HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION

Lewis E. Weeks Series

Daniel Pettenghi

DANIEL PETTENGILL

In First Person: An Oral History

Lewis E. Weeks
Editor

HOSPITAL ADMINISTRATION ORAL HISTORY COLLECTION
Lewis E. Weeks Series

Produced in cooperation with

Library of the American Hospital Association
Asa S. Bacon Memorial

Sponsored by
American Hospital Association
and
Hospital Research and Educational Trust
Chicago, Illinois

Lewis E. Weeks
2601 Hawthorn Road
Ann Arbor, Michigan 48104
(313) 662-4298

Daniel W. Pettengill

CHRONOLOGY

1916	Born March 4, Cambridge, MA
1937	Bowdoin College B.A.
1937-1978	Aetna Life Insurance Co., Vice President
	1964-1978
1978-	Consultant

MEMBERSHIPS AND AFFILIATIONS

American Dental Association, Task Force on National Health Programs, Member

American Hospital Association, Council on Financing, Special Committee on the Financing of Comprehensive Health Care Delivery Organizations, Member

American Life Convention-Health Insurance Association of America, Ad Hoc Committee on Expansion of Military Medicare, Member

American Life Convention-Health Insurance Association of America Joint Group Committee, Group Statistical Subcommittee, Member

American Life Convention-Life Insurance Association of America Subcommittee on New York Health Insurance, Member

American Society of Internal Medicine

President Elect's Advisory Council, Member

Canadian Health Insurance Association

Committee on Medical Services, Member

Commission on Hospitals and Health Care (Connecticut)

Joint Experiment Committee, and three Subcommittees, Member

Commission on Hospitals and Health Care (Connecticut)

Task Force on Ambulatory Surgical Programs in Connecticut, Member

Commission on Hospitals and Health Care (Connecticut)

Task Force on Computerized Tomography, Member

Connecticut Hospital Association

Task Force to Study National Health Insurance

Connecticut 65 Operating and Policy Committee

Chairman

Connecticut Regional Medical Program

Committee on Financing of Health Care, Member

Connecticut Statewide Coordinating Council

Member

Governor's (Michigan) Action Committee on Health Care

Consultant

Governor's (New York) Steering Committee on Social Problems

Consultant

Greater Hartford Chamber of Commerce

Member

Harvard Visiting Committee on Health Services

Member

Health, Education and Welfare Department

Advisory Council on Health Insurance for the Disabled, Member

Health Insurance Association of America

Actuarial and Statistical Committee, Member

Health Insurance Association of America

Ad Hoc Task Force on Hospital Reimbursement, Chairman

Health Insurance Association of America

Board of Directors, Member

Health Insurance Association of America

Committee on Medical Economics, Chairman

Health Insurance Association of America

Health Care Program Task Force, Technical Advisory Subcommittee, Member

Health Insurance Association of America

Medicare Administration Committee, Chairman

Health Insurance Association of America

Overinsurance Subcommittee, Member

Special Task Force on Proposed Amendments to P.L. 93-641, Chairman

Health Insurance Association of America

Subcommittee on Drugs, Chairman

Health Insurance Association of America

Subcommittee on Health Care Delivery, Chairman

Health Insurance Association of America

Subcommittee on Health Services for Veterans and Their Dependents, Chairman

Health Insurance Association of America

Subcommittee on Prepaid Group Practice, Chairman

Health Insurance Association of America

Task Force on Health Insurance for the Unemployed, Member

Health Insurance Association of America

Task Force on State Health Care Pools, Member

Health Insurance Association of America

Technical Advisory Committee, Board of Directors, Member

Health Insurance Association-American Hospital Association

Board Liaison Committee, Member

Health Insurance Association-American Hospital Association

Board Liaison Committee, Member

Health Insurance Council

Chairman

Health Insurance Council

Central and Budget Committees, Member

Health Insurance Council

Community Health Planning Committee, Member

Health Insurance Council

Consumer Relations Task Force, Member

Health Insurance Council

Executive Committee, Member

Health Insurance Council

Subcommittee on Coordination of State Committees, Member

Health Insurance Council

Technical Advisory Committee, Chairman

Health Planning Council (Hartford)

President, Trustee, Member

Life Insurance Association of America

Subcommittee on Duplication of A & H Benefits, Member

National Association of Insurance Commissioners

Advisory Committee to Technicians' Committee, Member

National Association of Insurance Commissioners

Task Force on Coordination of Benefits, Member

National Center for Health Services Research and Development

Ad Hoc Advisory Committee, Member

National Center for Health Statistics,

Adviser

National Center for Health Statistics,

Technical Consultant Panel for National Health Insurance Statistical System, Member

Office of Technical Assessment,

Advisory Panel on Efficacy and Safety, Member

Presidential Commission on Mental Health,

Panel on Cost and Financing, Member

Social Security Administration,

Medicare Carrier Representative Group, Cochairman

Social Security Administration,

Fiscal Intermediary Group, Cochairman

Society of Actuaries,

Board of Directors; Vice President

Society of Actuaries,

Committee on Experience under Group Health Insurance, Member

Statewide (CT) Health Coordinating Council (Appointed by Governor),

Member

Surgeon General's Advisory Committee,

Member

Task Force to Study Connecticut's Title XIX (Medicaid) Program,

Member

United Church Board of Homeland Industries,

Vice Chairperson; Board of Directors

U.S. Chamber of Commerce,

Social Security Committee, Member

WEEKS:

Several persons including Walter McNerney suggested I ask you to reminisce about your days as an actuary and an officer of Aetna. They suggested that you might give the me the best account of the commercial insurance companies' part in the growth of health insurance, and of your own efforts in the national health insurance movement.

I understand you joined Aetna soon after graduating from college and were associated with the company all your professional life.

Possibly, you would like to begin to discuss some of the topics we mentioned before we started recording this conversation.

PETTENGILL:

With respect to your friend's comment that I favored social insurance, I'm not quite sure how to take that. Possibly, his opinion came from the fact that I always felt the insurance business should try to provide for the health care insurance needs of the American public. I did come to realize that, for the people who have no income or essentially no income, there was no way that the private sector could handle the need all by itself. For such persons, government would have to do the financing--either through self-insurance or the purchase of private insurance.

I favor government paying premiums to private insurers for the poor and near poor because I believe that private insurers can do a better job of administration than the government.

The reason for this belief lies in the fact that government has to put in more checks and balances in order to assuage the politicians and the public that everything is being done exactly right. Whereas the business community is able to eliminate those checks and balances which do not seem necessary for a reasonable degree of accuracy.

Getting back to the history of my connection with the health care insurance business, I came in, as you said, in 1946, after World War II, when there had been a modest growth in group health insurance since the Depression, due the fact that wages were frozen during World War II but employers were permitted to purchase group insurance for their employees.

In 1937, which is the year that I went to work for the Aetna, the Aetna wrote its first group hospital expense benefit policy for an employer and it provided a $3.00 daily room and board benefit and a $15.00 maximum allowance for ancillary services. Interestingly enough, that was very adequate for the day.

When I entered the Group Division in 1946, the room and board rate was up to about $5.00 and the ancillary services were up to about $50.00, for a maximum limit, although we would occasionally write a $100.00 maximum limit. Again, those were reasonable benefits. What has happened since then--and many people today fail to realize it--is that the services which doctors know how to perform and for which hospitals must make facilities available, have increased fantastically. As a consequence, not only did inflation raise health care costs but also progress in medical science did so by increasing

both the services that could be performed and the equipment and trained personnel needed. Today, of course, we wouldn't think of anything less than $100 for a room and board benefit or less than several thousands of dollars as the benefit for hospital ancillary services.

So it needs to be borne in mind that it was a relatively simple matter in the early days to design a hospital benefit that was adequate and yet had a modest, finite dollar limit. Whereas today, insurers have to write, not a specified dollar daily benefit, but the average semi-private charge, whatever that may be. Insurers also must be willing to pay all or a major portion of the ancillary services, virtually without limit. Consequently, there is a much greater variation in the benefit provided. The benefit is much more sensitive to inflation because, without modest dollar limits, every time there is an increase in the cost of care, the average benefit payable goes up.

I'm getting ahead of myself, however. I'd like to say that by the time that I came into the group business, Aetna not only wrote hospital expense benefits for employees and their dependents but also wrote surgical benefits and in-hospital medical expense benefits as well.

Shortly after I came, we introduced the medical expense benefit which paid for office and home calls, as well as in-hospital visits, by the attending physician for non-surgical cases. We also introduced coverage for diagnostic X-ray and laboratory examinations.

The primary competition, in terms of physician services, was the Blue Shield plans which did not get into these latter two areas for quite some time. As a result, many physicians failed to realize that under many insurance company group policies the patient might have available benefits for home and office calls . . . and more importantly, diagnostic X-ray and

laboratory examinations. So they would unnecessarily confine Aetna patients in hospitals thinking they had to in order to get the X-rays paid for, just because they had to do that under the Blue Shield plan with which they were generally familiar. This was an unfortunate situation and for many years we were unable to correct that false impression. And some people still think that insurers force patients into the hospital.

Speaking of the surgical benefit, it might be worthwhile to note that, in the early days, insurers did not know much about surgery and surgical charges and were primarily concerned with establishing a benefit which was simple enough to administer as well as to sell. So early surgical contracts would pay, say $5, if the surgery was done in the physician's office and $25 if it was done in the hospital.

Insurers failed to realize that human nature being what it is, the doctor would admit his patient to the hospital in order to collect the $25 benefit, for a $5 procedure. So again, the notion arose that insurers were forcing people to go to the hospital in order to collect benefits. There were a few policies written where that was actually true; you got nothing unless you went to the hospital. But most of the group insurance business did not require you to go to the hospital. Unfortunately, sometimes you got a bigger benefit if you went to the hospital. Although, usually it was the physician who got that larger benefit rather than the patient.

I think it's worth noting that in 1948, the executives of the General Electric Corporation became concerned about the "high cost of health care," particularly with respect to serious illnesses and accidents. They were able to persuade the Liberty Mutual Insurance Company, which is a casualty company headquartered in Boston, to write, on an experimental basis, a catastrophe

benefit which was called Major Medical. Actually, the group was known as the Elfund Club because that was the club to which the General Electric executives belonged. And they took the coverage out as one of the fringe benefits of belonging to that club.

This experiment immediately created a tremendous stir with the public because the typical policy of that time didn't help you if you got into a real serious accident, even though the expenses then were nowhere near what they are today, for the same problem.

So there was real pressure on the insurance industry to do likewise. And we did. Aetna and other major group underwriters went to work; we studied the limited experience that the General Electric executives had and we came up with Major Medical coverage at the beginning of the 1950s, I think the Aetna wrote its first policy in 1951. Major Medical then became the most rapidly growing coverage because people who had basic hospital/surgical benefits wanted to add, to superimpose Major Medical.

The Blues were reluctant to write the supplementary Major Medical simply because it didn't fit nicely into their respective areas of operation. The Blue Cross plans had their contractual arrangements with hospitals and the Blue Shield plans had their arrangements with physicians. So the Major Medical concept of lumping together all other medical expenses in a given period (usually a year), applying a deductible of, say, $100 and then paying 75% or 80% of the excess up to some specified maximum dollar amount just didn't fit conveniently into their methods of administration. The Blues countered with richer hospital-surgical benefits, but were ultimately forced to write Major Medical benefits. They did so by establishing a couple of captive insurance companies which wrote the Major Medical benefit when the

Blues needed it to compete with the insurance companies.

The next question for insurers was, why do you have a set of basic hospital, surgical, medical, diagnostic benefits and then superimpose a Major Medical benefit? It makes a very complicated plan to describe to employees and an expensive one to administer with all the separate benefits to calculate and pay. In 1953 the United States Fidelity and Guaranty Company in Baltimore, Maryland, decided to purchase a single benefit, comprehensive plan for their employees. All medical expenses incurred in a given year were to be combined, the employee was to pay a front-end deductible (I believe it was $50) and then the plan would pay 80% of the excess, up to a $10,000 maximum lifetime. This comprehensive approach, though logical, is not as popular as "first dollar" basic hospital-surgical benefits plus supplementary Major Medical. It achieved real prominence in 1960 when the insurance companies used it for federal employees to compete against the Blues' offering of basic hospital-surgical benefits and supplementary Major Medical. I would estimate that probably 20% of the business today is written using the comprehensive approach. Insurance companies write both approaches.

In recent years, there has been expansion in the so-called first dollar areas: dental, vision, drugs (prescription drugs) are the three primary ones. Of these, I would say that dental can be a valid coverage because bridgework is expensive and some of it is truly desirable. With respect to vision care, that's really questionable. Prescription drugs is part of most major medical and comprehensive plans so that technically it isn't needed as a separate benefit, but insurers were forced to write it because many of the labor unions negotiated it as a first dollar benefit.

This brings up three important points, namely, in 1949, it was firmly

established that health care benefits were to be part of collective bargaining; that employers were clearly entitled to deduct as a business expense their contributions for health care insurance for employees and dependents; and that the employer contribution was not taxable income to the employee. Thus, from that day to this, unions have been demanding better and better health care coverage. So insurers have to concede that, whereas we were in the business to sell insurance, actually the sales were aided by, and in some cases the direct result of, union negotiation. In this regard, there was one difference between the late '40s and the late '50s.

In the late '40s, if Aetna came out with a new benefit, such as the benefit for radiation therapy treatments, I knew any number of employers who would buy it immediately because they wanted their employees to have the best possible plan.

But, by the late 1950s, those same employers would reluctantly say to me, "Dan, we appreciate your notifying us of this new benefit but there is no way we can put it in until the union has negotiated it." So that's one of the changes that I saw over time.

Well, some other interesting things. Earlier, I mentioned the Federal Employees Health Benefits Program. I think that's of interest from the point of view that it was an important milestone in the history of both the Blues and the insurance companies. It should be appreciated that, in general, insurance companies did not permit employee-pay-all plans, because they didn't get satisfactory participation and the experience was generally poor.

The Blue Cross/Blue Shield plans, on the other hand, did. They were a bit more agressive in this regard because they would usually make arrangements with one or more of the employer's employees to act as their "agent" and to go

around on payday and collect the employee contributions. So it's estimated that about half of the federal employees had local Blue Cross/Blue Shield coverage on an employee-pay-all basis at the time Congress considered a uniform health insurance plan for federal employees. And, of course, the Blues were pushing that their plan be the federal plan.

Henry S. Beers, who was then the Vice President in charge of the Aetna Group Division and who subsequently became President of the company, felt very strongly that coverage of the federal employees solely by the Blues would affect insurance company business adversely. So he went to work and lobbied Congress that the federal employees program ought to be either just an insurance company plan or a choice between a Blue Cross plan and an insurance company plan. And, I'm sure you know, it was that choice situation which appealed to Congress because no Congressman wants to offend any constituent. By giving the employees the right to choose between a Blue Cross plan and an insurance company plan, a Congressman could say, I gave you your choice, I didn't pick for you.

Another unusual feature of the federal employees program was that Congress required each of the two types of insurers--the Blues are an insurer in spite of their protests to the contrary--to offer both a very rich plan and a modest plan, the so-called high options and low options. Aetna urged Congress to omit this requirement, pointing out that people are, within limits, able to estimate their health and the healthy risks will choose the less expensive low option while the poor risks will choose the high option. And this proved perfectly true. In setting the premiums for the high and low option under the Indemnity Benefit Plan for that first year, I not only took the actuarial difference between the two sets of benefits, which frankly wasn't too great,

but I increased it 20% for the selection that should result. My estimate was low; the actual difference was almost 60%.

During its deliberations, Congress was petitioned by the existing union plans, primarily those of the postal workers, to be allowed to continue as yet a fifth option for federal employees who were members of the union concerned. My understanding was, that Congress intended only the existing union plans to be allowed to continue. Subsequent administrations interpreted the law as meaning that any federal union could institute a brand new plan and that plan would have to be recognized. Consequently, there has been a fantastic proliferation of such union plans. I think that's been to the detriment of the federal employee, by and large, because it has produced such a confusing array of plans to choose from that he really hasn't known what to do. And it's cost the government more money because the more plans there are in the program, the more expensive it is to administer.

Finally, it should be realized that Kaiser Permanente, which is the nation's leading and at that time one of the very few prepaid group practice plans, had sufficient clout so that they too were included in the program as yet another option. And today, of course, any federally qualified HMO has to be included in the program.

In spite of its huge size and complexity, the federal employees program worked quite smoothly for many years. Recently, however, it has gotten into a tragic mess because the federal government has tried to cut back benefits rather severely, the unions have gone to court and heaven only knows what is going to happen next. Incidentally, although all insurance companies may share in the reinsurance of the high and low options of the Government-Wide Indemnity Benefit Plan, only about 100 or so do. Aetna Life Insurance Company

administers this plan on behalf of the insurance industry.

From a historical point of view, because Congress did decide that there was to be a choice between the Blues and the insurance companies, both types of insurers survived. The Blues did gain an advantage because they kept, that is they enrolled, most of the 50% of the federal employees that they presumably already had covered on an employee-pay-all basis and then gained some of the remaining 50%. And the insurance companies got about half of the remaining 50%.

