SB
74

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB No. 74

Revision Date: ____________________ Department Affected: Health and Social Services

Title: An Act Relating to Pooled health Insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date.

BRU: Medicaid

Component: Medicaid Non-Facility

Sponsor: Kertulla

Requestor: ____________________

COMPONENT SERIAL NO 2-2-9

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0.00	0.00	0.00	0.00	0.00	0.00
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00

POSITIONS:						
FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Prepared By: Kimberly B. Busch Phone: 465-3355

Division: Medical Assistance Date: 2-25-91

Approved by Commissioner: ____________________

Agency: Health and Social Services Date: ____________________

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ies).

Rev 10/90

FISCAL NOTE ATTACHMENT 2-25-91

SB 74

We believe it is the intent of SB 74 at Sec. 21.55.300(b) that coverage under the plan proposed by this bill would cease when Medicaid eligibility was found to exist. We recommend, if this is correct, that this section be amended to specifically exclude Medicaid recipients from coverage in order to prevent confusion on this point. In our view, it would make little fiscal sense not to exclude the few Medicaid recipients who would qualify as "high risk" state plan eligibles, as each person who has, if even for a short period of time, overlapping dual coverage would result in the state plan making some payments in lieu of Medicaid payments. This would produce small Medicaid program savings, but would result in the loss of the 50% federal funds employed in the Medicaid program.

Even if this assumption is correct, there may be a very small number of persons, possibly fewer than 200 per year, for whom the plan may pay for medical expenses which could have been paid for by Medicaid. Medicaid provides for coverage of unpaid medical bills for a period of up to three months prior to the month of application, provided that the recipient would have been eligible in any of those months and that unpaid bills exist for covered services provided in that month. Anyone who had bills paid by the plan during this retroactive Medicaid period would <u>not</u> have Medicaid payment for these bills.

The Medicaid application provides none of the information that is necessary to determine whether a recipient would be a plan eligible, and even if it did, we would be unable to accurately assess the average costs such potential dual eligibles might shift from Medicaid to the plan. Therefore, this fiscal note presents no calculation of potential savings from this cost shift.

Alaska State Legislature

Senate

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO:	Senator Pearce, Chair Senate Labor & Commerce		**RE:**	SB 73 & SB 74 Health Insurance
FR:	Senator Kerttula		**D:**	May 1, 1991

Thank you for postponing the recent hearing for SB 74. I would appreciate it if you would reschedule SB 73 and SB 74. Thank you very much.

JK:kh

APR 9 1991

Alaska State Legislature

Senate

Committee on Finance

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO:	Sen. Pearce, Chair Senate Labor and Commerce Committee	**SUBJ:**	Senate Bill 74- High Risk Ins.
FROM:	Senator Jay Kerttula	**DATE:**	April 9, 1991

I would appreciate it if you would reschedule Senate Bill 74, establishing a high-risk health insurance pool.

I have been contacted by many individuals who are desperate for the opportunity to purchase health insurance. Some of these Alaskans are considered high-risk, and therefore uninsurable, because of disease -- lupus, cerebral palsy, diabetes, PKU. Some of these Alaskans are considered high-risk, and therefore uninsurable, because they have developed a medical condition such as a heart murmer. Many elderly would also benefit from a high-risk health insurance pool. Many of the people who contacted me were informed of Senate Bill 74 by insurance agents.

As you know, Senate Bill 74 is based on model legislation which has been approved by 24 states, and would require all health insurance companies to join a health risk pool. Senate Bill 74 currently places a cap on the high-risk premium of 125 percent of the "average" health insurance premium in the state.

I am aware that the 125 percent provision is opposed by insurance companies. I would support raising the cap to 200 percent. This would ensure financial viability of the plan -- the pool would have the flexibility to raise the price of their premium to correspond to the claims paid. Attached is analysis from an Indiana actuary concluding that the typical mature plan in other states is financially viable with a premium price around 140 percent of the average health insurance premium.

I do not support a tax offset for the assessments on the insurance companies for the cost of the pool. I feel that tax offsets are generally poor public policy. In addition, I believe that a tax offset is unnecessary since we have every reason to believe that claims can be handled within the flexibility of a 200 percent premium cap.

