or later, 48 per cent have a second pension. If we look at this figure alone, it appears that about half the people retiring today enjoy a second pension. This is certainly a higher percentage than is implied in some of the loose talk that has at times circulated around the pension field.

However, this figure of 48 per cent, too, is misleading. Lower ratios are found for females, and for both males and females applying for social security old age benefits at ages before 65. For females retiring at age 65 and for males retiring earlier, the proportion having a second pension lies between 35 and 40 per cent, and for females retiring early it is only 27 per

cent. Particularly with respect to the interpretation of this last figure, we must recognize that many of the women applying for social security benefits at age 62 on their own wage record really have had little attachment to the labor force and not much chance, or reason, to earn a second pension.

Persons who are highly likely to have a second pension would include long-term employees of well-established companies in the private sector and long-term employees of government. On the other hand, there are groups who have relatively little second pension coverage. I am now thinking of (1) employees of small employers, (2) employees who change employers frequently, (3) the self-employed, and (4) widows. Although both government and private pensions usually make it possible for the pensioner to cover his wife under a survivorship annuity, not nearly all of the pensioners involved are willing to accept the lower pension that this election implies. In the event of death prior to retirement, only rarely would a private plan provide pension coverage to the aged widow.

I certainly have no clear-cut answer to the question regarding expansion of the social security system. I can only point out certain indicators and let you draw your own conclusion.

The history of the system since 1969 has certainly been one of rapid expansion. There have been three benefit increases accumulating to more than 50 per cent, and the earnings base will also have gone up by more than 50 per cent when the $12,000 maximum becomes effective in 1974. Were one inclined to extrapolate similar expansion into the future, the private pension area seems to be pretty well pushed out.

When we look back over a longer period—say, over the twenty years since the major overhaul of the social security system in 1950—we have a somewhat different picture. The benefit table has increased at only about the same rate as the increase in average covered earnings; about the same is true for the taxable wage base. In a sense the period since 1969 has been one of "catch-up," making up for the 1955–65 period during which the OASDI system remained relatively flat and hence fell behind the economy as a whole.

The hopeful sign, for those who want to see social insurance stay within bounds, is the indication that taxpayers are really beginning to feel the bite of the social security payroll tax. Although the benefit increases for 1972 were enacted with relatively little addition to the contribution rate, this is somewhat accidental, resulting from a change in actuarial methodology. A similar opportunity will not occur again, and future expansion can come only with fully commensurate additional financing.

For many of our lower-paid citizens the 5.85 per cent social security tax for 1973 is greater than income tax. The additional 5.85 per cent paid by

the employer is thought by many to be borne by the employee as well. The 11.7 per cent tax may be getting close to the maximum that the traffic will bear, and there is not much mileage left in raising the earnings base further. You are beginning to hear more about the "regressive" nature of the payroll tax and to hear suggestions for reducing the burden on low-income people. Clearly, major future expansion of social insurance must face some formidable hurdles.

It is my personal feeling, and of course I represent no one but myself, that the United States public is entitled to as generous a system as it is willing to pay for. If the cost implications are clearly set forth, and particularly as long as social insurance is financed by a highly visible tax on covered payroll, I have confidence that social insurance will not grow beyond the level of acceptance of the American people, and that private insurance and pension arrangements, and individual thrift, will continue to play an important role in the financial aspirations of the people of the United States.

Is the concept of the "three-legged stool" valid? I say that it is, but for some individuals certain legs of the stool may be missing.

The social security leg is almost universal, but there are some important problems because it is not quite so. United States government employees are still outside the system, state and local government employees may be in or out, and there is a particularly confusing situation regarding railroad employees. There are certain other individuals with insufficient attachment to the labor force to become entitled to a social security benefit.

The private or government plan leg of the stool seems to exist in no more than half the cases. Private pensions have some important problems: (1) the integration problem, (2) the vesting problem, and (3) problems arising from inflation. Private plans are far from universal, and there are problems within private pensions that challenge the energies of all of us.

Finally, individual savings are still an important part of the retirement picture. I have no idea as to the part that investment income plays in the financial picture of the typical aged person, but we do know that many of them, even relatively low-income people, have some individual savings. Particularly, people are likely to own their homes by the time they end their working careers. While homeownership does not add to direct cash income, it does have an important role in cutting down expenditures. Other important forms of individual savings are individual endowment or annuity arrangements, savings accounts, savings and loan deposits, mutual funds, and direct investment in stocks, bonds, or mortgages.