Thus, the Blues ended up with 54.4% of the enrollees, the Indemnity Benefit Plan with 26.7% and employee unions with 13.2%. This split did not reflect a true preference for the Blues but rather the fact that the Blues had federal employees working as "agents," something Aetna was not allowed to do.

Another point to keep in mind about the federal employees program is the fact that the various local Blue plans did not initially have a good record of continuing benefits for retired employees. This was due in part to the differences in the benefits of the local Blue plans and the fact that many retirees moved to an area served by a different Blue Cross plan. This problem should not have been a factor for federal employees because the high and low options of the Government-Wide Service Benefit Plan were to be uniform regardless of where the employee worked. But the fear remained. As a consequence, many federal employees, when they reached retirement, switched from the Blue plan to the Indemnity Benefit Plan which the Aetna administered.

While the total number of persons enrolled in the Indemnity Benefit Plan remained relatively constant, this influx of retirees from the Blues meant that there were fewer and fewer new active employees. This was a real disadvantage in the sense that the retiree has a higher claim cost than the

active employee.

With the advent of Medicare, this disadvantage was eased a bit because some federal retirees have eligibility for Medicare by reason of employment in the private sector either before or after their government employment and the Medicare benefits were used to offset the Indemnity Benefit Plan's own benefits.

The retirees I have been referring to were those who retired after July 1, 1960, the effective date of FEHBA, the Federal Employees Health Benefits Act. Following the enactment of FEHBA, Congress recognized that something should be done for those federal employees who had retired prior to July 1, 1960. So another act was passed the following year which did offer such retirees a very modest benefit. This closed group of retirees and their dependents had the option of taking the government's modest contribution and applying it to buy the "Uniform Plan" which the Aetna was chosen to administer or to buy any other qualified plan that they wanted to purchase. I would say that roughly 40% chose to come into the Uniform Plan. The Uniform Plan was effective in 1961. Now it is 1981 and most of the participants have died off. The experience was a little better than expected, perhaps because age prevented some from filing their claims.

The hard fact remained that, for any employer, health care coverage for a retiree was about three times as expensive as for an active employee, and hence was not a coverage to be purchased voluntarily. Furthermore, many unions were wary about using their bargaining power in this area. So insurance companies were left with the problem of how to provide coverage for the aged who need it the most but can afford it the least.

No one insurer could handle the problem alone. A joint effort was needed in order to obtain the large volume of insureds needed to cover the extra risk and the expense. Unfortunately, the Southeastern Underwriters decision of 1944 had declared insurance to be interstate commerce and hence subject to anti-trust statutes. So a joint effort per se was illegal. The matter stood at this impasse until one evening when George Light, an attorney for the Travelers, and I were returning to Hartford by train from an industry meeting in New York City. We said, look, we could do this in Connecticut if we could get the right for the companies to cooperate and to underwrite the coverage as a single pool. So the next day we went to our respective Presidents and got permission to draft and seek passage of the necessary legislation.

That legislation did pass and so was established the "Connecticut 65 Plan," which offered reasonable benefits to persons age 65 and older residing in Connecticut. Connecticut 65 kept its expenses low but still had to charge a fairly high premium rate in order to cover the claims. Employers were encouraged to help pay the premium for their retirees--but few did so.

Connecticut, being a small state, did have difficulty getting the volume of coverage sold that was needed to make the pool self-supporting. But the idea caught on and although I think there were only seven insurance companies that participated in the Connecticut pool, we were able to persuade the industry to set up similar pools in other states. I believe Massachusetts was next, followed by New York, California and Ohio. These state 65 plans were just getting rolling when Lyndon Johnson's 1964 landslide election occurred and he was bound and determined to have a federal program for the aged. So the fact that the insurance industry was doing something constructive for the elderly was just lost on the Congress. As a matter of fact, in late November,

1964, following the election but before the new Congress started in the subsequent January, I talked with Wilbur Mills, who was then Chairman of the House Ways and Means Committee and he said, "Dan, the jig is up, President-elect Johnson has just called me and said we are to have a bill in the hopper as soon as Congress convenes and it is going to go through."

WEEKS:

May I just interject here? Didn't Johnson also increase the size of the Ways and Means Committee and stack it with people favorable to his plan?

PETTENTILL:

It was a simple device of saying the Democrats have a larger majority in Congress. Whenever a party gets a substantial increase in the number of their members in Congress, that party is entitled to take the committees and re-ratio, the ratio of Democrats and Republicans. Because Lyndon's victory was a landslide, the Ways and Means Committee was very clearly enlarged and, yes, in making that enlargement, he was very careful to be sure that the House leadership chose people who would be supportive.

WEEKS:

Mills didn't tell me this but I've heard from others that Johnson told Mills, you've got to do something because we've got enough people here to out-vote you on the committee.

PETTENGILL:

At that point we still had an industry effort to try to defeat Medicare but I knew from the start that it wasn't going to work. One of the problems was that even in January of 1965 I still couldn't get the industry to agree to a national pool. We had the several state 65 plans that I've just described. But I couldn't get the industry to agree to a national pool. And I couldn't

get them to take any risk on a national pool, even though we couldn't have taken all the risk. My feeling was that if we could take a piece of the risk with the government taking the rest, we might have a prayer.

At any rate, we weren't willing and so didn't have the muscle to defeat Medicare. When it became obvious that it was going to go through, I went to Wilbur Cohen, who was then the Secretary of the Department of Health, Education and Welfare, and said to him, "I realize that the jig is up and the nation is going to have this Medicare program, but there is a provision in the legislation that Medicare shall be administered by the private sector, unless you find the private sector unable to do it."

Wilbur, who is a very pleasant individual even though he was not exactly in my corner, smiled at me and said, "Dan, I've been planning on this ever since the Great Depression. Because, you know, they tried to get this into the original Social Security Act and just missed by the skin of their teeth because President Roosevelt had a change of heart at the last minute."

WEEKS:

I think he was afraid that he couldn't sell the whole package.

PETTENGILL:

Then Wilbur said, "I could do this all with my own hand, but you're right, Congress is putting that feature in so I appreciate your coming and telling me that you are willing to participate."

I was able to persuade a number of other insurance companies to participate. Walter McNerney, as President of the Blue Cross Association, was also in Washington saying that the Blues would be very happy to do it all.

So there was considerable competition between the Blues and the insurance companies over the administration of Medicare. I must confess, the Blues got

a much larger share than we did, and that was a second milestone for them.

The federal employees program in 1960 saved the Blues because it gave them the ability to offer a uniform plan nationwide for the first time--an ability the insurance companies had always had and used effectively. Furthermore, it united them at a time when their prestige in the group health insurance field was slipping. Medicare was an even greater savior because it lowered the high expense rates of the smaller Blue plans--remember, the Blues are an aggregation of a lot of local plans, frequently one per state but in some states, several per state. In 1965, many of those Blue plans were sufficiently small that they had very high expense rates and could not compete with the bigger insurance companies, whose expense rates were down reasonably low primarily because of their size. Getting the contract to administer Medicare in its area gave the small Blue plan a much, much larger base over which to spread its fixed expenses. This was a salvation for them. If they had not gotten that, a number of them would have simply folded their tents and gone away. Walter McNerney achieved for the Blues two major successes, in '60 and again in '65, for which they should be eternally grateful.

Medicaid, which is Title XIX of the Social Security Act and was enacted along with Medicare, was recognized as a non-insurable item. I felt that it ought to have been on a privately administered basis. However, I could not get the insurance companies to agree to do that, even in areas where they were administering Medicare. A little bit of the Medicaid administration did go to Blue Cross plans. The bulk of it is administered by the states because Medicaid is an aggregate of state plans with federal subsidies. The states were very jealous of the power to do the administration themselves. Even when they subsequently discovered that it was a nightmare, they still haven't done

much in the way of farming it out.

Well, we ought to talk a minute or two about health planning. Before we do that, it would be well to point out that in the early days of health care insurance, the hospitals and the physicians, quite understandably, had real trouble with the fact that there were lots and lots of insurance companies. Usually, in their area, there would be only one Blue plan and it would pay the Blue Cross benefit directly to the hospital and the Blue Shield benefit directly to the doctor. Because there were so many insurance companies each with different benefits and claim forms, insurance companies had real difficulty in getting, particularly from hospitals, acceptance of their benefits as good credit. In many cases relations were so poor, some hospitals wouldn't even admit people covered by an insurance company unless that person made a cash deposit.

So one of the jobs that the insurance companies had to do was to improve their image with health care providers. this was done through the formation of the Health Insurance Council by the then major insurance trade associations. This Health Insurance Council sat down with the American Hospital Association, and to the credit of both, worked out coverage identification forms and uniform claim forms which bore the symbols of both the Health Insurance Council and the American Hospital Association. This enabled cooperating insurers to get over this hurdle of getting the hospitals to honor benefits and admit patients.

Another thing that helped was that the minimum benefits sold improved over time so that the hospital was getting a better deal in accepting them as credit.

The Health Insurance Council also met with the American Medical

Association and worked out a uniform attending physician's form. Then, subsequently when we got into the dental business, the Council worked out a uniform dental form with the American Dental Association.

So the insurance companies have recognized the problem they create by virtue of their multiplicity and have eased that problem by virtue of working out uniform admission and claim procedures. The Health Insurance Council, by the way, is no longer an independent entity but part of the Health Insurance Association of America--which is the major health trade association.

WEEKS:

Now in your early days, most of the commercial insurance companies were paying on an indemnity basis, weren't they?

PETTENGILL:

Not if by the term "indemnity" you mean a fixed dollar amount unrelated to the actual expense incurred. It's true that up until about 1950, we offered to write the hospital room and and board benefit on either a reimbursement basis or a fixed basis. Originally it was perfectly feasible to write this benefit on a fixed basis because of what I mentioned. This was a $3 benefit in 1937 which grew by 1946 to a $5 benefit and by 1950, it was still only about a $10 benefit. So it was not unreasonable, for a plan that could be used all over the nation, to offer a fixed room and board benefit.

But notice, we were reimbursing for ancillary services up to whatever the maximum was, up to $15 on that original plan, and then up to $50 and $100. The ancillary service benefit was always on a reimbursement basis. Please note that insurance commissioners would never let us require the claimant to pay the bill before we paid our benefits. So, technically, we do <u>not</u> reimburse, we pay up to the amount incurred.

By 1950, I said, look we cannot afford to offer this fixed benefit, because if we are going to provide, as we are very clearly going to be asked for, $12 and $15 daily benefits (those seem so ridiculous today, but we were looking ahead to that), we're going to be in the position that the claimant, by shopping around, can find a hospital with a $9 room and board charge and with a fixed benefit of $15. He will make a $6 profit.

I was able to persuade our company to go out of the fixed benefit basis and most other companies followed very quickly, thereafter.

Now, the individual health insurance business does offer room and board benefits on a fixed basis but they have always kept the amount of the benefit sufficiently low so as not to really give the insured an opportunity to make a profit. As a matter of fact, today, about the only thing an individual can buy is a fixed indemnity for each day that he or she is in the hospital. One can't buy reimbursement up to a blanket amount such as $5,000 or $10,000, except under an accident only policy. The problem is one of pricing. Benefits written on a reimbursement basis will rise with inflation whereas a fixed benefit does not. A benefit of $25 per day for each day one is in the hospital is a fixed indemnity, and inflation doesn't change the price. The fact that hospital room costs have gone up to $150, that's your tough luck.

That's a point to keep in mind.

As for surgery, there may have been a few fixed benefit plans, but basically they were written on reimbursement up to a specified dollar amount. On the other hand, the surgeons, bless their hearts, managed to raise their fees sufficiently fast, even before we got into this horrendous inflation, so as to keep them at least equal to the dollar amount specified by the plan. For example, if the plan would reimburse you the surgeon's actual charge for

performing an appendectomy up to $100, his fee was normally at least $100, so the plan became, for all intents and purposes, a set of indemnities.

The early surgical benefits were all on a scheduled basis. In other words, the policy would list about the fifty most common surgical procedures and show the maximum amount the insurer would pay for each of these procedures. Then the policy would say that for all other procedures the insurance company would determine the maximum amount payable on a comparable basis. The insurer's local office would know the maximum amounts for another 100 or so procedures. Any other procedure had to come into the home office where a surgeon would look at it and make a decision as to what the maximum ought to be. So eventually the home office would have a manual with, say, 1,000 procedures in it and the maximum amounts payable.

Surgical schedules are another interesting story. When, in 1938, the first surgical benefit was written on a group basis, somebody designed the so-called $150 schedule. It paid up to $100 for an appendectomy and for most procedures it paid considerably less than that, while for certain very rare procedures, it paid up to $150. If more than one procedure was performed, the maximum benefit for all procedures combined was $150.

When I first came to the Group Division, in some of the lower cost areas of the country, and there wasn't that much variation in fees in those days, you would find doctors who would accept what was in that $150 schedule as their full fee. It was a convenience to their patients and to some extent to themselves because there was no hassle.

The surgeon knew that the scheduled maximum amount was what the individual had and that's what he was most likely to collect as a fee. But then what happened was that surgeons began to say the benefit is entirely unrelated to

the skill required to perform the surgery and you insurers ought to do something. So in 1946 the Society of Actuaries made a schedule based on actual charges under claims received by several of the major insurers . . . that's one of the first things I worked on. This new schedule had a maximum benefit of $200, and better relativity among the scheduled amounts for the various procedures.

Then in 1956, the Society of Actuaries made another study and came out with a $300 schedule. There never was another schedule made, basically for two reasons. First, the California doctors came out with the California relative value schedule which covered far more procedures than the typical insurance company schedules. Second, there was then such a spread in medical care costs, from one area of the country to another, that large employers who had employees all over the country, were saying, look, there is no schedule that does us any good. If we take your $300 schedule and double it, why that might be appropriate for New York City and Chicago but it's too low for San Francisco and Los Angeles and it's too high for New Orleans.

So insurers were forced to write an unscheduled benefit which would pay the surgeon's actual charge, provided it was reasonable. This was the reason, when Medicare came along, for the government saying under Part B that it would pay for 80% of the physician's usual and customary charge but not more than the prevailing fee in the area. Unfortunately, the government overlooked two very important facts. First, most insurance plans then in force still provided surgical benefits on a scheduled basis so that physicians generally were not accustomed to benefits based on a "usual and customary" charge. Second, few, if any, insurers knew what each physician charged, and had only a rough idea of the prevailing charge, and then only in areas where it had many

people covered for Major Medical benefits. (Most Major Medical and Comprehensive plans require that the service be necessary and the charge reasonable.) With Medicare saying that "If you accept an assignment of benefits, you're going to get 80% of your usual and customary fee," many physicians in the country, suddenly, increased their usual and customary fees, but valid statistical proof of these increases was often lacking.

And this was but one of the many problems and changes caused by Medicare that affected all health insurance. Although I have no proof, I am reasonable sure that Secretary Cohen was instructed by President Lyndon Johnson to make the administration of Part B of Medicare acceptable to organized medicine so that the physicians wouldn't strike and ruin the operation of the Medicare program.

Time and again, I would say to Secretary Cohen, "Look, you don't want to do that. I know from personal experience it's going to cause all kinds of problems." But he would ignore my advice whenever the doctors would say, "We want it this way."

One of the best examples of sound advice ignored because of pressure from organized medicine was the handling of the charges for radiation therapy, diagnostic X-rays and pathology. Prior to Medicare, when a patient received one of these services in the hospital, the charge for it was considered as being a hospital charge. Indeed, the charge for the service normally came through on the hospital bill. There was not a separate bill from the physician involved. The physician generally had a separate arrangement with the hospital to pay him for his part in the service, but the hospital did not itemize this on its bill to the patient. So insurers paid the one charge as part of the hospital/ancillary service benefit.

The doctors came down and said, look, we don't want that. We want to bill the patient ourselves. And Secretary Cohen gave into them even after the hospitals said that they would continue to bill the patient for supplies and the use of equipment and hospital employees. What Secretary Cohen finally did was to permit the physician to charge for the "professional component" of the service and the hospital to charge for the nonprofessional component. The former to be covered under Part B and the latter under Part A of Medicare.

So, overnight, the cost of these services was virtually doubled, not just for Medicare but for everyone because physicians very quickly did this for all their patients, not just their Medicare patients. The result was a tragic increase in costs.

That was a battle, it was a bitter battle, but it was lost because Secretary Cohen, I believe, was under instructions from President Johnson to give in to the extent necessary to keep peace with the doctors.

WEEKS:

The AMA was very powerful at that time, weren't they?

PETTENGILL:

Not powerful enough to prevent Medicare from being passed, but powerful enough to mess up the administration.

Those were quite some days. I served on a number of the advisory committees that Secretary Cohen set up. He'd have a doctor, an insurance person, a Blue plan person and one or two others on these advisory committees and we would hammer over the regulations and the administration of Medicare for days on end. It really got quite discouraging because it was so clear that the Administration was not at all concerned about how much it was going to cost to administer the program.