I appreciate your consideration of this request.

JK:kh

Alaska State Legislature

SENATE

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO: Senator Drue Pearce, Chair
Senate Labor and Commerce
Committee

FROM: Senator Jay Kerttula

SUBJ: Senate Bill 74 --
High Risk Health Insurance Pool

DATE: January 30, 1991

I would appreciate your scheduling Senate Bill 74, establishing a high-risk health insurance bill.

This bill, which is based on model legislation which has been approved by 24 states, would require all health insurance companies, hospitals and medical service corporations (that offer subscriber contracts for major medical coverage) to join a high risk pool. All state residents who are "high risk" would be eligible for insurance through this pool, at a "reasonable rate." Other states place a limit on the amount of premiums of between 125 percent and 200 percent of the "average" health insurance premium in the state. Alaskans who have had their health insurance terminated once they have become "high risk" would be eligible for this health insurance, also.

Costs: In theory, premiums cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient, because of a premium cap, and the poor health status of the insured. A 1988 GAO study concluded that for every $1.00 received in premiums by the current operating pools, $1.60 is paid out in claims. This bill takes the approach taken in most states with pools -- to assess the pool members the excess costs in proportion to their share of the state health insurance market. Experience in most states indicates that plans lose money over the course of a year. While losses can at times be large, the cost has

been in the range of 1 percent of the total amount of premiums collected from all health insurance policies sold in those states.

I have attached further information. I appreciate your consideration of this bill.

JK:kh

Information provided by Senator Kerttula:

SENATE BILL 73 and SENATE BILL 74
BACKGROUND

The common goals of Senate Bill 73 and Senate Bill 74 is to expand insurance coverage among Alaskans through a combination of forming new large groups of insured, lowering insurance costs and public and private subsidization of a portion of premium costs for low income Alaskans. Other states' initiatives to expand health insurance coverage have focused on the same three approaches which are structured in SB 73 and SB 74.

1) Forming new large groups or including more people in existing groups, under the assumption that the same insurance product will be less costly and more accessible in a large group than in a small one. Some state insurance pools provide comprehensive coverage, some offer catastrophic protection only. Senate Bill 74 would establish a high-risk health insurance pool.

2) Public or private subsidies to further reduce costs for the individual employer or employee.

a) Private Subsidy: One very common form of private subsidy in state and local initiatives is substantial discounting by providers. For example, hospitals in Flint, Michigan have reportedly agreed to accept 20 percent less than the customary Medicaid reimbursement levels for their Health Care Access Project. Senate Bill 73 has a provision authorizing the Health Insurance Authority to contract with hospitals for lower rates.

b) Public Subsidy: While private subsidies and donations can lower premium costs somewhat, the sizeable gap between the cost of coverage and the available resources of currently-uncovered workers (and their employers) has led many developers of state and local initiatives to conclude that it will be impossible to make a real dent in the employed uninsured problem without using public subsidies. For example, in Maine's Robert Wood Johnson Foundation-funded program, the state will provide subsidies for small employers unable to meet the full cost of premiums, and will also subsidize the premiums of individual enrollees, using a

sliding fee scale based upon income and assets. SB 73 takes the sliding fee scale approach.

3) Changing the Product or its Delivery to design a special, less expensive, product or delivery mechanism in order to make coverage more accessible to employers and their workers. One approach is to focus on primary and preventative care, omitting or discouraging more expensive services such as inpatient care. The rationale is that providing preventative and primary care is less expensive, and will result in healthier patients. Plans in Alabama, Denver, and Utah emphasize preventative or primary care, but offer inpatient care as well. For example, the Denver plan is expected to provide broad primary care coverage. This is an approach taken in Senate Bill 73.

The major advantage of a plan which restricts coverage to special products is that it can be much less expensive than a traditional comprehensive package. For those who cannot afford the higher premiums associated with a richer package, a limited product plan with low cost premiums may be the answer.