The main enemy of the three-legged stool, and of each of its legs separately, is inflation.

MR. K. ARNE EIDE: It is unfortunate that various news media have given so much publicity recently to projected large social security cash benefits that workers might expect to receive and the high taxes they might pay in future years, now that automatic escalator provisions are in effect under recently enacted amendments to the social security law. The news accounts fail to mention that, when the escalator provisions operate in response to increases in the consumer price index and in the level of wages covered under social security, the value of our currency is concomitantly decreasing. As a result, the seemingly large future benefits may be more illusory than real. I believe that as actuaries we could aid the public's understanding of these complex happenings by providing more realistic and accurate explanations than those which have recently appeared in the news media.

MR. G. ASHLEY COOPER: The question posed in item 4 of the program outline can be rephrased, "What is the impact of a pension plan on the employer's personnel policy?" Most of us in the consulting business would like to answer, "None." A large part of our job is to assist clients in designing a pension plan that reflects personnel policy or, in other words, acts as an extension of personnel policy. We like to believe that the reason there is so much variety in plan provisions as between one employer and another is that they have different personnel policies. They also have different budgets, I might add, but that is partly a reflection of personnel policy too. In practice, however, it does not seem to work exactly as planned.

Let us take a quick look at the objectives for having a pension plan. The catch phrase commonly used is that the plan is intended to "attract, motivate, and retain" good employees. What is not so frequently mentioned is that a pension plan is of vital importance in getting rid of employees. After all, that is what retirement is all about—leaving the work force.

The concept of using a pension plan, and other employee benefit plans, to attract employees is bound up in the philosophy of total compensation. In its purest form, this philosophy maintains that benefits are just another form of compensation. It is therefore a matter of personnel, or, more specifically, pay, policy to decide how generous the over-all package should be and what proportion should be paid in indirect form through benefit plans, as opposed to direct compensation.

Motivation of employees through benefit plans is a splendid idea, but as far as pensions are concerned, at the risk of contradiction, my opinion is that it just does not work that way. Changes in plans, like changes in

compensation, may motivate, but just having a pension plan, like just receiving a monthly pay check, appears to me to add no incentive at all.

Retaining employees seems to involve two considerations. The first is that the employees must be prevented from becoming unhappy. Here again, I will be blunt, since I contend that employee benefits have very little to do with whether an employee is happy or discontented with his job. Have you ever heard of someone's quitting because the pension plan was inadequate? There are so many other factors, and besides, by the time the employee has realized that the pension is poor, it is probably too late. The second concern in retaining employees is to ensure that one's total compensation package is as good as that of other organizations that might try to pirate away your best employees. In fact, if you were to ask a hundred personnel directors why their firms had pension plans, probably seventy or more would answer, "Because all our competitors have them."

A comment on vesting might be interjected here. One of the arguments, from the employer's viewpoint, in favor of modest vesting is that it holds down turnover or, at the very least, produces an actuarial gain if heavy turnover takes place. It is interesting to note that the introduction of more generous vesting, either as a self-induced trend or by legislation, will further reduce the capacity of a pension plan to retain employees.

The utilization of a pension plan to get rid of employees is probably the oldest rationale for having such a plan. To take an example, Joe at age 83 may be totally unproductive and yet be drawing full pay. There are essentially three options open to the employer: to reduce Joe's salary, to fire him, or to put him on pension. For many years now, social considerations allied with public policy have dictated that a salary reduction or dismissal are unacceptable and that a pension is the only proper course.

All these comments on attracting, motivating, retaining, and releasing employees merely indicate the general interaction between personnel objectives or policies and pension plan objectives. They lead to certain general, and rather obvious, conclusions about the influence of a pension plan on personnel policy.

In the first place, merely having a plan makes a difference. Other things being equal, it provides a more generous compensation package. Moreover, it allows for the development of a policy as to the retirement of employees, which we will discuss more fully below.

In the second place, the level and nature of pension benefits can be adjusted to make the compensation package more attractive. This, in turn, affects the ease or difficulty likely to be experienced in attracting and retaining employees.

The only other general point I want to make is that it is not unknown

for a pension plan actually to cause personnel problems. Clearly, this is the sign of a poorly designed plan, and, since none of us here could possibly be associated with poor design, I can pass on quickly to the next subject.