WEEKS:

Well, my impression of Mr. Cohen is that he is looking at the social effect of the legislation and not worrying about the cost.

PETTENGILL:

That's perfectly true. But, as I say, I think we might have won some of these points if there hadn't been the basic premise that the Administration does not want a physician strike.

Another area that probably it would be well to talk about a little bit is health planning.

The insurance industry was solidly behind that and helped to get that legislation enacted and re-enacted. The legislation didn't come out exactly the way we would like to have had it come out. But we have tried to make it work. Insurance companies have urged their employees to serve on both the Health Systems Agencies and the Statewide Health Coordinating Councils. Unfortunately, the average citizen wants the best health care available in his hospital and in his immediate area. It's very difficult to persuade him that the cost of having a fully equipped hospital in every town in the nation would be horrendous. Highly specialized procedures, such as open heart surgery, and very expensive equipment have to be located in centers where they can serve a number of towns and villages, quality of care alone requires this. Even well educated citizens still want the best care right where they are. So it's true that the Health Systems Agencies have not been anywhere near as effective in controlling excess hospital beds and equipment as we had hoped they would be.

Another area where the insurance companies have worked is in trying to get the states to be active in regulating hospitals so as to avoid the unnecessary duplication of facilities. Unfortunately but quite naturally, the hospitals

objected to this and fought such legislation. So what would start as a reasonable bill, in the insurers' opinion, would be compromised in the legislative process and often end up as a non-workable bill. Even a workable bill can be, and in some cases has been, poorly administered by overzealous state officials who work on the hospitals with a meat axe instead of a scalpel. Thus, the record of hospital cost control by state agencies has not been as good as it should have been. In fact, in some states like New York, government has reduced only what Medicaid and Blue Cross are to pay and as a consequence, the hospitals have taken the deficits suffered on those two programs and charged them off to other private pay patients, who are basically the insurance company patients.

There are situations where the hospital charge differential (often called the Blues' discount) has become so great that an employer can't afford to insure his group plan with an insurance company. He's got to insure with Blue Cross and that means that the hospital has essentially nowhere to recover its deficits because most paying patients have coverage of some sort. Thus, some hospitals are facing bankruptcy. The answer has to be reasonable equality of charges for all types of carriers. But equality doesn't exist today, although the insurance companies have tried their darnedest to secure it.

The problem started way back in the Great Depression when several hospitals asked insurance companies to write hospital expense insurance and we properly said it's not insurable. So the hospitals formed their own entities to write the coverage and these eventually became the Blue Cross plans. Because, relatively speaking, both the benefits sold and the amounts of service provided by hospitals were modest, the Blue plans succeeded in those early days. Insurance companies then wrote the coverage in order to compete.

But neither type of carrier, Blue plan or insurance company, was insuring in the normal sense. They were and still are providing an annual budgeting mechanism. At the end of each year, the "insurer" reassesses and says, "Next year the budget's got to be bigger. So if you want the same benefits, Mr. Employer or Mr. Union, you've got to pay more for them." And that's been the story ever since about 1961. We're kidding ouselves when we say we insure it. We insure it for the year and if you are able to change carriers at the end of the year and leave the carrier with a loss, yes, you've had insurance.

While the hospital charge differential is the major problem, another important problem faced by insurance companies is tax differentials. They are not only taxed on their profits, which they should be, but on their premiums as well. But, the typical Blue plan does not pay state premium taxes, although some states have recently taxed them because of the state's need for additional revenue, not because of the justice of the position. In addition, the Blue plans generally pay no property or other taxes because they are considered to be doing a charitable function.

Insurance companies tried to eliminate these differentials on the basis that they constitute restraint of trade. The Travelers actually brought an anti-trust suit against the Western Pennsylvania Blue Cross, only to have the Pennsylvania Supreme Court say, yes, this is discrimination but the state may do so if it chooses. The state licenses the Blue Cross. If it chooses to discriminate, the state has the power to discriminate. So, it has been established that there is discrimination but, unfortunately, there is not a thing insurance companies can do about it.

WEEKS:

They have advantages on reserves, too, don't they?

PETTENGILL:

Well, the basic situation on reserves depends an awful lot on the state. Where the states have been lenient and the Blues have not been required to really set up an adequate reserve, that's been an advantage for them. In other states, the state has required them to set up adequate reserves. So it hasn't been an advantage.

There was one other advantage that some Blue Cross plans had initially, but I think it's pretty well gone now. Michigan was a classic example, namely, the hospitals actually reinsured the Blues. Thus, if, at the end of any year, the Blue plan had suffered a financial loss, the member hospitals had to pay a special assessment to bail out the Blue Cross plan. Such reinsurance has pretty well disappeared. But the fact that the hospital will sell service to the Blues at cost or less, and then charge the public rates for their services which are higher than costs, has been a much greater disadvantage. For example, under the federal employees program, I estimated, and the Civil Service Commission never denied it, that Blue Cross enjoyed at least the equivalent of a 10% discount. It wasn't an actual discount per se, but the costs that the Blue Cross was paying the hospitals were at least 10% below the charges the Indemnity Benefit Plan was having to pay.

Medicare eased the "discount" problem initially. But the present situation, where a state merely holds down the rates that Medicaid and the Blue Cross will pay but not what the hospitals can charge the rest of the people, has made it worse than ever.

We might discuss Health Maintenance Organizations for a minute. Before the term "HMO" was coined by Paul Ellwood in the late 1960s, its predecessor, the Prepaid Group Practice Plan, was not a competitive factor except in

California and Hawaii where Kaiser Permenante was so strong. And even there, a strong insurance company was usually able to avoid dual choice. Furtheremore, when an employer wanted or had to recognize Kaiser, Kaiser for its own protection, always insisted on dual choice. That is, it wanted the employer not only to offer the Kaiser plan but also to offer another plan, so that any dissatisfied employee could switch. That way, the satisfied employees would stay. Kaiser wants to be able to say, "If you don't like us, you don't have to stay. You can change." Most Prepaid Group Practice Plans (PGPP) have generally insisted that an employer offer dual choice. This meant that if an insurance company had the employer as its policyholder, it could usually retain 90% of the employees. Therefore, as far as insurance companies were concerned, PGPPs weren't hurting them. If it were a brand new case that the insurance company had never been in on, the PGPP might do as well as 25% and the insurance company would enroll the remaining 75%. Sometimes a PGPP would enroll all the people that its facilities could take care of and thereafter was not that much of a competitive factor.

The PGPP that survived was the one that controlled hospital utilization, but the concept was an anathema to most physicians. Paul Ellwood then conceived the IPA, the Independent Physicians Association which would offer services on a per capita basis, and which physicians could use to combat PGPPs. To conceal this latter fact and to promote both of them in the cost-conscious Nixon Administration, Ellwood created the term "Health Maintenance Organization" as an umbrella term that would encompass both the PGPP and the IPA.

The IPA usually lacks the strong centralized administration of most PGPPs and usually does not have adequate control of the utilization of services by

either the physician or the patient, whereas a well-run Prepaid Group Practice Plan controls both the patient's demand for care and the physician's use of care.

As you know, and unfortunately, the original HMO Act was not well-drafted, and then HEW delayed unmercifully publishing the regulations. So those of us who felt that the HMO was an idea that should be promoted and who were trying to establish HMOs which our companies would own and operate, were suddenly caught in an impossible situation. Yes, the law specified an employer had to offer his employees enrollment in an HMO if one were in his area--at least one of each type--but the regulations weren't out yet so the employer didn't know what he had to do and he wasn't under any penalty until the regulations came out, so he wouldn't act until they did. You couldn't blame him. "After all, Dan, if I offer my employees your HMO now, the regulations might subseqently say that it is not one that's acceptable and that I've got to do it all over again. There is no way I will put myself in such a bind."

So there we were with our money invested in bricks, mortar, equipment and staff, but no customers. (Most of us were starting PGPPs rather than IPAs.) A lot of money was lost and most insurance companies got out of the HMO business. The situation was most unfortunate because that, in my judgment, hurt, not only the development of the HMO, but also the insurance companies' attitude toward the HMO. A subsequent amendment to the HMO Act made it much more reasonable, so that the present situation isn't too bad. If we were starting today, we could probably live with the law and its regulations. But having gotten into it and lost lots of money--well, once you burn your fingers, you are very gun shy. So today, not too many companies are doing something to promote Health Maintenance Organizations. Basically, the ones

that are doing so are the ones that didn't get burnt the first time. Prudential has done a lot.

WEEKS:

Aren't some of them buying established HMOs?

PETTENGILL:

That's another approach to doing it. One of the things I had hoped to do and we did make one experiment in that regard, was to say to an existing clinic, "Why don't we convert your patients gradually to an HMO scheme, by getting their employers to put in dual choice."

There was nothing radically wrong with our one experiment except: (a) it didn't move fast enough to really pay for itself; and (b) the physicians, by and large, could not be restrained from their old habits and they continued to put too many people in the hospital for too long. So we didn't get what Kaiser got by having its own hospitals, namely, limited use of the hospitals. That's the key to this whole secret of the HMO. It spends more money in providing physicians' services, because it usually provides more physician services than does the typical insurance company plan, but it saves on the use of the hospitals.

WEEKS:

There is no need to hospitalize a person just for economic reasons.

PETTENGILL:

You are correct. Speaking of economic pressure, Medicaid is a classic example. When a poor person who has no home is in ill health, where are you going to keep him? In the hospital, of course! Another illustration is the child being bitten by rats in the run-down tenement where he lives. He is taken to the expensive hospital, treated for the rat bite and then sent back

to the tenement where he just gets bitten all over again. It's a vicious circle.

Under Medicaid, there is no question but what there is excessive use of hospitals. Part of the problem is that in this nation we do not have a good backup system of skilled nursing facilities and the so-called "intermediate care" facilities which should provide some of the care now provided in hospitals. When Medicare was enacted there were some facilities that could have qualified as intermediate care facilities with little extra expense. However, most of those tried to jump up and qualify as skilled nursing facilities (originally called "extended care facilities" under Medicare). This was an unfortunate situation because many of them did not succeed or succeeded only at great expense and sometimes poor service.

In most areas of this nation, we still don't have a good, coordinated step-down system of intensive care, regular hospital care, skilled nursing care, intermediate care and home care. Knowing human nature, I believe that all of these levels except home care need to be in one building, so that the physician feels comfortable. Sure, he will have to walk down four different corridors to see his patients. But he wouldn't have to drive a mile over here and two miles over there to go to a skilled nursing facility or an intermediate care facility.

WEEKS:

We've had something of that kind over at Manchester.

PETTENGILL:

Manchester is a good example and there are a few other hospitals. But it's unfortunate that most hospitals do not see that coordinated step-down care is something that would work. Of course, if I were in the shoes of a

hospital administrator, I would probably say; "The patient who doesn't need much care is where we make money and we lose money on the patient who needs an awful lot of care. So we've got to have both types of patients in order to live."

It is true that the more accurately patients are classified by level of care, the more expensive "regular" hospital (acute, nonintensive) care will become as the "easy" patient is reclassified to the skilled nursing care level. I say: "So be it," because the third party payors would be paying their respective shares more accurately. Today, there are any number of situations under Medicaid where, unfortunately, the state and federal governments are paying through the nose because there is no step-down facility into which to put the individual who has either no home or an unfit dwelling to back to. If discharged, he'll be back in another week or so. This is a real tragedy for the nation and it's something that ought to be worked on.

WEEKS:

I was going to say that Medicaid in itself is very bad in that there is no uniformity of benefits throughout the states. Some states, I believe, don't even offer so-called nursing home service. For a long while . . .

PETTENGILL:

It could be a very tiny benefit. Basically speaking, what Title XIX of the Social Security Act requires is that the state have a benefit, but the size of the benefit is unspecified, in each of several categories, hospital, surgeon, diagnostic, x-ray and so on. I'm not sure whether it's still true or not, but at one time Oklahoma, for example, only provided ten days of hospital care a year. Now it's true that medical science has reduced the average hospital stay from fourteen days, which it was in 1946, down to less than

seven days today. Nevertheless, there are plenty of people who need more than ten days of hospital care. As you say, most states do not provide for much long-term nursing care. Those that do are finding it eats up most of their Medicaid budget. Such states include Connecticut, New York, Massachusetts and California. The amount of money that goes into long-term nursing care is just incredible under the Medicaid program.

I think custodial or long-term care, where there is no reasonable hope that the individual is ever going to recover, has got to be a welfare benefit in this country. I see no way of insuring or "budgeting" long-term care that is going to go on year after year.

WEEKS:

Because the costs are so great.

PETTENGILL:

Not only is the cost so great, but it's the fact that the level of comfort demanded will vary. It will be whatever the third party payor is willing to pay for. Let's face it, one of the reasons people turn up their noses at some nursing homes is because they don't provide the appurtenances that they are accustomed to. And those that do, of course, are gold plated.

WEEKS:

Yes, I was in one this week, the Upjohn Nursing Home in Kalamazoo. Upjohn family endowed and so forth. It's a beautiful place. Anyone who had to be in a nursing home would certainly enjoy being there.

PETTENGILL:

I recognize that we are all human beings and we've got to be treated reasonable. On the other hand, if you are so unfortunate that you have become a cabbage, there is, in my judgment, a limit as to the amount of public

dollars that can be spent. We've got to give you humane treatment, but we can't give you luxury treatment in plush surroundings.

WEEKS:

I agree with you.

PETTENGILL:

Speaking of this problem of the poor, we haven't talked about national health insurance. As you will recall, that has been on the docket for decades. I guess it was put on the docket before World War I but my knowledge of that time is not that great. It certainly was on the docket during the Great Depression and has stayed on the docket ever since. Fortunately for our business, it was seldom a priority item; the only activity in Congress each year being the introduction of a few bills and the making of a few speeches. It became serious, of course, after Medicare was enacted in 1965. I must confess, I would have said in 1965, that Medicare would be extended to virtually the entire population within ten years.

So, in addition to going to work on administering the pieces of Medicare, Aetna got the insurance industry to go to work on a national health insurance program, the basic principle of which would be the continued use of the private sector and the group mechanism to the maximum extent feasible. The industry's bill made it mandatory for an employer to provide a certain minimal level of benefits. For small employers, the bill would establish a pool in each state from which they could buy the minimum benefits at a lesser cost. Let's face it, the per employee administrative cost of a group plan for ten lives is much more expensive than that for a thousand lives. So we recognized that a mandate for small employers to buy coverage for their employees and dependents would force the insurance business to develop pooling mechanisms so

the cost of administration would not raise the premium unduly for such employers.

But we were still left with the problem of the poor, who don't have the money to buy insurance. In fact, the near-poor are hard pressed and probably cannot really pay for a good plan because they don't have that much income. To solve these two problems, we proposed that the federal government require each state's Medicaid program to be uniform as to both benefits and eligibility. The Medicaid benefits would be the same as the minimum benefits employers were being required to provide their employees and dependents. Eligibility included the poor and the unemployed near-poor, with the latter required to pay a part of the premium proportional to their income for the previous year. Finally, these revised Medicaid programs would be administered by private insurers. In my judgment, this proposal would solve most of the problems of the present Medicaid programs. Obviously, if the benefits were to be reasonable, the total dollar outlay would be greater.

As you perhaps know, my company was having a little difficulty getting the industry back of this proposal. It's the old story. So I guess I did a sort of end-around play. Wilbur Mills invited me to appear before the Ways and Means Committee in the fall of 1969 at which point I presented this proposal in outline form, as being what I, D. W. Pettengill, thought ought to be done.

This presentation had the desired result in that the industry got very concerned as to what I was doing. They wanted one or two changes in what I was proposing. They were minor changes, so that, fortunately, the industry did get together and adopt a program of national health insurance, which was quite similar to that which I outlined before the Ways and Means Committee in 1969. This agreement came in part because NHI was a red hot issue in 1970 and

the insurance needed a positive position on NHI in order to combat Senator Ted Kennedy's Health Security Program which was a complete takeover of the private health insurance business by the federal government. We were really pushing very hard. We had a good program and we got it introduced in the Congress so that it would get more recognition. The pressure for some sort of national health insurance continued until about the end of Nixon's administration when Caspar Weinberger, now Secretary of Defense, then Secretary of HEW, really did make a last-ditch effort, as did Wilbur Mills, to get something through. And, as you know, Wilbur was short just a few votes of getting his compromise through. Since that time, the NHI issue has quieted down, primarily because of the very rapid rise in health care costs.

WEEKS:

Yes, it's a very quiet issue. I must, as an aside here, remark that I think that your name is probably the only one I've seen attached to a national health insurance proposal that wasn't the name of a member of Congress. You've probably seen the Research & Statistics back from that time which includes your "Pettengill Proposal."

PETTENGILL:

A topic I think we might discuss is the over-insurance problem or the duplication of benefits problem, whichever you prefer to call it. This was first noticed by those states in which, in the late 1940s and early 1950s, the medical societies established surgical schedules. Wisconsin was one; Tennessee and Rhode Island were others. In these states, the medical society felt that the surgical schedules used by the insurance companies, in particular, and to a certain extent the Blues, were inadequate and that they obviously knew better how to prepare a schedule. So they did.