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

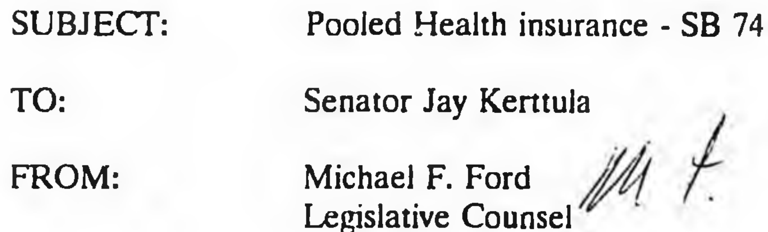
Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM January 24, 1991

SUBJECT: Pooled Health insurance - SB 74

TO: Senator Jay Kerttula

FROM: Michael F. Ford
Legislative Counsel



The following is a sectional analysis of SB 74:

Section 1 - Purpose.

Section 2

Sec. 21.55.010 - Establishes the comprehensive health insurance association and provides that membership in the association consists of certain insurers.

Sec. 21.55.020 - Establishes the board of directors of the health insurance association and provides for voting rights of members.

Sec. 21.55.030 - Establishes the general powers of the association.

Sec. 21.55.040 - Requires the association to submit a plan of operation. Establishes specific items that the plan of operation must include.

Sec. 21.55.050 - Exempts the association from the Administrative Procedure Act.

Sec. 21.55.060 - Provides that the association is exempt from taxation, except for taxes on real or personal property.

Sec. 21.55.100 - Requires the association to make insurance available to residents who are high risks. Specifies the type of deductible to be offered and requires that a medicare supplement plan also be provided to certain residents.

Sec. 21.55.110 - Establishes the minimum benefits that must be offered under a state health insurance plan. Establishes a maximum lifetime benefit of $1,000,000 per individual.

Sec. 21.44.120 - Establishes the deductible and copayment amounts for a state health insurance plan.

Sec. 21.55.130 - Limits the use of a preexisting condition to exclude coverage under state health insurance.

Sec. 21.55.140 - Establishes that certain care and benefits are not covered.

Sec. 21.55.150 - Provides that premium rates for state health insurance may not be excessive, inadequate, or unfairly discriminatory. Requires that premium rates be based on the age and geographic location of the insured. Limits the amount that can be charged as a premium.

Sec. 21.55.200 - Establishes criteria for selection of a writing carrier.

Sec. 21.55.210 - Provides the duties to be performed by the writing carrier and provides for reimbursement of expenses.

Sec. 21.55.220 - Provides for enrollment, for sharing losses, and for determining each member's liability.

Sec. 21.55.300 - Provides that a state resident who is a high risk is eligible to enroll in the state insurance plan. Prohibits enrollment if other coverage exists.

Sec. 21.55.310 - Specifies the procedure for enrollment and the contents of the application.

Sec. 21.55.320 - Requires acceptance or rejection of an enrollment application within 30 days.

Sec. 21.55.330 - Establishes the date that insurance will become effective.

Sec. 21.55.340 - Requires the association to solicit eligible persons for enrollment, by increasing public awareness of the state health insurance plan.

Sec. 21.55.400 - Establishes the duties of the director of the division of insurance.

Sec. 21.55.410 - Provides that the state is not liable for acts of the association.

Sec. 21.55.500 - Definitions.

<u>Section 3</u> - Requires the association to make insurance available to eligible residents by January 1, 1992.

<u>Section 4</u> - Effective date.

MFF:pl
91-024.plm

February 26, 1991

Drue -

Had a meeting with Gordon Evans & Jan Meisel yesterday. One of the bills we discussed was Kerttula's SB74, Pooled Health Insurance.

They say its patterned after Coghill's SB 304 from last year. That passed out of L&C 4DP and HES 5NR.

They have four concerns:

1. State plan premium maximum is lowered from 150% to 125% of average of 5 estimates. (pg 8, ln 17)

2. Deductible lowered from $1,000/$5,000 to $200/$500/$1,000. The industry considers these deductibles to be too low. (pg 5, ln 26)

3. Includes a Medicare supplemental coverage section that is considered to unnecessary.(pg 3, ln 27)

4. National Association of Insurance Commissioners is on the verge of adopting new regulations, should be in next 6 months, which will override this legislation. Would like amended effective date.