Since I would like to concentrate on old age retirement, it might be as well to dispose of ancillary benefits at this stage. These benefits, usually payable on death or disability, are undoubtedly valuable and an important part of any satisfactory benefit program. However, it appears to me that they have little effect on personnel policy.

Death benefits do, of course, "sweeten" the compensation package and thus improve the employer's ability to attract and retain employees. As far as getting rid of employees is concerned, in most occupations death is not a part of personnel policy.

Much the same comments apply to disability benefits. However, two additional points appear to deserve mention:

1. In some organizations, either by accident or by design, disability benefits are a disguised form of early retirement. Personally, I believe that this is a mistake.
2. Other organizations take the position that they have no disability plan. frankly, this is usually untrue, since, if an employee actually becomes totally and permanently disabled, the employer will almost certainly decide to grant a pension. Thus there is really a disability income plan in effect, but it is informal, unannounced, unfunded, and with no predetermined benefit formula. You will no doubt agree with me that in many instances this represents an inefficient personnel practice.

Turning back to old age pensions, it might be instructive to consider which provisions of a typical plan have any significant relationship to personnel policies. Obviously, benefit levels and retirement ages are material, and we will discuss these shortly. On the other hand, it appears that most of the other provisions are without significant impact, except, of course, to the extent that they affect benefit levels. Such items as options, termination provisions, administrative arrangements, and funding are important parts of a pension plan, but they seem to have little impact on personnel considerations. Even eligibility conditions and employee contributions have, I contend, relatively little significance.

Let us then focus attention on what pension is payable and when. The setting of benefit levels is not a simple process. It is largely subjective, although objective factors such as competitive practices and budgetary restraints enter into the equation. And, since the choice of benefit level is, in effect, the selection of an amount considered to be adequate for the "gracious" retirement of an employee, it is plainly a part of personnel policy.

Because the process is subjective, it is not easy to make valid general observations on it. However, some over-all trends are discernible. These appear to be as follows:

1. Benefit objectives are usually deemed applicable to a career employee with, say, thirty or perhaps thirty-five years of service, with lesser benefits for shorter and higher benefits for longer service.
2. Objectives are related to pay close to retirement, although the actual benefit formula may be expressed differently.
3. Objectives are inclusive of social security.
4. It is often thought desirable for benefits, expressed as a percentage of pay, to be higher for low-paid employees than for high-paid employees.
5. Typical objectives are around 70 per cent of final average pay for low-paid employees, grading down to 60 per cent of pay for medium-paid and 50 per cent for high-paid employees.

As I have indicated, these should be taken as broad guidelines to what employers are thinking about today. Personnel policy, and the ability to pay, heavily influence the objectives chosen. Likewise, the level chosen obviously affects labor costs and influences personnel policy, especially as to the attraction and release of employees.

When should the benefit be payable? This seems, to me at least, to be the most interesting part of the subject under discussion. Moreover, it is a subject that is being actively considered by employers, employees, and unions, and their advisers.

Not so many years ago it could be fairly stated that customary practice was to set normal retirement at age 65, any benefits paid earlier being based on the actuarial equivalent of the accrued normal pension. Typically, on late retirement the benefit was not increased or was based on actuarial equivalence.

Today this approach is largely outdated, and there is no clear pattern of standard practice. The change has come about largely from shifts in personnel policies and employee attitudes. We have seen a "tug-of-war" between employees who feel that the full objective pension should be available whenever they are ready and willing to retire and employers who, ideally and in the absence of outside interference from the Internal Revenue Service, would like to choose who retires when.

In the past several years these forces have pulled in the same direction, that is, toward retirement with "full" benefits before age 65. Many employees have wanted to retire before that age, perhaps because they wanted to leave the rat race or because their jobs were dull, repetitive, or exhausting. Employers, too, have been interested in having substantial numbers of employees retire early, mainly because of technical obsolescence and the desire to counter the "Peter principle."