In some states, like Rhode Island, the medical society said that only the Blue Shield could write the schedule. In others, notably Tennessee and Wisconsin, insurance companies were permitted to write the schedule as well as the Blue Shield plans. The advantage to these schedules was that the physicians agreed to accept its allowance as their full fee. So insurers had the advantage way back in those early days of a really fine 100% insurance program as far as surgeons were concerned.

There was a problem, however, namely, that the surgeons frequently wanted to change those schedules. Policyholders soon became unhappy because often they weren't ready for a change, particularly if they had a labor agreement in force, yet they were having to change in order to have their schedule meet the medical society requirements and hence continue to qualify for the full service feature.

Then, in addition to that fact, the schedule only benefited the employees of the employer who lived in that state. So if you had a multistate employer, he soon lost interest. Thus, unfortunately, this very fine effort on the part of the medical profession to come up with full service surgical schedules eventually fell on its face because of those two problems.

Now, getting back to my point about duplicate coverage, the doctors soon found, to their dismay, that some patients would have coverage under more than one group plan. The physicians were adamant that no one should make a profit on their services. So, finally, the Rhode Island Medical Society actually passed a resolution saying that any physician who found a patient with more than one coverage was to charge more than one fee. In other words, he charged a fee for each coverage that the patient had. So, if the patient was covered under three policies, and the normal surgical benefit was $50, why, the

surgeon was to charge $150.

Well, you can imagine the reaction of the insurance industry to that sort of situation. So we began to worry about it. When the supplemental Major Medical came along in 1950, we were particularly concerned about what on earth would happen if the claimant had two benefits each of which paid 80% of his expenses up to $5,000; that was going to be 160% of his expenses.

So, we said there has got to be some kind of a provision which will avoid that situation. We wrote the original early policies in those states that would permit us to do so with an actual exclusion. We just didn't pay if there was other coverage. Well, that wasn't a very acceptable solution as far as the public was concerned.

A number of us in the insurance business went to work to try to find solutions. Each company came up with a different solution and that made for all kinds of problems because solution A would clash with solution B and the claimants would be unhappy. So, in 1961, the Health Insurance Association of America appointed a committee to study the problem. This committee came up with a definition of the problem and a list of possible solutions. Then the HIAA Board said, "We can't have more than one solution. If we are going to have coordination of benefits, there has got to be just one solution that all carriers use." The committee got sent back to decide which was the best solution and to recommend it.

This we did and in 1962 we recommended what is known as the model coordination of benefits provision. It was adopted by all the major companies, and ultimately by all insurers, even Blue Cross/Blue Shield. Basically, it was a very simple statement. It said that the insurers had to take into consideration all of the expenses that the individual had insured

under any one of his policies, regardless of whether they were insured under all of them or not. So the insurers would count as "allowable" expenses all the expenses that the claimant had insured under any one of his policies and would permit him to collect benefits under all of the policies combined up to 100% of those expenses. To determine which insurer would pay first, the provision set up an order of benefit determination. The committee tried to come up with something very simple. We said if the insurer covers the claimant by reason of the claimant being an employee, that insurer will pay first. If the insurer covers the claimant as the dependent of an employee, that insurer will pay second. Next, we added a rule that if the claimant were an employee under both policies (because there is moonlighting), then the period of time that the claimant was covered would govern. The policy covering the claimant longer would pay first and the policy covering him the shorter period of time would pay second, and so forth.

In addition to the rules determining the order of benefit determination by the carriers, there was an overall rule that a carrier could not reduce its benefits unless and until it could show that the claimant would be collecting more than 100% of the expenses which were "allowable" expenses. It was a liberal rule, and was criticized for being too liberal. However, it was a fair rule because it said to the employee, okay, if you want to carry more than one coverage or if you are forced to carry more than one because the unions have negotiated noncontributory coverage, this model coordination of benefits (COB) provision at least permits you to collect all of your "allowable" expenses. You're not out of pocket anything for expenses you insured but you're not making a profit on them. And, therefore, you, Mr. Physician, have no business charging an extra fee by virtue of the fact that

this person has multiple coverage.

As I say, this provision spread quite rapidly and is, I think, in virtually every group health care policy today. Insurers who didn't want to use any COB provision, particularly those who wrote individual coverage only, were not very happy about it. In fact, there was a suit, the American Family Life of Georgia sued the Aetna and a half dozen other companies. The Aetna was sued because I was the chairman of the committee that designed the model COB provision. Fortunately, we won the suit. The courts properly said that COB was a necessary thing and the use of it was not in restraint of trade. Overinsurance was a problem that had to be solved and all the defendant insurers had done was to come up with a workable solution.

WEEKS:

Wasn't there an expose? I think it was "60 Minutes" or one of those programs that exposed practices of some of these smaller companies selling to individuals, particularly to the poor and people who didn't understand. Some people would have five or six policies with probably an indemnity of so much a day or something. This has been a problem too, hasn't it?

Also, isn't there some kind of an argument as to how two types of insurance will work, let us say automobile insurance. Whether the automobile policy covers the health benefits necessary to take care of the person injured in an accident?

PETTENGILL:

In the initial report, the HIAA committee did work out a schematic diagram as to how all of these various coverages would be coordinated, including a government program. But, what happened was, the various state insurance departments, backed up ultimately by the state legislatures, finally said the

only plans that could coordinate were group plans with other group plans. There was to be no coordination with individual plans. This was a most unfortunate development, as far as I am concerned. Basically, the HIAA's committee recommendation was that any government program should pay first, because it would be a tax-supported program. Then, the group plan, being a sort of a social scheme of the employer, would pay second. Individual policies would pay last.

The rationale was partly equity and partly ease of administration because under an individual policy, the insurer can say to the insured, "If you want to collect your benefits you must report what other coverage you have." It's easier for the insurer of an individual policy to detect other coverage than the insurer of a group policy. The insurer of a group plan relies primarily on the employer and the employer has no way of knowing what other coverage a claimant may have. Admittedly, both types of insurers can ask: "Where does your wife work?" And if you tell me that she works at the ABC Company, I may know what benefits the ABC company group plan provides.

It's true that group coordinating only against group is easier to administer. But I don't think it was simplicity of administration that caused the insurance commissioners and the state legislators to so decide. Their concern was that if the claimant bought an individual policy and paid a premium for it, the insurer shouldn't be allowed to reduce the benefits. The fact that an insurer should be allowed to reduce the benefits in order to prevent a claimant from making a profit, just never had that much appeal. In addition, labor was opposed to any reduction. In fact, I spent an awful lot of time racing out to states to testify against bills where labor would try to outlaw any coordination of benefits provision. Fortunately, the HIAA managed

to keep COB intact and now it's generally accepted. It was, in my judgment, a very fair solution to a very difficult problem.

WEEKS:

Do you mind if I ask you a few questions about some of the things we may have covered?

One of the things I asked Walter McNerney was why Blue Cross was losing some of its share of the health insurance market. They have lost some of the percentage, although Blue Cross is very great and it's still the biggest of any of the insurers, I believe. Is it because there is more competition now?

PETTENGILL:

Both the Blues and the insurance companies have lost a substantial portion of the group health care insurance to self-insurance, partly because of the premium tax and partly because of claim reserves. In virtually all states, if an employer self-insures his group plan, he is not subject to premium taxes. Let's face it, for a large employer, the premium tax was frequently 40% to 50% of the total administrative cost of the plan. Forgetting the claims, say the insurer's actual expense rate was 3% and the premium tax was 2%, so a large employer would have to pay an insurance company a total of 5% over claims. Whereas, if the employer self-insured the plan he would save the 2% premium tax or 40% of the total expenses. This assumes he could administer the plan as cheaply as the insurance company, which is questionable, but large employers often feel they can.

The other problem was the claim reserve and this applied to both the Blues and the insurance companies. An insurance company, and in most states the Blues as well, is obligated to set up a reserve for claims which have been incurred but haven't yet been paid. Such claims range all the way from the

accident that just happened and the insurer does not know a thing about it except that the individual has a potential benefit equal to the maximum provided by the plan, to the claim that has been reviewed and approved but the check has not yet been mailed to the claimant. The claim reserve is the actuary's best estimate of the aggregate of all these claims that are in process.

The claim reserve depends on the type of coverage, but the reserve for a typical plan would amount to anywhere from two to three months' premium. So you can see, therefore, that that's a substantial amount of money. If an employer is paying you, for example, a million dollars a year, and you've got to set up three months' premium as the claim reserve, that's $250,000. In general, insurers do not pay interest to policyholders on that reserve. In one sense, insurers may not earn interest on it because even though they have to hold that reserve, they are constantly drawing it down to pay old claims and then rebuilding it to pay new claims. So it's a real question as to just how much of the claim reserve the insurer actually earns interest on. The insurer does earn interest on a piece of it, but seldom pays that interest to the policyholder.

So, large employers argue, if we self-insure, we won't have to pay premium taxes, which will save us anywhere from 2% to 3%, depending on the state, and we won't have to set up claim reserves. Now, perhaps we should, but we don't have to. And in a tight cash-flow situation, that is a very important consideration.

Thus, employers started to self-insure. They did find the task quite difficult because the modern day group health care claim is not a simple one to settle. So there was pressure on the insurance company to sell its claim

service. In other words, the employer self-insured the plan but then hired the insurance company to settle the claims. Most insurance companies refused to write such "administrative services" contracts for a long, long time. Unfortunately, or fortunately, depending on which side of the fence you sit, independent agencies started to say, "We'll be very happy to settle the claims for you." And then one insurance company after another weakened and agreed to sell their claim service.

Insurance companies devised all sorts of schemes in between pure insurance and pure self-insurance. All at least partially reduced the amount of premium taxes payable and many reduced the claim reserves necessary.

One of the earliest of these schemes was the Metropolitan's minimum premium plan. Under this scheme, the employer set up a bank account from which the insurer paid the claims and the premium the employer paid the insurer was primarily the insurer's administrative expense. So if a pure insurance plan had required $900,000 for claims, $80,000 for administrative expense and $20,000 for premium taxes, this minimum premium plan would require the same $80,000 for administrative expense but only $1,633 for premium taxes. This saved the employer $18,367.

Some states ruled this minimum premium plan illegal, others said it's perfectly legal. Today, such schemes have generally been replaced by pure self-insurance with or without a separate administrative services contract exempt from premium taxes. Thus, while inflation has kept premium income rising, most insurers' premium income in constant dollars has been reduced. For example, when I retired in 1978, Aetna had about a billion and a half of group health premium which would have been well over two billion were it not for self-insurance.

Self-insurance has had the same effect as far as the Blues are concerned. Indeed, I suspect an administrative service contract is more difficult for Blue Cross plans because they are used to paying costs to hospitals rather than charges. Sure, life is more competitive, but I think that's the thing that's hurting the Blue Cross.

WEEKS:

Until there's some default somewhere, someone is unable to pay a claim, this is going to be the big test if that ever occurs but I suppose most of the companies that are doing it are large enough so they have access to cash sufficient to borrow from somewhere to meet this.

PETTENGILL:

Let's face it, I hope International Harvester doesn't go bankrupt, but there's a company that's on real tough times now and they are self-insured. So it's conveivable. Insurers said to the state legislators and the state insurance commissioners, that self-insurance should not be permitted because there is no guarantee that benefits are going to get paid. But it's the old story, in any one state, a big employer has more weight than you do.

WEEKS:

When you are in Dearborn, Michigan, Ford speaks loud.

We talked something about indemnity versus the service contract and I think we have a fairly good picture of that.

PETTENGILL:

I hope so. For example, the federal employees program is a perfect illustration of the confusing use of the terms "indemnity" and "service." The plan which the insurance industry offers (and the Aetna administers) is called the Government-Wide Indemnity Benefit Plan, but it is on the "payment up to"

basis rather than a "fixed amount" basis. The plan which the Blue Cross administers is called the Government-Wide Service Benefit Plan, but it does not provide any service. It simply pays the provider for such covered service as is rendered and if the provider is not a "participating" provider, there is a dollar limit on the amount paid. Note that the benefits of the GWIBP can be, and generally are, paid to the provider by the execution of an assignment. The HMO does provide a true service plan because it is doing both the delivery of the care and the insuring of the care. That's the key ingredient of the HMO. But Blue Cross and Blue Shield are both really insuring. Now that's a nervy thing for me to say and it bothers the Blues to be called an insurance carrier but in essence they are mutual insurance companies.

Some employees may be misled into thinking the GWSBP provides service but I doubt that many think the GWIPB provides specified fixed dollar amounts regardless of what the individual's expense may be. Most employees today don't even know that there used to be a fixed hospital room and board plan. I don't think there are any left on the group side. There are a fair number on the individual side because that's the only thing individual insurers can find to write.

WEEKS:

That's a good explanation.

I wanted to ask you about deductibles and copayment. The purpose, as I understand it, in all cases where it has happened, particularly Medicare politically, was for possibly controlling the use of services, preventing over-use. But then the Blues and Aetna, I'm sure, and other big companies sell insurance to cover the copayments and deductibles. Has something been

lost here?

PETTENGILL:

Let's put a few definitions in the book. The word "copayment" is a loose term which generally includes both deductibles and coinsurance. Coinsurance is a specific percentage of each expense that the claimant must pay himself, the carrier paying the balance, i.e., 100% minus what the claimant pays. People frequently speak of an 80% coinsurance - that's a misnomer because what they mean is the insurance company will pay 80% and the claimant will pay 20%. So, really, the coinsurance is the percentage the claimant pays.

The deductible is normally intended to mean an initial dollar amount which the claimant must pay before the insured benefits start. Alternatively, the deductible may be expressed in terms of services. For example, the plan could say that it won't pay for the first two visits to a doctor, or it won't pay for the first day's confinement in a hospital. Medicare, you may remember, was originally going to be written to say, we won't pay for the first day in the hospital. The insurance industry finally convinced the House Ways and Means Committee that that was totally impractical, dealing as Medicare would be with low cost hospitals in Mississippi all the way up to high cost hospitals in California, a difference of over 100%. What the committee finally did was to take the national average cost of one day's hospital stay and set the deductible equal to that average. Of course, that again was unfair to the people in low cost areas because they had a much greater deductible than did the people in high cost areas, but at least it was administrable.

One of my complaints about the Medicare program is that it failed to take into consideration the fact that medical care costs vary tremendously from one

area to another. The government's argument was the tax rate is the same nationwide so that employees who had low wages in Mississippi didn't pay as much as the people did in California who had higher wages.

Given that a deductible is either a dollar amount or a service amount at the front end that the claimant is responsible for before he can get any benefits, it is a mistake to think of it as a claim cost control item unless it is very large. I think you'll find very few knowledgeable insurance company people who ever consider it as such. It is simply a device for lowering the premium. It does this in two ways. First, it saves claim dollars. For example, a $50 deductible means the insurer does not have to pay the first $50 of expenses the individual incurs. If the benefit is 100%, the insurer saves up to $50. If the benefit is 80%, the insurer saves up to $40.

Second, a deductible saves on administrative expenses because the insurance company does not have to pay the little claims which are less than the deductible. This is particularly important when you are talking about a comprehensive medical expense benefit plan that covers everything from hospitals and surgeons, which are big bills, to ordinary physician's visits and prescription drugs, which can be quite small.

The deductible normally eliminates the claim involving only one visit to the doctor at which he tells you that you've got the current virus, here's a prescription, so get yourself some penicillin and take it.

So you see, a deductible is a device that will reduce claim costs and claim settlement expense, thus permitting the insurer to charge a lower premium. But it was never intended as a health care cost control feature. Unfortunately, many laymen and some people in Congress do not understand this and, therefore, are very unhappy that the deductibles in Medicare have not

provided control on health care costs.

In theory, coinsurance, i.e., requiring the individual to pay a percentage of each expense he incurs, or each expense he incurs after the deductible if there is one, not only permits a mathematical lowering of the premium because the insurer is paying less than 100% of the bill, but also, supposedly, has some control on health care expenditures. This is so because the claimant should think twice before he incurs an expense of which he has to pay a percentage. So coinsurance should be a claim cost control measure and, to a certain extent, it is. But it is not as great a claim cost control measure as we might like, for a number of reasons.

First of all, the percentage of an expense that the claimant must pay has to be strongly related to his or her income for it to have an effect. A 20% coinsurance on a $1,000 bill has no effect on a $100,000 per year executive. It's just a nuisance. So, it doesn't deter him one iota. But if you're only making $10,000 per year and you are faced with a $1,000 bill--20% is $200 and that hurts. To be effective, therefore, the percentage of coinsurance must be related to the claimant's income.