SB 73

Health insurance authority in Commerce
Provides health insurance for uninsured only.
Board of Directors
- Commissioner of Commerce
- Commissioner of H&SS
- Director of Insurance
- Insurance industry rep
- Provider rep
- Enrollee reps?

Executive and Deputy Executive Directors in exempt service and employees.
Design healthcare package
Purchase managed health care package
Provide healthcare group plans
Allow PFD checkoff for premium pmts. — EXEMPT FROM ADMIN PROCEDURES ACT.
Coverage required:
- acute hospital care
- in/out patient physician services
- diagnostics & screening tests
- preventive care
- pre-natal & well baby care
- Pedically necessary emergency svcs

Subsidized premiums for small employers
Creates HI reform commission
- Membership:
  - Nonprofit hosp rep
  - Dept of Law employee
  - health care consumer rep
  - health maintenance org rep
  - chair apptd by Gov (unspecified catagory)
- Sunsets 11/15/92

MARY PEARCE

HE CONSULTANT.

SB 74

Creates HI Association
Membership:
- Hospitals & service corps offering major med coverage
- Insurers offering major med on expense incurred basis
- Mandatory membership

Board of Directors seven members of association.
- Weighted votes based on fees and/or premiums

Mandatory plan of operations
Exempt from Admin Procedures Act
Tax Exempt
Must offer high risk HI
Must offer Medicare supplement
Lifetime max of 1mm
- hospital services
- no dental or mental but all other administered by doc of nurse
- mental diag or treatment up to $4m per year
- legend drugs
- nursing facility up to 120 days
- home health agency service including terminal ill
- hospice service - six month max
- radium or other radioactive
- chemotherapy
- oxygen
- anesthetics
- prothesis
- medical equipment
- x rays & lab tests
- oral surgery
- physical therapist
- ambulance services
- drug & alcohol treatment - 45 days
- alternative inpatient services
- second surgical opinions
- other doctor prescribed services

varied deductibles and double credited deductibles
special pre-existing condition provisions
services not covered:
- conditions covered by worker's comp or other coverage
- cosmetic surgery
- travel not previously covered
- private rooms
- charges exceeding usual & customary
- services not medically necessary
- unlicensed services
- service government covered
- custodial care
- services performed because of presence of insurance
- eyeglasses, contacts or hearing aids
- dental care not previously covered
- related registered nurse
- experimental services

uncharged services
premiums may not exceed 125 of usual and customary average rates
provisions for writing carriers
Operation of plan provides for year end assessment but excess
premiums are held in trust
everyone with no health insurance coverage is eligible
plan may be advertised
State not liable

SB 83

requires certificate of need evaluation
establishes an authority
gives authority access to state info
Board of directors is 1 or 2 of the following:
- exec branch
- labor organizations
- school districts
- municipalities
- private sector employer
- health care provider

exempt service or contracts
bid purchase or self insurance
establishes State Health Resources Fund with approps & premiums
once enrolled an entity can only withdraw with board approval

Alaska State Legislature

SENATOR JIM DUNCAN

P.O. BOX V JUNEAU, ALASKA 99811-3100

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COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

SECTIONAL ANALYSIS

SENATE BILL NO. 83

"An Act creating the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for the residents of the state, and to the issuance of certificates of need; and providing for an effective date." By Senator Duncan.

Section 1. This section outlines the goals and objectives of the Alaska State Health Resources Authority in providing cost effective health insurance coverage for an expanded pool of employees.

Section 2 and 3. The authority has advisory responsibilities to the Department of Health and Social Services' certificate of need process. The responsibility is determination of group health insurance cost effects resulting from proposed new or expanded health facilities.

Section 4. is a new chapter establishing the Alaska State Health Resources Authority (ASHRA hereafter) and its powers, duties and requirements:

Sec. 4. Section 21.77.010. Requires ASHRA to establish a health care provider reimbursement system and utilization standards for eligible employees of the state, a municipality, or a school district, and other employers that apply to the authority. ASHRA must provide a group health insurance pool or pools for eligible state and local government employees as well as other employees that elect to participate.