However, I believe that today the situation is much less clear cut. Some important factors have cropped up to muddy the waters, among which the following are illustrative:

1. A 30-year-old employee is convinced that he will want to retire at age 55 or even earlier, but, when he gets there, he may not be so enthusiastic.
2. Some individuals are finding retirement not so attractive as anticipated.
3. Many employees who do retire early immediately start looking for another job. People are beginning to realize how ridiculous this is.
4. Employers now realize how expensive early retirement can be. The usual rule of thumb is an addition of about 10 per cent to pension costs for each year early, assuming unreduced benefits.
5. Employers and consultants are experiencing great difficulty in pitching early retirement benefits at exactly the level which will induce the unproductive employees to retire but will not appear too attractive to employees whom it is desired to retain.
6. IRS regulations not only deny the employer the right to pick and choose who will retire early; they also vary the amount of integration allowed by the degree of generosity of the early retirement benefit.
7. From the point of view of the society as a whole, the active working population must support the nonworking population. Undue numbers of early retirements can affect this balance.
8. The public may also be coming to the conclusion that, as long as a man or woman wants to work and is able to perform a job adequately, it is in the public interest for him or her to continue working.

Beyond these thoughts, there is even greater evidence that the proper age of retirement, from the point of view of the employee, the employer, and the society as a whole, varies widely from one individual to another. Physically and mentally, we all age at different rates.

The big question is: "Where do all these conflicting tendencies lead?" In my personal opinion, the pendulum will swing away from emphasis on early retirement toward greater flexibility in retirement. We could see a range or band of ages, all of which are considered normal. This would put considerable pressure on personnel officers to persuade the less productive employees to leave and the more productive to stay. We could see the adoption of partial retirement, with the employee putting in less than full time and receiving part salary and part pension. This would be similar to the arrangements quite prevalent today under which employees retire and are re-engaged as consultants. We might even see acceptance, by employees and others, of the concept that employees should be transferred to less exacting and less high-paid positions when they become less productive. In other words, I am suggesting that, from the personnel and

plan design angles, other solutions may be more appropriate than merely improving the early retirement pension.

Finally, here are a few brief thoughts on the subject of mandatory retirement. Presumably, the idea behind instituting a mandatory retirement age is to prevent employees (and directors, too) from staying on after they have outlived their usefulness. If a high age, say 80, is chosen, it will have no meaning. On the other hand, a low mandatory retirement age, for instance, 65, may force out individuals who could still perform valuable services. So it is usual to choose an in-between age of about 70.

It seems to me that this represents a "cop-out" from the fundamental personnel problem of getting people to retire when their productive careers are over. Mandatory retirement, by imposing an arbitrary cutoff date, tries to evade a decision which should be made on the basis of the merits of each individual case. The danger is that it will bring about too-late retirement for many unproductive employees, while others, who are still productive, will be cut off too early. At the risk of controversy, I will vote against the concept of mandatory retirement ages, from the point of view of employer, employee, and the public.

MR. ROWLAND E. CROSS: Mr. Cooper has spoken of the many variations in pension plan provisions that are being introduced or at least sought after in the current pension market. We at Metropolitan have encountered a number of situations where employers seem almost to despair at the constant pressure for liberalization in such features as vesting, early (or, alternatively, deferred) retirement, election of options, voluntary employee contributions, variable benefit accumulations, and the like.

Although we see many problems in the money-purchase approach, we find an increasing interest in this technique—at least partially, we suspect, because it does save having to try to guess what the ultimate cost of these various liberalizations will be.

Furthermore, from the employee's point of view, this approach has the advantage of a kind of definiteness, in that he can know at any time what his current equitable interest is and from that can estimate the equivalent in terms of annuity income, immediate or deferred, normal form or optioned, and so on. Some employers with definite benefit plans seem to feel that a fair number of employees are putting off retiring in the anticipation of forthcoming liberalizations which would be essentially retroactive in effect. Under money purchase, the effect of liberalizations is (almost by necessity) prospective only.

This is similar to the growing interest we notice in thrift or savings plans, which perhaps in certain respects is in response to Ralph Nader's

philosophy of "consumerism in pensions"—a term he uses to refer to a more or less universal individual accumulation approach with maximum flexibility given to the employee as to the way in which funds are to be invested during the preretirement period and eventually paid out to the employee and/or his beneficiaries.

MR. JAMES L. CLARE: In the pensions it is paying out, the Canada Pension Plan (CPP) is playing favorites, giving large subsidies or "gifts" to a few people, and heaping these gifts in the wrong directions.

Fully mature CPP retirement pensions from age 65 are available correctly to those born around 1910 or more recently, thanks to the giving in full of "past service" for years of work before the CPP began. However, older people born in 1909 or before and retiring also at 65 are given too little past service or none at all. So, running up and down the age scale vertically, the CPP is fundamentally wrong.