Now, it just isn't practical to write a group plan with coinsurance that varies by earnings. There are two reasons; one, it makes the administrative costs of handling the plan that much greater, because the coinsurance has to be determined separately for each claim. Second, employers are sensitive about divulging income information and don't want to do it. In the early days, insurers tried to grade the deductible under major medical plans by income class--$50 for the low paid, then $75 and $100 and possibly $200 from the top executives. Well, most employers resisted saying the classes practically reveal income and anyway I want to give my executives a little

plus, so use a $50 deductible for everyone. After all, the employer's contribution toward the cost of the plan was a valid business expense for him and was not taxable income to the employees. And there won't be any objections from the rank and file employees, because they don't understand how much of a nicety the executives are getting. In the days prior to Medicare, executives often got charged higher fees for a given service. So a common deductible was a real benefit to them.

Twenty years ago, certainly thirty years ago--and I argued this with Nancy Reagan's father, Dr. Davis, when he was the president of the American College of Surgeons--the thinking of most surgeons was, I will charge the patient one month's income for my services. And, oh, how he believed in that principle. I tried to tell him that the principle was no longer valid. I told him that if most people are going to have insurance, then doctors have got to have one fee for a given procedure. It should be a fair fee for the service provided but that fee has got to apply whether the patient is dead broke or a millionaire.

WEEKS:

I raised that point with a surgeon one time and he explained it this way. He said, "Well, if I operate on John D. Rockefeller, I'm taking a lot more risk that if anything goes wrong, it'll ruin my reputation."

PETTENGILL:

And there's a little bit of justice to that, but you're going to have the John D. Rockefellers sufficiently infrequently that I don't care how you handle that fee as long as you don't expect me to recognize your $5,000 fee as being valid when $100 is the going rate.

Getting back to coinsurance. We soon found that grading coinsurance was

difficult to administer and caused all kinds of problems with respect to divulging salaries, so it just never flew. Even the deductibles, that initially were slightly graded by class of salary, faded away quite quickly. Aetna gave them up inside of about three years. The Connecticut General was one of the insurers that held on to them longer than most, if my memory serves me, but even they gave up eventually. So there is no data on how effective copayments are when related to earnings. We do know that 25% coinsurance is not effective as a deterrent to spending for most employees. We also know that unions do not like plans with any form of copayment. Even if coinsurance related to earnings were feasible, insurers would have to be concerned with the heavy burden coinsurance imposes when the claimant has large medical expenditures that are necessary. This concern led to the development of a special policy provision limiting the total dollar amount of coinsurance that would be required of the individual or the family in any one year. These limits have ranged from $500 to $2,500 with a $1,000 annual limit per family being the most common. Another way of describing this feature is a statement that if the coinsurance would exceed $1,000 in one year, then beyond that point, the plan will pay 100% instead of 80%. This feature avoids the heavy expenses of a major illness becoming a financial catastrophe for the family. As I say, a lot of employees in this nation do have good catastrophic coverage because they've got a limit of $1,000 per year on what then can be out of pocket with respect to covered expenses.

The phrase "With respect to covered expenses" is terribly important because none of us can insure the custodial or long-term care we discussed earlier today. Thus, even with catastrophe coverage, an individual can go bankrupt if he or she is so unfortunate as to need custodial care for a long

period of time. But, as I said earlier, I see no way of handling long-term care except as a welfare benefit, which is unfortunate.

Another problem area for insurers is mental disorders. I tried my damnedest and originally had no exclusions or limitations on mental benefits because I was sympathetic with the people who had a real mental illness. But the insurers' difficulty is that the psychiatrists and the psychologists, with a few exceptions, just were never willing to differentiate between what was essential care and what was desirable but not essential.

Consequently, there are situations where, if the individual is willing to pay, the care will go on year after year. The only visits that never get made are the visits in August when the doctor takes his vacation. Other than that, he sees the patient at least once a week. Now, I can't say that he isn't doing the patient any good. On the other hand, there isn't any visible evidence that he is doing the patient any good. The patient might say, "I feel more comfortable." So the insurer is really hung, with no ability to control visits. Furthermore, in some jobs there is a much greater tendency for the employee to use psychiatric care. The federal employees are a prime example--their jobs are so insecure, a change of administration from Republican to Democrat or Democrat to Republican--and WHAM!, there's a great housecleaning. Sure Civil Service saves jobs for a lot of them, but even Civil Service can't help the employee whose job has been abolished unless there is some other federal position to which he or she can be transferred. Many of them do get "saved" by reason of the new jobs that new legislation is constantly creating.

In any event, the federal employee does have a greater degree of job insecurity than many employees and, therefore, is more apt to use psychiatric

care. The psychiatrists found this fact out early in the game, and Washington now has more psychiatrists and psychologists per capita than any other city in the nation. As a consequent result, the Indemnity Benefit Plan got to the place where 8% of its claimants were taking 32% of the claim dollar. These were all mental situations. The old once-a-week visit, ad nauseum. It wasn't schizophrenia or something serious like that. It was just an anxiety neurosis or whatever you want to call it. I simply had to say, the plan can't afford to pay regular benefits. I tried various things. I increased the coinsurance from 20% to 50%. The result floored me. Even medium paid secretaries nevertheless continued paying 50% of the cost of one visit a week, year after year. So my final conclusion is that mental and nervous benefits--except for a case that's covering just heavy laborers, such as coal miners, who are not apt to take psychatric care--must have a specified dollar limit that the employer is willing to pay year after year. So I say, Mr. Employer, how much of your premium do you want to go into this mental category? You tell me and I can pretty well dictate to you whether I can provide thirty visits per year or 100 visits a year, so tell me what you want to spend. Ambulatory care for mental conditions is a perfect illustration of where even a 50% coinsurance for moderately paid employees has essentially no significant effect.

WEEKS:

That's a very interesting thing. I had been under the impression, particularly in Medicare, that the so-called supplemental insurance was destroying the purpose of the copayment.

PETTENGILL:

I'm sorry, I didn't answer your question. Unfortunately, we do not know

the effect of an insurer writing a supplemental benefit which pays the 20% coinsurance or the $75 deductible or what have you.

Interestingly enough, it was primarily Blue Cross and Blue Shield who did this, at least initially. The reason was the fact that the Blue Cross plans had contracts with the hospitals and the Blue Shield plans had contracts with physicians and both types of providers wanted to be paid 100% of their charges. Medicare charges a deductible before one can even get either the hospital benefit or the physician benefit. So it was provider pressure more than insurer pressure that caused the offering of private policies to supplement Medicare. There was also union pressure.

Initially, I refused to provide a supplement that would pay Medicare's 20% coinsurance because I agreed with Congress that the nation should have a chance to see how it was working. But with the Blues having almost half the private coverage in the country and the Blues covering the coinsurance almost at once, the insurance companies gradually did too. Now, almost all insurers will do so if pressured. Unless Aetna has changed after I retired, Aetna willingly agreed to write the hospital deductible because that was an expense that it was insuring even before Medicare, so no violation of principle was involved. Furthermore, the hospital deductible under Medicare was large enough to warrant being insured. In general, however, I recommended against insuring the 20% coinsurance under Part B of Medicare. Except for one or two cases where the employer was faced with a union demand and Aetna was faced with multi-million dollar loss of premium if it didn't, Aetna has not written coverage of the Part B coinsurance. But so many insurers have that Congress is correct that there can be no proof of whether or not it might have exercised some claim cost control.

WEEKS:

We talked something about reimbursement and about Blue Cross's cost plus. I've always been concerned about trying to arrive at cost. As you mentioned before, there are some things that finally end up in the bill of the private-pay patient and he may be one of your customers who just is being paid a sum, an indemnity, which doesn't cover what he is being charged as a private-pay patient. Is there any better way that this can be done, do you think? Any better way that reimbursement can be made?

PETTENGILL:

I think the American Hospital Association finally came to realize that the only long-term solution that's viable from the hospital's point of view is to set its charges so that each is reasonably related to the cost of the service provided, but with a little margin because, after all, you've got to set your charges today and your costs don't get incurred until tomorrow. It's humanly impossible to set your charges precisely equal to your costs. You've got to have a little margin in there for breakage.

Nevertheless, hospitals should set charges reasonably related to their costs and then those charges should be the basis for reimbursement by everybody whether it is Blue Cross under an agreement whereby Blue Cross pays directly to the hospital or whether it's an insurance company that the hospital wouldn't touch with a ten foot pole because it sells such modest benefits. The point is that everybody should pay the same fair charge for a given service at a given hospital.

The hospital's difficulty is that it started originally by saying to Blue Cross, yes, we'll sell it to you at "cost" and then permitted various definitions as to what cost was. Most Blue Cross plans became strong enough

so that they defined "cost." Some would cover bad debts and others wouldn't. Some would cover interest payments, some wouldn't. So you had a whole gamut of things that were either in the Blue Cross formula for determining "costs" or not.

Then Medicare came along and set up its own definition of "cost." To the extent that the Medicare definition was more liberal than the Blues' definition, the hospitals forced most of the Blues to agree to a similar or better definition than Medicare. However, there were still inadequacies in these definitions of cost; for example, the costs not covered by Medicare, Medicaid or the Blues continued to be passed on to the other private sector patients. Finally, in those states that regulate only costs for Medicaid and the Blues, this disparity has just gotten out of bounds.

WEEKS:

You were speaking about areawide planning. I suppose certificate of need and all that sort of thing that might come about. I'm thinking now of our hospital that's being built at the University which will replace some beds which have been kept up over the years, there have been continuous renovation programs going on, yet someone, I think, is building a monument. Nearly three hundred million dollars for less than a thousand beds. When I tried to translate that into depreciation and into--I don't know it's going to be financed . . . I think it'll be a bond issue of some kind. Just think of the cost per day per bed, just for financing and depreciation.

PETTENGILL:

Then you throw in the fact that they will want cobalt bombs, they will want CAT scanners and everything else that goes with the territory.

But the problem is that the average citizen, as I said earlier, just wants

to have the best of everything and it's very difficult for him to say no.

WEEKS:

Do you think that some of this has come about because the employer has paid the premium and the average man doesn't realize what his employer is paying out each year?

PETTENGILL:

This is quite true. It's because the unions negotiated an ever larger share for the employer to pay and an ever smaller share for the employee to pay that the average employee does not understand. Now a few employers have adopted a PR program whereby at the end of each year they put out a little report to all of their employees saying, last year we paid "umpty-ump" thousand dollars in benefits (premiums) and our share was this and your share was that. And, of course, in many labor-negotiated plans the employees' share is zilch.

Employer-pay-all benefits started first with the employee's own benefit. Today, close to 90% of all employer plans require no employee contribution with respect to the employee's own coverage. Also, today, the employee seldom pays more than 50% of the cost of the dependents' coverage, and in many plans it's less than that. In some cases, employee contributions are non-existent. You are absolutely right that labor's pressure, not only for greater benefits, but for smaller employee contributions, has resulted in the employees' not realizing the total cost.

The other thing that's horrendous is that the average physician doesn't realize the total cost of care. Sure, he knows what he charges for his services but he is generally unaware of the typical total bill that results from his "treatment." And he does order essentially all the services even

though someone else often performs them.

Now, a better job is being done and the insurance industry and the Blues have worked to get the medical schools to put in a course on medical economics.

If I remember correctly, as late as 1970, there wasn't a single medical economics course in any medical school in this country. So here's a graduated physician and he has never once been told that the health care is the most expensive commodity in these United States. Sure, he has taken an oath to do everything he can for his patient but he also has a responsibility not to bankrupt the patient, and this he needs to know.

WEEKS:

Of course, we've got the other variable there of defensive medicine where they overdo things to protect themselves against malpractice suits, which complicates things again.

PETTENGILL:

This is one of the real tragedies that has occurred just in my lifetime. Partly it's because of the fact that many people have more coverage for which they pay less and hence are not worried about its cost. Partly it's because society itself--quite apart from health insurance because you see it in the casualty lines as well, has become so contentious. We sue everybody at the drop of a hat, so that it's a double-barreled situation. And the amount of defensive medicine that's practiced is just incredible. You see it primarily in the x-ray and laboratory tests ordered but you also see it in unnecessary days as a hospital inpatient, etc. So there is no question in my mind but that we're paying substantially more for health care in this country because of our contentiousness.

A multiple line insurer like the Aetna is in a real bind. As a group

health insurer, we ask the "doc" to keep the costs down, while as the underwriter of his malpractice insurance we say, "Hey, man . . . get in there and do all these things so that you've got a good record to show to the court in case you get sued." So the insurance industry, therefore, is in a real schizophrenic position, the group side of the house saying don't do these things and the casualty side saying to do them. It's a real rough situation. Inside Aetna, both sides try to work together. However, most of the time the group health company is not the same as the malpractice company. And even with all the costly defensive medicine, the malpractice suits continue.

It should be appreciated that even the most conscientious physician has a hard time keeping abreast of the very rapid development of medical science that has been occurring since World War II. Indeed, it is easy for a physician's knowledge to become out of date. So, part of the lawsuit problem is that some physicians do get out of date and into trouble. Even those who stay up-to-date have trouble with patients who expect them to perform the impossible.

The need to keep up-to-date has pressured physicians to specialize in just one area of medicine. As a result, a patient seldom has one physician looking after his total health. Each specialist may do in his area what was perfectly proper but if the patient has more than one health problem, the sum of what specialists "correctly" did may kill the patient, or at least harm him.

WEEKS:

There's no question about it that the people who look ahead say that when we get to the point where we can put a patient on a table and run him through a machine and run all kinds of tests automatically, then we'll have a complete profile, then we can treat him. I don't know whether that day will ever come

or not. There are some other things, too, that I noticed in this progressive patient care such as they have at Manchester. I worked in Michigan with some visiting nurses for a week or two and made calls with them and went into homes. I've come to the conclusion that we've missed something in giving up house calls by physicians because physicians, many times, don't know how their patients are living or what their influences are, what the environment, what the family is like, what they are eating. Unfortunately, I realize we can't go back to that, but we've lost something there.

PETTENGILL:

In spite of his severe limitations, the physician of fifty years ago generally had the advantage of knowing the individual, knowing the family, knowing the living conditions and was therefore able to do things or avoid doing things that today's physician is completely blind to.

WEEKS:

I had an experience a few years ago, I was thinking about it the other day. Pearl Harbor Day, I was in bed with typhoid fever. I had the doctor I knew down the street. I should have called a couple of my friends who had different training. One of them was a German who had grown up in Europe where when there was a fever, first you eliminated typhoid before you went to anything else. The other was a man who had worked in a lumber camp right after he got out of medical school, where there was an outbreak of typhoid. Both of them said that they had seen enough cases of it so they could smell it when they walked in the house. Now, the man I had was a young man, had never seen a case, had no idea about it. I looked up the incidence of the disease in Detroit in the Wayne County Medical Journal. I think at that time they had about two cases a year in Detroit and those were mostly affecting persons

coming from the South. I don't know how I got it or where I got it. But I can understand how the young doctor didn't know anything about it, he had never seen it.

But, on the other hand, these other men had different backgrounds and experience. That was something that was just built up by being on the scene and seeing people and smelling people. Today it isn't possible to have that.

PETTENGILL:

On that point, note that some states do not give reciprocity. If a doctor wants to move from state A to state B, state B may make him go through a battery of tests all over again to get his license there. There is no reciprocity. Just because you're coming from state A with a license doesn't mean that state B will give you one. And if state B wants to discourage an influx of doctors, as some states did at one period of time and perhaps still do, state B would ask on its tests questions with respect to diseases, bug bites, snake bits and so on which were generally peculiar to that state. Somebody coming from the East to the West would flunk the exam completely.

WEEKS:

As a matter of fact, the German who could smell it went to California and he had to go back to school for a year before they would let him write the reciprocity exam.

One thing I'd like to ask. I've asked this of several people. You mentioned a bit about the fiscal intermediaryship and the carrier role. We know they came about but I've been trying to find out where they originated. For a long time, it seems that certain persons have said that if there is any kind of health insurance program backed by the government or through the government, that private insurance companies and Blue Cross and so on should

have a role. Have you ever heard that statement before?

PETTENGILL:

Oh, yes, there was a number of members of Congress who were sympathetic to the private sector. Basically, they were saying to Lyndon, look, we've got our friends in the private sector, we've got to give them a bone somehow. They do well in administration so why don't we, the government, use them for administration even though this is our program. Now, who specifically, I must confess, I don't know that I ever knew who really pushed that idea in the Ways and Means Committee. By the time I got there, it was well evolved.

Of course, one of the things that really bothered me on that whole deal was we were only talking Part A of Medicare originally. As you perhaps do know, because it's a matter of record, Bob Myers, who was then the actuary for the Social Security Administration, had made cost estimates for just Part A (Part B had not yet been thought of) and so had I. Unfortunately, our estimates differed considerably. Mine were higher than Bob's. We were both well qualified professional actuaries testifying as to the future costs of Part A. At the end of two days of testimony, Wilbur Mills said, "Look, you gentlemen are respected members of your profession yet you've got this marked disagreement. Will you please sit down and, regardless of your personal feelings, give me a memo for the committee which explains item by item where you disagree. In other words, all I'm seeing now is your total dollar costs which differ by many millions of dollars, but I don't know what your assumptions are and your difference must be due to different assumptions."

So Bob Myers and I sat down and we looked at each of the assumptions and where they differed. A memo to that effect was given to Wilbur and Wilbur said (I don't know whether it's in the record or not, but he said it

verbally), "Look, gentlemen, I have the highest regard for both of you. You are both men of fine integrity and reputation. I have no alternative but to go half way in between your figures." And that's exactly what he did.

Now, it so happened, that for the first two years of Medicare Part A, I was right. But even I had no idea of the horrendous escalation of hospital costs that would occur. So both Bob and I were wrong on the long-term costs. As I recall, I estimated utilization of hospitals more accurately than Bob. He anticipated somewhat higher rates of inflation long term than I. I was lucky and happened to be close on my estimates for the first two years. But thereafter both of us were so low, it was academic as to who was right and who was wrong.

It was Part B that bothered me. To this day, I don't understand why the Ways and Means Committee did not call Myers and me back in to price Part B. Part B was the compromise which Mills gave to the Republicans who wanted an all private plan. John Byrnes, from Wisconsin, was pushing this. And so Wilbur pulled a real coup by turning to Byrnes one day late in the discussion and saying to him, "Okay, Part A is going to be what we Democrats have been talking about but we'll take your plan limited to just physician services except that we'll insure it and we'll hire the insurance companies and Blues to be the carriers, i.e., administrators."

Byrnes was caught flatfooted. What was he to say? Here was the perfect political compromise. Part A was Lyndon Johnson's, Part B was Johnny Byrnes', Republican. So, unfortunately, they agreed. It went so fast that neither one of them worried about cost. Johnny Byrnes did call the HIAA up to say this is what's happening, but never did we get called in to price Part B. Both Myers and I could have done a much better job of pricing and we could have suggested

a few changes that would have eased the administration no end. But it went like greased lightning and we never were called in. We got a phone call late one night from Johnny Byrnes saying it was in and I got over to see Wilbur, I think, two days later because he was so tied up with the bill that it took me two days to see him. Normally I could see him about 6:30 at night. I'd go down to his office late in the afternoon, about five o'clock and sit there until he would come over from the House. Then, when he had taken care of his other urgent business, he would finally call me in, put his feet upon his desk and say, "Okay, Dan, what's on your mind."

WEEKS:

He's a very courtly man, isn't he?

PETTENGILL:

His liquor problem was tragic. In reality, if I'd stopped and thought about it, I could have seen it coming on because his wife had that problem long before he did.

WEEKS:

I saw him a year or so ago. He was speaking about his life and when he came to that time, he said, "Well, I just fell apart." That was all that was said. I met him in Detroit after that at the airport when he was coming back from a speech I had read about his making up at an alcoholic sanitarium we have near Ann Arbor. He said, "I get out and make these speeches now, maybe I'm doing some good, maybe I'm not." He's putting a lot of time in that.

PETTENGILL:

He really was a great guy.

WEEKS:

Cruikshank told me a story, pre-Medicare, when all of you people were

working on some kind of a bill--whether it was King-Anderson or whatever it was that preceded Medicare. He said that there was some question of compromises going back and forth and Mr. Meany was in Europe and they had instructions from him as to what they could give and where they couldn't give. The point where they couldn't give was they had to hold out against any underwriting role for the insurance companies. Does that strike a bell?

PETTENGILL:

Yes, indeed.

WEEKS:

Strangely enough, just a few months ago, I was at Blue Cross in Chicago, talking with some people there and one of the guys kind of grinned and said, "You know, things would be a lot different with Medicare and all of these others if they'd just let us do the underwriting."

PETTENGILL:

The basic answer is, you cannot have competition in risk taking and not have underwriting, because underwriting is judging the risk you are going to assume. Underwriting is a judgmental process and two insurers can and often do differ on the evaluation of a given risk. The risk may choose an insurer solely on the basis of price but should also consider service and solvency.

Now the thing that I had so much difficulty getting the insurance industry to go along with me on for so many years, was the fact that with underwriting you've got to have a pool into which you put all the rejects and you've got to operate that pool so that the premium rates are feasible for the cases that have got to be in that pool. This probably means, in fact, I'm darned sure it means that you will take a loss on the pool. And that loss will have to be spread over all your other business.

I think if you look into the history, most local Blue Cross plans operated their individual conversions as a pool and did so at a loss which they charged their group cases. The rates the Blues charged, when an employee left the group and took coverage as an individual on the so-called "direct pay" basis, were seldom self-supporting. The Blues did not talk about group and individual policies. Instead, they talked about "group remittance" and direct pay."

Insurance companies tried to make the individual policies issued as conversions from group policies self-supporting. Admittedly, they did not always succeed. One result of this practice was that few employees converted.

WEEKS:

The excuse that I was given, I don't know whether it was Mr. Meany's excuse or whether it was some part of the membership, Cruikshank didn't give it as his reason. But the reason was, that if a profit-making concern is doing the insurance you have to watch them on the claims because they might not be so fair on the claims because they want to make money. That bogey that you can't be a profit-making organization and still be ethical, you know.

PETTENGILL:

I'm happy to say that, by and large, I think the insurance companies of America have stood up very well on that score. But you can find the exception that proves the rule. You only need one bad egg to give the industry a terrible reputation.

For example, there's one large company, it wrote more individual business than it did group but nevertheless it was a large company, and in its early days, this was the 1940s and 1950s, it was very tight in its claim settlement and did appear to look for every possible means for not paying, with the

result that they got a terrible reputation. So much so that in the group side of the business, they were almost no factor whatsoever. Management finally said, this is not the way to do business. We're cutting off our nose to spite our face. So the company turned around and began doing a very good job but it took at least fifteen years to outlive the reputation the company had developed.

WEEKS:

Walter McNerney tells the story about when he first went to Blue Cross Association, this must have been in the late 1950s or about 1960, that he became embarrassed because he was making statements about the aged and so forth and Blue Cross wasn't doing anything about it. Do you remember that incident?

PETTENGILL:

I don't remember the particular incident but it was absolutely true.

WEEKS:

So he said that he went to AHA and there was a combined effort on the part of the two organizations to make a study of the aged. The purpose was merely to make a study and to be able to state what the actual status of the aged in this country was and what their health needs were and so on and so on and so on.

His idea was to submit this to the government and say this is something that we can't change. This is something the government may want to do something about and, of course, if we can help, we will. He got himself into a lot of trouble because the idea became quite widespread very quickly that the Blue Cross plans were going to do something for the aged and everybody started calling the Blue Cross plans and most of the individuals didn't know

what was going on . . . and said we don't know. Did Aetna do some studies of the status of the aged in this country?

PETTENGILL:

They were limited studies. We had a pretty good idea from those employers for whom we not only wrote the health care benefit, but also the pension benefit, of what the situation was. Because in those early days the health care coverage was terminated when the pension started. So we knew there was a problem. For a while, and I am being very frank with you, the individual side of the Aetna wouldn't take a group conversion. They didn't know exactly what it would cost but they were reasonably sure it would be 300% higher in morbidity and they were right. So I finally said to the company, look, this is embarrassing. The Blues, while not taking the retirees, are taking the actives and they're surviving on it. It's true that conversions have higher morbidity, but the Blues are getting so much favorable publicity for doing it and we're getting adverse publicity. We've got to do something. The company finally said, you go ahead. It'll have to be individual insurance, you'll have to file it with the state insurance department as individual insurance but you write it as a separate unit of the Group Division and take all the losses. So that's exactly what I did.

Now, the interesting thing is that the antiselection did not run more than about five years. In other words, at the end of five years, the experience on those conversions that were still in force was no better or no worse than that of the typical group case. The initial antiselection was high. It was over 300% the first year and then slid down to about 250-200. By the end of the fifth year, though, you couldn't see any.

The difficulty is that the typical convertee, at least for us, only paid

one premium. So I made them pay quarterly rather than monthly. One premium permitted the convertee or one of his dependents to get into the hospital and have whatever surgery was then pending. Having gotten that claim paid, the convertee would then let the policy lapse in about half the cases. Thus, I often had one quarterly premium which was only enough to cover the administrative expenses and not a dime for paying claims.

WEEKS:

But then came Medicare after a while.

PETTENGILL:

Well, I'm talking again about the under 65. This is the employee who is either laid off or fired or leaves for whatever reason. Technically, we did provide it for the people who retired but the premiums were so awfully high that they couldn't afford to convert even though the conversion benefits were less liberal than the group benefits.

WEEKS:

I was riding on a plane not long ago when there was a young Ford employee sitting next to me. He was telling me about being out of work and I was asking him how long his benefits went along. He said, "Well, I've got another month yet. I've got to get my glasses changed, I've got to get my dental work done." He was getting it all in before then.

PETTENGILL:

That's something that the unions did do . . . some of them, not all of them, namely a fair job of negotiating that the employer would have to permit the continuation of coverage during layoff or leave of absence for three months, six months, sometimes even a year.

WEEKS:

I think this was a year in this young man's case.

PETTENGILL:

UAW had a year. That was a good feature and as a matter of fact, although it looked to Meany as though I was always fighting him, any time he came up with a good idea like that I would try to sell it to our policyholders.

The difficulty was that health care benefits became so labor-oriented that employers would not buy a darned thing that wasn't negotiated. If the union wasn't willing to negotiate a benefit, we couldn't get that benefit in the plan.

WEEKS:

I'd like to try another thought on you. My friend Howard Berman at AHA sent me the testimony he was going to give before a House committee. Unfortunately, this has been delayed so I don't know whether it'll be given this month or next, or not. Anyway, Howard had been quite closely connected with the voluntary effort that AHA has been putting on. In his testimony he was admitting that the voluntary effort wasn't going to work very well. They had tried it for two or three years (in controlling hospital costs). He was saying now that in controlling hospital costs we had to look to the demand side. I called him. I said, "Howard, are you going to open yourself up to that?"

He said, "Yes, that was the only thing I could see; we're going to try a couple of experiments and see if we can influence the demand side."

Do you think there is any way . . . we were talking a while ago about the employee not knowing how much his insurance costs. Is there any way we can "educate" policyholders not to be so demanding of service?

PETTENGILL:

You are having to persuade the employer to permit an educational program for his employees, so it's a two-step process.

Motorola has been highly successful with such programs, but that is because management saw them as being essential and has sunk much time and money into them. The typical management, however, says, look, I have a tough enough time getting my employees to produce. Let's not waste time with this educational stuff. After all, the insurer can't demonstrate the dollars and cents savings the employer will get out of this educational program. Furthermore, it has to be a repetitive process. Then, with some people you never will make any difference because they say, it's my benefit and I'll use it to the hilt. That, frankly, used to be the problem when there was a large employee contribution. Hell, I paid my money, I'm going to collect all I can. So I'm not overly optimistic. I believe you've got to have the doctor involved, as well as the patient.

That's why, to me, the Prepaid Group Practice really has substantial appeal. The Blues have done much better than the insurance companies in trying to get them started, but even they have not been overly successful. One of the problems is, not only don't the doctors like it, but also, the patients don't like it. They've been spoiled for so long and that you are basically trying to turn a Sherman tank around 180 degrees in a space of ten feet. It can't be done.

WEEKS:

Dick Stull made a pretty good point. Do you know him? He was at the American College of Hospital Administrators. Dick Stull was telling me on his interview about going to California during the period of its great growth, around the time of the war. He said they had to build two or three new

medical schools and two medical centers and so on. They said, we're getting thousands and thousands of people moving in here. But most of the people who are coming are younger people, maybe newly married and so on. So they haven't established any roots. They don't have any traditions as a family, back East, or wherever they come from. So it's easy to set up a new program. It's easy to set up a group practice here because they haven't used this kind of service before.

PETTENGILL:

And something is better than nothing.

WEEKS:

If they had come from Connecticut, maybe they would have grown up in a community and had a tradition of two or three generations of doing it a certain way. I think that seemed to be a very reasonable view.

PETTENGILL:

The Harvard Community Health Plan, which is the first major HMO in the New England area, had real difficulty getting going because of this Yankee tendency to not be willing to try anything new. Aetna was promoting the Harvard Community Health Plan to the extent it could and took its Boston office employees aside and had the Harvard people explain the plan to them. We told them that this was a fair choice. They would have an annual right to change and we thought it was a good deal. Out of the about three hundred employees that Aetna had in Boston at the time, exactly one had any interest in joining. That was a brand new individual who had just come to Boston and had no connections.

WEEKS:

It would have seemed a fertile ground for persuading somebody, in an

insurance background. If you couldn't persuade them, you certainly would have trouble persuading anybody else. We talked about Nelson Cruikshank. Did you have any other impressions of labor's interest in legislation for health insurance?

PETTENGILL:

Labor was divided on this NHI issue as it was on many issues. Generally, it was a division between a pragmatic local and the ideal national office. The local is interested solely in its own problems, and might well buy something that the national didn't want for political reasons. For example, we had no trouble with many locals in accepting the concept of a supplementary major medical with its deductible and coinsurance. And yet Walter Reuther, as a matter of principle, would not stand for any coinsurance. He would not negotiate a benefit or accept a benefit that had a drop of coinsurance in it. Many is the time that we thought we had something solved only to have Walter call the local union and say, hey, you can't do that. So that is one dichotomy.

The other dichotomy is the dichotomy between those unions which run their own health and welfare funds under the Taft-Hartley Act, vis-a-vis the AFL-CIO, and UAW which do not. Although Taft-Hartley welfare funds have 50% management trustees and 50% labor trustees, as a practical matter, the labor trustees were usually far more aggressive than the management trustees. So they pretty well thought they were in control. Consequently, it struck me, that when the NHI chips were down, my friends at the national AFL-CIO were going to have some real difficulty because their Taft-Hartley brothers would not really want to give up their health and welfare funds and then have them taken over by Uncle Sam.

Now, Nelson Cruikshank was a great guy. I worked with him on two or three committees and enjoyed him very much.

WEEKS:

He had such a wonderful background. I asked him how he got into labor, I knew that he had trained for the ministry. He said that he had worked on the boats on the Great Lakes during the summer and he had joined the seaman's union and that's how he got started.

I don't know whether you've had any conflicts or any dealings with the AMA, but it's always seemed to me that the AMA has been pretty short-sighted about things. I don't know whether you've come to that conclusion or not?

PETTENGILL:

In terms of the AMA versus the American Hospital Association, I agree with you wholeheartedly. In other words, the AHA always attempted to take a broad look at the problem. True, it had to protect the hospital's interests, but nevertheless it was trying to solve the problem. I was too, and I guess this is why I got along so well with the AHA. I believe that just because something is going to be a nasty problem to solve, there's no excuse for not getting out and trying to solve it. And I always felt Alex McMahon and many of his associates believed that too. They got ahead of their constituency sometimes and had to back off, but that happens to most leaders. The AMA had an election process for their trustees and their officers which pretty much favored the long service doctor and therefore tended to support entrenched views that had developed over thirty years of practice and this made change much more difficult.

Don't misunderstand me. I worked intimately with both AMA and AHA. The HIAA needed the help of both organizations, because, as you can appreciate,

the insurance business had remarkably little clout in the Congress. To digress a moment, it's amazing to me that Henry Beers was able to pull off the federal employee program, and my hat's off to him. I don't know how he accomplished that. The AHA and AMA were neutral, so it was simply the Blues versus the insurance companies. I suspect that had something to do with it.

After that, I got pretty heavily involved and when Henry Beers became president of the Aetna, I took over the work of government relations. I knew that as a practical matter, if insurance companies were going to get anywhere, they needed assistance. Now, as I mentioned earlier, Walter Reuther and I agreed to disagree, primarily because I felt that coinsurance was a useful device. I must confess at that time I hadn't realized the problems you could have with coinsurance and how little good it was going to do simply because insurers couldn't sell a high enough degree of coinsurance. Reuther's intransigence on coinsurance plus several other items meant that he and I were often in disagreement on many fundamental issues. So I knew there was very little help that I could expect to get from labor, and leaned, therefore, primarily on the AHA and the AMA.

On many issues, you could almost always get a uniform defense <u>against</u>. The problem came when you tried to get a positive program <u>for</u>. And that's where I could frequently reach a compromise with the AHA but not with the AMA.

WEEKS:

I could understand that. I have talked to people in the AHA about what a job it is to represent seven or eight thousand hospitals in all parts of the country in all degrees of difference as far as economics of the situation, tradition and all those things. An organization of that sort has to be semiconservative at best. They can't be too liberal and bring their

membership with them.

PETTENGILL:

But AHA has only got seven thousand hospitals. AMA has hundreds of thousands of doctors.

WEEKS:

But I'm wondering how much AMA really represents the medical profession?

PETTENGILL:

The AMA has slipped. I must confess I haven't watched its percentage membership in the last five years. But from about 1960 on, it started slipping in terms of really representing the younger doctor. This was one of my major concerns. AMA was so weak in '71 and '72 when we were fighting Senator Kennedy's National Health Security Act, labor's act actually, but he was the front for labor on that bill, that I was worried.