Looking across the age scale horizontally, at two people of the same age but with different incomes, the CPP gives larger gifts to the person with the higher income. The other person, with the lower income, gets a smaller gift. Here again the CPP is also fundamentally wrong.

Moreover, because of the playing of favorites and the paying out of so much in gifts, the CPP retirement pensions being paid are a long way from being in direct relation to the CPP contributions the individuals in question have paid. Thus the CPP is *not* "insurance."

While playing favorites with the wrong people, the CPP does nothing to pay pensions to those Canadians in greatest need and does little or nothing for most other needy Canadians. The CPP lavishes its largest gifts and subsidies on those who have above-average incomes. Thus the CPP is *not* "social." Defending the CPP by claiming that it is "social insurance" is therefore no defense at all. The CPP is *not* worthy of being called "social insurance."

It is time to reconsider the CPP and to seek reasonable results for all the CPP taxes we pay. For a start, the CPP should now be changed so that it is deliberately aimed at the objective of providing pensions to people currently in need.

At this point, before charging blindly ahead, it would be well to face a few facts as to the magnitude of this objective. For example, simply giving every Canadian aged 65 or over an equal and adequate amount of pension, on top of his private income from nongovernmental sources, would require excessive taxes from those of us who are working. In round numbers, there are 9.0 million Canadians working, and 1.8 million aged 65 or over, so that there are roughly five Canadians working per person aged 65 or

over. Paying a pension of, say, $175 a month (or $2,100 a year) to each Canadian would therefore require a tax burden per working person of about $420 a year, for all retirement pension taxes, CPP plus Quebec Pension Plan plus old age security (including the guaranteed income "supplement").

Many working Canadians cannot afford to pay as much as $420 in taxes every year for government retirement pensions alone. That is why we aim at having "progressive" income taxation, with high-income Canadians taxed more and low-income Canadians taxed less.

A working person with a really low income pays no regular income taxes at all, so a new strategy for the CPP should begin with the elimination of the CPP taxes currently imposed on such a person—taxes that push him deeper into poverty.

However, having some working Canadians pay no pension tax and having others pay only a small amount would mean some sizable pension tax increases for middle-income and high-income Canadians in order to bring the average up to $420 per working person.

There are several reasons why any such tax increases should be avoided. They would be unpopular with the taxpayers concerned. They would be increasing tax burdens now, when federal tax reform has only just considered the matter in relation to other income taxes and has arrived at generally accepted answers (at 1972 price levels). Finally, such tax increases would be quite unnecessary, for it is possible to develop a strategy for government pensions that will enable us to attain simultaneously the twin goals of adequate pensions and no pension tax increases.

For collecting taxes, a "progressive" strategy is in order. Those with high incomes are taxed more, and those with low incomes are taxed less. The other side of that coin is to have a "selective" strategy for paying out government pensions, giving elderly people with high private incomes fewer net extra dollars to spend and giving those with low private incomes more net extra dollars to spend.

However, a selective strategy by no means requires the adoption of "selective tactics." In fact, selective tactics should be avoided. We have "selective tactics" currently in operation in the supplement as now paid under old age security. The supplement is a "negative income tax" that makes selective payments as follows. Those with zero private incomes can get the full supplement. Anyone with a small private income has his supplement reduced by 50 per cent of such private income, which, in effect, constitutes "taxation" of these private incomes at a 50 per cent rate. Those with larger private incomes get no supplement at all.

This negative income tax approach should not be adopted for paying

out CPP retirement pensions. The taxation of incomes imposed by the supplement is at a rate of 50 per cent of the lowest band of $2,600 of private income. For a single Ontario pensioner in 1973, the taxation of the next band of $500 of income is to be only 20 per cent. On the next band of $500 of income it is to be only 23 per cent, and so on. Taxing the first $2,600 at 50 per cent upsets the progressive taxation of income. Instead, it makes the taxation of the private incomes of low-income pensioners unfair and regressive. It also discourages those with low incomes from working and saving. Further, the supplement is complex and is widely misunderstood, so that thousands and thousands of pensioners entitled to supplements are not getting them. The supplement divides retired Canadians into two classes, those who are on the supplement and those who are not. Further, as a tax on income applied "in advance," the supplement is rigid and does not adapt flexibly to fluctuations in private income.