WEEKS:

Talking about this bill that he was sponsoring, backed by labor and so on. I talked to Ig Falk about this because I knew he helped draft it. I said to him, "Please explain to me how you think that you are going to control the costs to doctors, monies paid to doctors and paid to hospitals." You know they have a neat little formula in there about lumping some money regionally and that sort of thing. I said, "Do you think the doctors are going to buy this?" And he seems to be quite convinced that they would buy it. But everyone else I've talked with says, "No, the doctors won't buy it."

PETTENGILL:

Well, he was counting heavily on that feature, and at least one version of the National Health Security Act had a family practitioner controlling the utilization of all the specialists. Therefore, Dr. Falk was counting on his

ability to get that segment of medicine to support his program. Now I have real reservations about that.

WEEKS:

You mean it all had to go through a referral process?

PETTENGILL:

Yes, each person had to have a family physician, who would be paid on a per capita basis. As you say, labor proposed that the government dole out a budget to an area and say this is how much you can spend on health. Then that budget filtered down and a family physician got a per capita amount for the number of patients he had. So, if you were my family physician you would receive my per capita and you would dictate when I needed a specialist and which specialist I went to, whether I needed a surgeon or a radiologist or what have you.

WEEKS:

This is straight out of the British system.

PETTENGILL:

Yes. One of the things I used to needle Iggy on was the fact that we knew less and less with each census as to just where our people are and, therefore, we are going to have more and more of a problem in divvying up this pie among these various regional areas. Just look at the population boom in California, Florida and Arizona. Remember the money Congress allocates today is the money that's available for health care two years later.

WEEKS:

We are still having a battle in Ann Arbor. I guess it's going to be apportioned, our city wards. Each side, Democrats and Republicans, are claiming gerrymandering and all this sort of thing. It'll probably be, what,

five years before we have a census figure that's really settled.

PETTENGILL:

It could well be because this 1980 census figure has been contended worse than any.

WEEKS:

In Detroit we had a suit, and I don't know if it's been resolved yet.

This is a very difficult situation. I was listening to Congressman Pepper on the television the other night and I couldn't help but think . . . you know, he was supposedly defeated by AMA when he was Senator, Clements of Kentucky was also defeated by the AMA. I don't know whether they've defeated every other one they've tried to defeat or not.

PETTENGILL:

They didn't succeed on many other ones.

WEEKS:

It's a bad situation any way you look at it.

PETTENGILL:

Labor, you know, hasn't always succeeded and that goes back to the point that I made that rank and file labor really thinks fairly independently of what the national leaders think.

WEEKS:

I sat there watching the White House Conference on Aging, the scenes that they showed on television. How the man was there from the AARP, representing the many thousands and I thought, I carry a ticket on that too, but I don't know that I'd vote the way he told me to.

PETTENGILL:

I generally disagree with the AARP. But I wanted to know what they were

doing so I figured the way to do it was to go ahead and waste my money . . .

WEEKS:

That's right, it doesn't cost you very much and you begin to find out things. You get a lot of insurance mail, though.

I guess we've answered the questions about Aetna's HMO activity, and about the Federal Employees Health Benefits Program.

When you were formulating your Pettengill proposal for national health insurance, was this an effort that was coming out of your office alone or were there other major insurance companies who were interested also?

PETTENGILL:

Basically, Senator Ribicoff had a committee, it was not health or finance, and he held a set of hearings in 1968 which discussed the health care problems of the nation and for which he asked a number of people to come down and testify. I'm sure Walter was there and Olcott Smith, who was Chairman of the Aetna at the time, went. Naturally, Olcott was smart enough to take me along in case he got any technical questions. After the hearing, Mr. Smith said to me, "I know you have mentioned to me on various occasions that the insurance industry ought to do something but I didn't really think that there was much we could do, or should do. Senator Ribicoff challenged me today.

He said: "You have a green light, in fact, you have a mandate from me to show me something."

Then Mr. Smith said to me, "Can you do it, say, in six months?"

I replied, "I've done an awful lot of thinking on the subject because I believe something should be done. Yes, I'll get you something in six months." So I did.

Then Mr. Smith said, "Okay, you visit the other companies and see what you

can do to sell it."

The reaction I got from these visits was "The industry ought to do something; we can live with your plan but really do we want to."

I reported all this back to Olcott Smith and reminded him that I had good rapport with Wilbur Mills. Then I finally said, "Look, Wilbur is going to have hearings on national health insurance before his committee this fall (1969). My problem is that I've got a plan, you've looked at it, the Aetna's blessed it. We are satisfied we can live with it. The other companies are not really sitting down and helping me refine the plan. They tell me that they have a few problems with it but they won't take the time to sit down and tell me which "t" they want deleted. But I think, frankly, if the chips are down, they would buy it. There are going to be some things that we'd have to change, but basically they would buy it."

So Olcott said, "Okay, go ahead and tell Wilbur you would like to testify." Then he said, "You will have to present the plan as your own plan." He said, "Is that going to embarrass you?"

I said, "No, it's not going to embarrass me. It is my plan."

So I did. Wilbur, of course, asked the question, "What does the industry think about it?"

I said, "Well, I've had informal discussions with a number of industry people. They have never formalized an opinion on it. It seems to me that if the committee is interested, the HIAA ought to be asked to give its opinion on the plan."

So he said, "Fine." And eventually, the HIAA did give its opinion.

Well, I took advantage of the moment to say, "Look, fellows, the die is cast. We have got to have an HIAA national health insurance program to fight

the National Health Security Act." Fortunately, the good heads in the industry agreed. I did have to make, as I say, a few changes in what I had presented to the Ways and Means Committee, but they were relatively minor. So we came up with the HIAA plan.

WEEKS:

And you were taking care of the poor?

PETTENGILL:

Oh, yes. Everybody was taken care of.

But we were using the private sector and that was an anathema to the AFL-CIO.

WEEKS:

Yes, labor was against that, there is no question about that.

But getting back to the fiscal intermediaries. I'm wondering if maybe they didn't think, well, we'd better do something for them . . . for the insurance companies?

PETTENGILL:

This is after . . . Medicare was passed in '65, went into effect in '66.

WEEKS:

And we're talking about '71 now, aren't we?

PETTENGILL:

It was '69 when I gave the testimony and '70 before the HIAA got involved. I am talking about the real fights of '71 and '72 which were dog-eat-dog fights.

WEEKS:

That was about the time that Wilbur was hoping to run for President or Vice President, too, wasn't it? In 1972?

I think from what I've heard that he would have been willing to be the Vice Presidential candidate with Ted Kennedy as Presidential candidate.

PETTENGILL:

It could have been, because Wilbur was a politician. The only difference was that in tax matters, that guy, oh, man, he was keen!

WEEKS:

I've heard the story and I believe he admitted it to me that when he became chairman of the committee back in about '57, no, it was when he was appointed, just a member of the committee, he was told by some mentor that he should become a tax expert. That he should learn the tax code from beginning to end and I think he proceeded to do that.

PETTENGILL:

If he wanted to be the chairman, he had damned well better learn the tax code, and since he wanted to become the chairman, he did learn the tax code and he learned it backwards and forwards.

WEEKS:

I think he's a very unusual man.

PETTENGILL:

Oh, he was. The beauty of it was that he was somebody you could talk to. He might not agree with you but at least you had the reasonable feeling he understood what you were saying. Whereas, with so many Congressmen, and I won't embarrass them by using names, you knew perfectly well that after you sat there and explained something ten times over that, wow, they didn't understand it.

WEEKS:

Nelson tells the story about going into Mills' office one day, being

invited in, and Mills was on the phone. When he realized that he seemed to be talking seriously, he said, "Shall I go out?"

Mills said, "Sit down." It was Teddy Kennedy that he was talking to and he was trying to convince him that the two of them should run in '72 and rescue the party from--would it be McCarthy at that time? But Teddy didn't want to run and then shortly after that, of course, Mills cracked up. So it didn't make much difference.

I wanted to raise one point about areawide planning, the voluntary versus the government areawide planning which we have had the past few years. Do you know Karl Klicka? He's been many things. The last job he had was head of the People's Community Health Centers in Michigan. But at one time in his life, he was head of a hospital planning council in Chicago--a voluntary thing. We had quite a discussion one day about this and he feels very badly about what has happened to the voluntary health planning councils. I guess there are only one or two of them left. We have one in Detroit but there aren't many of them.

PETTENGILL:

We still have some, we had five in Connecticut. I think three are still left of which two are really working.

WEEKS:

He seemed to think that they did so much more. Now, maybe the circumstances were different then. I think that's probably it.

PETTENGILL:

This is important. The original planning law, which permitted, not mandated, the setting up of health planning councils, did not have the horrendous specifications of later laws such as boards with a majority of

"consumers," the rigid definition of "consumers" that knocked out the insurance people, not contributions from insurance companies and so on. These later specifications really hurt.

The old Capital Area Health Planning Council here in Hartford admittedly was set up, run and dominated by the insurance companies. Henry Beers, whom I have referred to before, played a major role. But then you had intelligent men with a high degree of integrity and a reasonable knowledge of the problems. They did more about getting the hospitals and, let's face it, Hartford is blessed with more hospitals than it needs, to at least do a certain amount of working together. I suspect they said, "Look, corporate contributions to your fund drives are going to be a little thin if you don't play ball."

That sort of thing, of course, is a terror to the politicians. It's as if I'm letting the fox watch the hen house. So the act was revised; the Health Planning Councils were tossed out and the Health Systems Agencies with 51% "consumers" put in on a mandatory basis. I couldn't be a consumer because I was running a health insurance business. I was a provider. So I converted the old health planning council into an HSA and complied with all the rules and regulations but it really did hurt. The "consumers" were just so interested in "let's have the best care available in our area" that when I said, we can only afford to have one CAT scanner, they thought I was crazy.

WEEKS:

Well, this is the trouble with commissions and committees and so forth that are trying to be representative of every facet of the community. You end up as a discussion group and that's about all.

One of the things that I've been wondering about is why we shouldn't have

some kind of control over hospital building. We just went through a new $50 million hospital and now we're going into the $300 million University Hospital project in Ann Arbor.

PETTENGILL:

Well, it's the old story. The benevolent dictator looks good in theory, but there are no benevolent dictators, so democracy struggles along.

WEEKS:

Of course, if we were allowed to run it it would be all right.

Could we say just a little bit about Social Security? Being an actuary, have you any opinions on what we can do here to maintain our Social Security and our Medicare and our Medicaid and our help for the disabled?

PETTENGILL:

Well, now you're getting into many facets. The original Social Security benefit was to be a minimum pension benefit over which private enterprise would provide additional and, in most cases, the major portion of one's retirement income. Then came the addition in the 1950s of the disability benefit which, I believe, was due to the fact that even though insurers had been writing group disability income benefits for nigh onto forty years, there were still a lot of people who didn't have that coverage and there was a strong feeling that there should be a minimum disability benefit. Then came the addition in 1965 of Medicare. These are the three primary benefits under the Social Security program.

The first two and Part A of Medicare each have a separate trust fund and a specified tax rate to support them. The intentions were that each would be self-supporting. Furthermore, there were to be reasonably accurate projections of the life and disability trust funds well into the future with

the trustees responsible for recommending adjustments in the tax rates whenever the actual experience differed significantly from the projected experience. For Part A of Medicare, the projections were to be made over a shorter period of time.

Medicare Part B is financed partly by the elderly beneficiaries themselves and partly by general revenues of the federal government. Originally, it was to be a 50-50 split. I suspect that by now the government is paying significantly more than 50%. Therefore, the Part B monetary situation is quite different from that of the Part A. Part B introduced, for the first time, the use of general revenues to finance a social insurance benefit.

This has led to the hue and cry, "Take the cost of Medicare Part A out of general revenues and free up the Part A Social Security tax to help finance the pension and disability benefits."

From the point of view of the private sector, insurers were not happy at seeing general revenues used to finance a social insurance benefit, feeling that such programs ought to be financed by an identifiable tax. On the other hand, Part B got by us and is now in effect, so that it is going to be a tough fight, probably, to prevent Part A from eventually becoming financed, partly at least if not entirely, out of general revenues.

At the moment this is a moot point because the federal government doesn't have any spare general revenues with which to make such a change in the financing of Part A.

The present financial problems of the Social Security pension and disability benefits are due to a number of factors. One arose when people demanded that they shouldn't have to depend on the whims of Congress to get the primary benefit increased to offset the effects of inflation. Instead,

the Social Security benefits should automatically increase with inflation. Congress warned that, if it acceded to this demand, it should not use the Consumer Price Index. Rather, it should use the wage index because the Social Security tax is based on wages. You couldn't afford to have benefit increases based on prices when revenue increases depended on wages. At the time, however, wages were racing ahead of the CPI so the warning fell on deaf ears. The problem should have been solved by setting the benefit increase equal to the lesser of the increases in wages or the CPI. But Congress left the tax base alone which merely reflects increase in wages and made the benefits automatically adjusted to the CPI. The CPI then proceeded to race well ahead of the increase in wages with the consequent result that the trust funds are now in trouble.

Another thing that has created trouble for the trust funds--and for all pension plans as well--is the fact that, in spite of our poor life styles and all of the crazy things we do, we are living longer. And, therefore, the trust funds have to pay out benefits longer than was anticipated. Although there was mention made back in the Depression 1930s, when Social Security was enacted, about its being an insured plan with actuarial reserves built up from the employee's contributions to pay his retirement benefits, it very quickly became clear that such funds would be too much of a temptation for politicians to spend on other programs. So Social Security has been and still is essentially a pay as you go proposition. This year's crop of workers will pay for last year's crop of retirees, in a broad sense of the word, and will be the case for the foreseeable future.

In addition to people living longer, which means that more benefits are going to be paid and higher taxes required, we have a really crushing

situation coming up that the World War II "baby boom" will eventually join the aged population and demand their benefits while the working population which will have to pay the taxes will presumably be suffering from the "zero population growth." So there will be far fewer workers to support far more aged people who are living far longer. In my opinion, and this is strictly my personal opinion, although I think you'll find a lot of people share it, there isn't any question but that we've got to take reasonable action now to compensate for these hard facts. There is no way you can put that big a tax burden on the working force to provide real rich benefits for all of these elderly. You've got to get a better balance. And I honestly think that the fair way to do it is to gradually advance or retard, whichever way you want to say it, the age of retirement so that the normal retirement age increases from 65 to 70 and the early retirement age increases from 62 to 67.

Now, that's got to be done over a probably 25 - 30 year period, so you don't get massive disruption for the people who are just about ready to retire.

WEEKS:

This month a year plan or something?

PETTENGILL:

I have no objection to going to yearly jumps but it's got to be spread so that people who are within five years of retirement right now get the old system. To me, that is absolutely essential.

Congress finally has broken the tie-in with the CPI. I don't think they broke it quite as well as they should have, and the financial burden won't ease for quite a while because you've got at least ten years of retirees who are under the old system, and hence will continue to get more benefits than they should have.

Another aspect of the Social Security financial problem is that the trust funds are not invested like a private pension fund, which, if well managed, has had its investment income improve as its assets grew or rolled over--the contributions of twenty years ago may have gone into a 4% bond, but the new contributions coming in today may go into a 14% bond, so that the overall average yield of the pension fund improves.

The government does not have a program to be sure that the excess of the taxes collected over the benefits paid out are invested in the best yield possible. It hasn't had, therefore, the advantages of management that you would expect in most private pension funds. To be sure, a few unions have murdered their investments, but that's a different story and it has not been a general situation, it's been just one or two unions that have mismanaged.

So, I think in fairness to the future workers the government should do a better job of investing the Social Security trust funds, assuming there are any left.

The Social Security disability benefit has a few extra problems of its own. There is always pressure to liberalize both the waiting period and the definition of "disability." Originally, the law provided that benefits would commence after the end of the sixth month following the month in which disability commenced. Congress subsequently changed this from the "sixth month" to the "fifth month," and is periodically pressured to reduce it to the third month.

The Social Security Administration started with a very tight definition as to what constituted "disability," but have quietly liberalized it over the years. Now, while most of the group disability insurance written by insurance companies is for very short durations such as 13 or 26 weeks, we do write

long-term disability benefits analogous to the Social Security benefit. There is a waiting period--usually six months--after which benefits are payable for several years or even all the way to age 65. Benefits are terminated at age 65, because theoretically you are then entitled to Social Security plus any private pension you may have.

All of the foregoing is a lengthy way of saying that insurers have a considerable amount of experience determining whether people have been "disabled" for six months. Aetna found in the early days that only about 40% to 50% of the cases it approved for benefits also got approved by the Social Security Administration for Social Security disability benefits. Today, well, I'm not there today, but when I left, between 70% and 75% of our approvals were also being approved by Social Security for Social Security disability benefits. So you can see there has been a tremendous administrative liberalization of what constitutes "disability."

One problem which is common to all of us, although Social Security is worse than the private sector because, again, it takes so long to get flexibility (you never get actual flexibility in a government plan, it's a question of getting changes in the regulations governing a government plan, whereas you can have flexibility in a private plan). Insurance companies recognized, quite some time ago, that you had to permit the employee to attempt to come back to work without wiping out his eligibility for benefits and making him serve a new six month waiting period. For, example, if an employee came back to work half time for a month and then had to go back home again because of the disability, the employee really should be paid half benefits imposed on him when he can't continue working. If you don't do this, why should he make any effort to come back to work either part time or full

time until he is fit as a fiddle.