For all these reasons, the selective tactic of a negative income tax is certainly to be avoided when it comes to making CPP payments to pensioners, and indeed to all dependents. (For working individuals the negative income tax approach is even more undesirable. On the assumption that their dependents are covered by appropriate income security payments, what a working person really needs is an unemployment insurance payment for sickness or unemployment, in a modest daily amount.)

The supplement negative income tax does, however, have two good features. First, the supplement does refrain from providing benefits "in kind" (such as public housing) and instead makes payments in cash. Second, the supplement does, in effect, "tax" the first dollar of private income from nongovernmental sources of someone receiving old age security, with no income tax exemptions at all. These two aspects should be retained in any alternative arrangements, but the supplement itself has so many disadvantages that it should be scrapped.

One alternative to the negative income tax approach of the supplement is to use the regular income tax mechanisms that we now have, which tax private income after it is earned but still achieve selective results. That is, the most net extra dollars (to spend) go to those with the lowest private incomes, as follows:

The full amount of the government pension to be paid from CPP taxes plus old age security taxes to a pensioner with no private income at all—whether $175 a month or some other amount—would be paid to *all* elderly Canadians. This government pension would be exempt from income tax, as "a positive tax credit." There would, however, be no income tax exemption applied against private income, so that the private income of pensioners would be subject to income tax from the first dollar. A special

scale of progressive income tax rates would then be applied to the private incomes of retired people, so that the net benefit in terms of extra dollars to spend would be greatest for those with zero incomes and would be less and less for those with higher and higher incomes. This special scale of income tax rates would reduce the over-all outlay on government pensions sufficiently that no extra tax burdens would need to be put on working Canadians. All now receiving old age security could have at least as many dollars (net of taxes) to spend as at present, the largest increases in spending power going to the poorest pensioners. Hence universal payments and universal income taxation by the Department of National Revenue would achieve selective results.

With tax withheld at source from private retirement income, such as company employment pensions, there would be no sudden cash drain on the federal treasury.

Similarly, CPP taxes could provide adequate payments to all Canadians now disabled, children, and mothers of young children, with existing payments such as Canada Assistance Plan payments and family allowances fully recognized and integrated.

About a year ago, an official of the Department of National Health and Welfare suggested that old age security should be merged with the CPP. As the above discussion implies, a merger is certainly needed, but the other way around. It is the CPP that should be merged into old age security, with the CPP also providing disability payments in equal, universal amounts to adults who are now disabled (or who become disabled in the future). Under other plans, adequate payments should also be made to children and to mothers of young children, funded in part by the appropriate share of taxes collected by the CPP.

Those who guide themselves by theories, and who wish to rule others by slogans, may complain that these changes will undermine the supposed "social insurance" basis of the CPP and will do away with the CPP's alleged pattern of "contributory pensions with wage-related benefits."

Slogans should be put aside, however, and instead debate should begin, freely and frankly, both within Parliament and without, as to how to achieve better results—better "value for money"—from our CPP taxes.

After the inquiries and debates are over, the changes have been made, and Canada has revised universal tax–universal transfer payment arrangements for retirement and disability pensions that are effective, efficient, and humane, then the whole new structure will, at last, be worthy of being called the "Canada Pension Plan."

Pensions currently payable under government pension plans with "earnings-related" benefits (United States social security as well as the

CPP) are by no means progressive, since they totally fail to subsidize the poor more than the rich. Such pensions are in fact regressive. For any two people at the same age, the number of dollars given monthly as a subsidy, as a gift, or as a windfall under United States social security is larger in the benefit that goes to the average better-off retired American and is smaller in the benefit that goes to the average less fortunate American. It is a question not of percentages but of actual dollars. United States social security (like the CPP) is most generous in ladling out subsidies and gifts to those who already have most by way of employment pensions, homeownership, other investments, and so on. This is "upside-down welfare."

"Earnings-related" benefits have no place whatsoever in government pension plans such as United States social security and the CPP. The basic plan, applying to everyone in a country, should be "social" along the lines of my earlier discussion. For those who do not have other adequate pension coverage, as for example under employer pension plans or, in the case of self-employed people, under registered retirement savings plans in Canada and under H.R. 10 plans in the United States, a second deck on a purely "insurance" basis (i.e., 100 per cent money purchase) indeed makes most sense.