If you can determine that the individual has a mental desire to recover and if you can get him started on a program of physical therapy and whatever other kinds of therapy are needed as soon as his condition will allow, then you've got a much higher percentage chance for success. In those instances, it is worthwhile for you, the insurer, to pay the cost of that therapy because you will generally save it in terms of fewer benefit payments. You'll stop paying benefits perhaps five years earlier than you would otherwise. This enables you to pay for quite a bit of rehabilitation care. A major problem is that you do have to be hardhearted in deciding when to use rehabilitation and this is very difficult, particularly under a government plan. You have to effectively say, "There's no evidence, Dan Pettengill, that you've got the mental wherewithal to be willing to do this. You're going to be stubborn and never really recover. You haven't got the mind set or the spirit or whatever it is that does it." The insurer has to be hard-boiled in such cases because it is going to take a licking anyway. If you're going to have to pay ten years of benefits anyway, why you can't afford to pay ten years of benefits plus $5,000 worth of rehabilitation work. If you are going to spend the $5,000 on rehabilitation, you really want to be reasonably sure you are going to save money or at least break even.

And the government, of course, is not in that happy position because judgment in government programs just isn't permitted. It's unfortunate, but people just seem to feel that it may result in too much discrimination. Heaven help the poor government official who tries to "use judgment."

WEEKS:

Every month I feel badly when I get my Social Security check because I

wonder if I've earned it, I mean if I've invested enough in it. I have no way of knowing but it seems to me . . .

PETTENGILL:

Don't worry. You sure earned it because most of us would have been better off had our Social Security taxes gone into a private pension fund.

WEEKS:

This I didn't know for sure. It just seemed to me, I thought I was, in a sense, buying insurance and that it would be like an endowment of some kind and that when I was 65 I would then benefit from it. But I would have been better off if I had put it into a pension fund?

PETTENGILL:

Yes, but you weren't allowed to. The basic problem, and this is where the rhubarb comes, is the minimum benefit. If you are getting the minimum benefit you probably did not contribute enough to pay for it. A minimum benefit may be justified for the hard working employee with an abysmally low wage record but who nevertheless contributed year after year for forty years or more. A minimum benefit does not seem justified for the individual who works just long enough to meet the minimum qualification and never contributes much more than a couple of farthings.

But Congress isn't willing to bite that bullet and, therefore, it is apparently going to allow both, whereas one has justification and the other has not.

Another point to remember is that in the beginnings of Social Security, there were literally thousands of people brought into the plan with very modest contributions. So a lot of employer contributions went to pay their benefits.

Generally speaking, if you paid anywhere near the maximum tax year after year for thirty or more years, you are not robbing the system.

WEEKS:

Well, that makes me feel better. I won't feel so badly in the future about that check when it comes. It's surprising how people have reacted to the supposed threat of cutting Social Security benefits. Witness the White House Conference, everybody in there fighting against the loss . . .

PETTENGILL:

It's a tragedy because in the sense that you mean, cutting back the retirement plan, people under, say, age 55 have no real cause to complain. If I'm age 50 and you know that I can't get my benefits until I'm 68 instead of 65 on a full basis and I can't get them until 65 for early retirement, I've got time to adjust to that three year change, I can plan for that. It's a nuisance and I'd rather not have it but the government isn't throwing me a curve that I can't handle. Because we are living longer and because the ratio of the aged to the labor force for the foreseeable future is going to be relatively large, a deferment in the retirement age is the proper way to keep Social Security taxes at an acceptable level. Otherwise, what you are going to have is a strike and no Social Security.

WEEKS:

I noticed one of your committee assignments was on military medicine. Was there anything there worth mentioning?

PETTENGILL:

CHAMPUS wanted the private sector to insure the CHAMPUS program which is the program for the dependents of people in the military service and certain retirees from military service. Unfortunately, we didn't see any sound way of

insuring that program. We foresaw a relatively short tenure as far as many of the dependents were concerned even though there are long service career people in the army. We feared we would have a whopping big maternity bill. So we really saw a grave problem in trying to insure CHAMPUS. It certainly would have required on industry pool with lots of companies participating in the risk and, unfortunately, in those days, this was pre-Medicare, we just had one hell of a difficulty getting anybody to even say we'll help administer the program.

The Blues were willing to do the administration and consequently got most of it. The Mutual Benefit of Omaha finally stepped up and said that they would do some of it. They did do some and, as far as I can see, they did a good job. So this was an unfortunate situation where there was a desire to use the private sector but the private sector couldn't insure it by one company and was unwilling to form a pool, and, of course, there would have had to have been special legislation to authorize such a pool.

Ever since the 1944 Southeastern Underwriter decision, insurance companies have not been able to do anything in concert without specific legislative authorization. I know it shocks people, but prior to that time there was a small group committee, the heads of the various group divisions--Henry Beers, J. Henry Smith, Reinie Hohaus, etc.--they would meet every other month for a nice luncheon in New York City and would discuss group insurance problems. "We probably ought to do that, or somebody wants us to do this, but should we, or, no, let's not do that ..." Group insurance in those days was as nice a controlled commodity as you would hope to see. There was a lot of competition in the individual insurance business, but the group side was remarkably controlled.

Now, in one sense, I don't think this control actually hurt the American people because you've got to remember the insurance companies were competing against Blue Cross/Blue Shield, so there was competition. And many of the decisions the committee made dealt with how to compete with the Blues. Furthermore, in the early days of group health insurance, this competition was vital. Because if the nation had only had the Blues, it would not have had the development of new coverages anywhere near as rapidly as occurred. The insurance companies were constantly trying to find ways to compete against the Blues' "discount," their preferred tax status, etc. So, consequently the companies were constantly looking for new expenses to be covered and new ways of handling the insurance. I don't really think that old committee was harmful. And, of course, the committee had to be discontinued just as health insurance got rolling because it was discontinued in 1944.

Oh, what a change in attitudes since that Southeastern Underwriter's decision. Now, if you walk in and say you want to discuss a joint effort, people say, get away, get away! Our lawyers won't let us talk to you.

The best illustration of this, in my judgment, has been the insurance companies' fear of working together to try to control rising health care costs. A joint approach that could be effective with hospitals, and probably ultimately with physicians, would be for the insurance companies to set up a computer system such that hospitals and insurers would be linked directly to the computer. The hospital would be able to wire in all its questions and data, i.e., is there coverage, here's the bill, etc. This would be sorted out by the computer, sent over the wire or by satellite communication to the insurance company concerned which would reply back via the computer. Monies could even be handled that way, although in the initial stages, perhaps

because of anti-trust, we might draw the checks separately, but that's a detail, as far as drawing the checks and sending them to the hospital. But the rest of it would be handled as I have outlined.

Now, the tremendous advantage to the public would be that the insurers could bargain with the hospitals for cost control data. They could say to the hospitals, for these advantages of quicker verification of coverage, prompter payments, etc., we are requesting that the uniform claim form be expanded to show certain minimum amounts of statistical information which we need to know to validate costs. The central computer would tabulate and analyze this cost and utilization data. Then when hospital A was seen to be higher than others, insurers could visit hospital A and say, we are puzzled as to why your costs are so much higher than those of neighboring hospitals B and C. It isn't as if you have all the CAT scanners and all of the cobalt bombs which might explain it. No, you seem to have about the same mix as hospitals B and C do. What is it that they are doing that you aren't doing? And shouldn't you be looking into that?

So insurers could really give some positive, constructive help to that hospital administrator. In many cases it is a hospital's inefficiency or a conflict between the docs and the board or something that's driving the costs up.

WEEKS:

Would you like to tell me something about some of the Secretaries that you might have worked with?

PETTENGILL:

Well, we have mentioned Wilbur Cohen, whom I can say I worked with because I am sure that if you spoke to Wilbur he certainly would remember me. In

general, of course, he was in favor of a government-run social insurance program whereas I was in favor of a privately run program. So we agreed to disagree. But having done that, I always found Secretary Cohen to be able and quite forthright. In other words, you knew where he stood even though you might be unhappy with where he stood, whereas with some of the other Secretaries, that hasn't always been true.

With respect to Elliot Richardson, he struck me as being a very intelligent person but he was not there long enough for us to really know whether or not he would carry through a health insurance program the way we would have liked.

Secretary Weinberger was a Secretary that I felt comfortable with and he certainly worked hard to get a compromise national health insurance plan that would appeal to both labor and the private insurance sector. I know he was terribly disappointed that I couldn't deliver to him industry support for his compromise position. The HIAA got one or two people who would agree but it couldn't get a large enough share of the industry to agree. So his efforts, tremendous though they were, failed.

Re Secretary Califano, I must confess I didn't see too much of him. My personal feeling was that his knowledge of health insurance was not that great.

The present Secretary I only knew briefly as a Senator, I don't really have that much of a feel as to how he is doing.

WEEKS:

How about John Gardner?

PETTENGILL:

John, I thought, was a very able man. He certainly had a deep interest in the American public. I had a great admiration for him. I didn't have that

much contact with him simply because the issues weren't quite that hot while he was in office.

WEEKS:

I guess, off the tape, we mentioned Jacob Javits.

PETTENGILL:

Senator Javits always puzzled me. I must confess, I basically left him to the men from the Equitable and the Metropolitan, which were New York companies, to deal with. I never really felt that I could get through to him. So I am not qualified to say "yea" or "nay" in that regard. He was a disappointment to me personally but that could have been my fault. Although I think others found him somewhat of a disappointment.

As far as Senator Ribicoff is concerned, you have an interesting story there. When he first ran for the Senate, he was opposed by the insurance companies and there were no bones about it. Consequently, he was not sympathetic to the insurance business in his early years in the Senate. I think it's a tribute to his statesmanship that he ultimately eased on that dislike, and where you were able to show him that what you wanted done was truly for the benefit of the American people, he would support you very vigorously even though he could be accused of being in your corner, which he never was. Since he was a very intelligent man and a very able politician, he was, on the Senate side, as helpful to us as anybody on matters of health legislation. I know he certainly assisted me in getting some amendments passed that we wanted. So I had a high regard for him.

The Health Insurance Association of America wanted him to introduce its national health insurance program. He declined and never did support it. How much of that was his old dislike for the opposition of the insurance industry

against him initially and how much was his playing politics because he did not want to offend labor or Senator Kennedy, I was never quite sure. I suspect that he basically was playing a role that he would be the man who would be effecting a compromise between the various positions. Therefore, he didn't want to be associated with any one position. That's my personal assessment. Certainly, I spent many hours in his office and working with his staff. I considered him an able person in this field, and the whole Social Security field, for that matter. I'm sure that the Senate misses him.

The Health Insurance Association's NHI bill was introduced by Senator Thomas McIntyre from New Hampshire. He was not a health expert, but he was a real fine man, of high integrity and high intelligence. His primary responsibility was in the area of defense. But, nevertheless, he realized that the health problems were a major problem of the country and our bill appealed to him and his good old Yankee background. So he was our sponsor in the Senate.

WEEKS:

Was that the Burleson bill?

PETTENGILL:

The sponsor in the House was Omar Burleson, the Congressman from Texas. And that's an interesting story.

The HIAA tried to persuade Wilbur Mills to sponsor its bill, which would have been a real coup. But Wilbur was the kind of a politician who would not sponsor a bill unless it was one he himself dreamed up, simply because he wanted to be in a position of working whatever compromise was necessary. He said that to the HIAA when it discussed the matter with him. But he said, "I know just the member of Ways and Means Committee that you should use. He's

from a safe district in Texas and therefore will not get hung for supporting an insurance industry bill. I like your bill and I want to see it introduced, it's got features that I want to be sure get into the national health insurance plan that is finally adopted. It's got other features that I think you're going to have to give on, but Omar Burleson is just the man." He picked up the phone and called Omar and said, "Could you come over to my office? I have some people I want you to meet."

Omar came over and we all met him--most of us didn't know him. I had met him because I had been testifying before the Ways and Means but I didn't know him that well. Wilbur, in about ten minutes, described my voluminous bill in the digest form, and said, "This is a bill that you could really support, Omar." He said, "I recommend that you give very serious consideration to introducing the bill."

Omar said, "Well, let me think it over and I'll be back in touch with you."

I then said, "You and your staff are going to want some more detailed explanation, so as soon as you can find time, give me a ring and I'll come down and do it." Sure enough, pretty soon he agreed to introduce it.

A lot of people thought I got taken in. They said, "Gee whiz, nobody knows Omar Burleson."

I said, "Now, wait a minute. This is a bill that we've got to get in. The fight is hot and it's our job to drum up the support. Sure, we'd love to have a top-notch person but you tell me, of the top-notch people who are in the House, who will touch it!"

The HIAA had done quite a bit of research before we even went to Mills, because I had said, "I don't think Mills will do it and therefore we need to know who we go to after Mills."

But we didn't have anybody, so we were fortunate that Mills persuaded Burleson. Mills' judgment, I think, was very good because Omar wasn't going to be defeated for doing this. He continued to be reelected until he finally retired. Ironically, the year Burleson retired was the year McIntyre got defeated. So both of our sponsors went out from under us but that was the year in which HIAA had decided that there wasn't going to be any NHI and that we would be just as well off not having a bill in the hopper. Shows you what happens.

So that is the story of how it came to pass that HIAA's NHI bill was called the Burleson/McIntyre Bill.

WEEKS:

But you put a lot of effort into it and you couldn't always tell whether it was going to work out or not. As you say, the timing was such that the following year you had no need for it.

PETTENGILL:

No. The bill was originally introduced in 1970 and reintroduced in '71, '73, and '75. It wasn't until '77 that the HIAA decided not to reintroduce it.

WEEKS:

I didn't realize that it had been introduced that many times.

PETTENGILL:

So the HIAA had that bill in during the crucial years when NHI was nip and tuck. We were offering a real alternative, not a half-baked alternative but a real alternative. While Walter McNerney would never support it, he never opposed it, because, after all, he could participate in it. The same thing was true of the AMA. Dr. Russell Roth designed the AMA's bill. He was a good friend of mine and told me, "Dan, we have to have our own bill. It can't be

anything that you have dreamed up."

WEEKS:

This was the Medi-Credit?

PETTENGILL:

Yes, and the AHA and the Perloff committee then came out with its own bill. But, notice, none of us damned the other guy's bill. I guess I was the worst offender because I would be pressured by Mills as to what were the main inadequacies of each bill. I would say, well, my problem with Medi-Credit is thus and so. Actually, I worked with Dave Drake and Paul Earl on designing the AHA's bill.

Those were very interesting times.

WEEKS:

I got in to see Mr. Perloff in Philadelphia. He is still alive, I believe. He's been very ill. Of course, Ed Connors, I guess, served on that committee too. He's in our town.

Well, you've been a part of a great many interesting events here.

PETTENGILL:

I've been most fortunate to have had my career coincide with so many interesting chapters of the health care history.

WEEKS:

When you were working in Washington, did you work with Kenny Williamson at AHA at all?

PETTENGILL:

Some, yes.

WEEKS:

He's now out in California, you know.

You said you knew Bugbee. And I suppose you knew John Mannix too. John seems to be a key figure. A lot of people say he shouldn't have tried to start the insurance company, the John Marshall Insurance Company. He seemed to come back all right.

PETTENGILL:

He was an able man.

WEEKS:

Did you know Rufus Rorem?

PETTENGILL:

He was a real character and an able character, too.

WEEKS:

I was reading his testimony that he gave to the House committee on Blue Cross when he was still with AHA, back in the late 1930s or early 1940s. It reads so clear and he expresses himself so well and with a little bit of humor now and then.

PETTENGILL:

He was an eloquent man.

That's been one of the nation's problems. Someone who thinks straight and talks lucidly is a rare person indeed.

WEEKS:

I was wondering if you used any of the family health surveys that Odin Anderson and some of those people made back in the 1940s?

PETTENGILL:

Sure did. I was often in contact with Odin.

WEEKS:

He's a remarkable person, too, isn't he? He's now retired again but he's

teaching part time at Chicago and part time at Wisconsin.

PETTENGILL:

He will die teaching.

WEEKS:

We've been working on an anthology together. One of my side jobs is that I edit Inquiry.

PETTENGILL:

That's a good publication.

WEEKS:

Thank you, we think it is. And thank goodness Blue Cross never, never has ever said, do this or do that about the journal. When Blue Cross and Blue Shield combined, I was a little worried because we became a part of Shield for about a year. We had to have a corporate connection. I talked to Walter about it and I said, "Would you make a statement to Shield people as to your position and our position and so forth?" He made the statement, "These people have editorial freedom. Whether we like it or not, what they put in, they have editorial freedom." So we never had any trouble. It's wonderful to work like that.

It seems our time is up, and it is time to go to the airport. I appreciate your courtesy in giving me this interview. It will be a valuable contribution to the oral history collection.

Interview in
West Hartford, Connecticut
December 10, 1981

INDEX