Sec. 4. Section 21.77.015. It is provided that state agencies cooperate in the development of the health care provider reimbursement system and utilization standards and share relevant information.

Sec 4. Section 21.77.020. ASHRA has a nine member board of directors from various occupations serving staggered four year terms. Members are entitled to per diem and travel expenses and are subject to conflict of interest requirements in AS 39.50.

Sec 4. Section 21.77.030. ASHRA may exercise the powers granted to insurers as well as other general powers.

Sec. 4. Section 21.77.040. Duties of the ASHRA board include providing lowest cost comprehensive health insurance, annual reports to the governor and legislature on fiscal activities, and review of certificate of need applications under AS 18.07.041. Every third year a cost and benefit analysis of its insurance pool or pools is required.

Sec. 4. Section 21.77.050. ASHRA may employ an executive director and other staff it requires. It may contract for professional services. Employees of ASHRA are in the exempt service under AS 39.25.110.

Sec. 4. Section 21.77.060. ASHRA shall purchase group health insurance for eligible employees after July 1, 1992 or act as a self insurer. When purchasing group health insurance, ASHRA must comply with the State Procurement Code and re-bid at least once every five years.

Sec.4. Section 21.77.070. The Alaska State Health Resources Fund is created of funds appropriated by the legislature and collected premiums. The fund is managed and invested by the board.

Sec.4. Section 21.77.080. ASHRA shall provide that sufficient funds are available for the purposes of employee group health insurance.

Sec. 4. Section 21.77.090. A participant in group health insurance offered by ASHRA may obtain a waiver to opt out under certain conditions.

Sec. 4. Section 21.77.100. Definition section.

Section 5 and 6. Technical amendments.

Section 7. A special, March 1, 1992 report to the legislature is required of ASHRA describing the progress in establishing the health care provider reimbursement system and utilization standards.

Section 8. Effective date clause.

SB 83/HB 71 - State Health Insurance Pool. Introduced 1/23 by Duncan and Zharoff, SB 83 is intended to implement recommendations of the Health Care Cost Containment Task Force (HB 71, the House version, was introduced on 1/24 by Representative Boyer and Navarre). The bill would create an Alaska State Health Resources Authority to provide the "lowest cost comprehensive health insurance" on a group basis, report annually on its activities, and review certificates of need for new or expanded health facilities.

The legislation would:

1. Create an independent state corporation, the Alaska State Health Resources Authority, with a board of nine members appointed by the Governor with at least one but no more than two members representing: the executive branch, labor organizations, school districts, municipalities, private sector employers and health care providers;

2. Require the authority to establish mandatory "health care provider reimbursement system and utilization standards" for the state, municipalities, and school districts by July 1, 1992;

3. Require the authority, "no earlier than July 1, 1992," to establish a group health insurance pool to provide health insurance to eligible employees of the state, a municipality, or a school district if the employer has elected to participate; the authority may provide health insurance to other (private) employers if they elect to participate and use the reimbursement and utilization standards; and

4. Require that if the state, municipality, district or other employer elects to participate in the group insurance coverage, then it must continue to participate unless a waiver is granted by the authority; a waiver may be granted if the employer can document by a time certain that it can match the "minimum benefit and financial standards set by the authority."

The intent of the legislation is to address a significant problem faced by many employers, including municipalities - the growing cost of health care and insurance for their employees. The Task Force, as stated in its draft report, found that:

- Health care expenditures in Alaska have increased 157.2 percent over the last 10 years, the second highest in the nation.
- The health care expenditures portion of the State of Alaska budget is the fastest-growing component of the whole budget, $385.5 million in FY 90 and, at this pace, will exceed $2 billion in FY 95.
- The number of uninsured residents in Alaska has increased at an alarming rate to an estimated 90,000 uninsured residents, representing 16.5 percent of the total population in Alaska.
- The cost of providing health coverage for state employees and their dependents has been reduced and stabilized at $385.00 for FY 90 and 91.

Some concerns:

1. Mandatory payment and utilization schedules: Although participation in the health insurance pool is not required, use of payment and utilization schedules for medical procedures, etc. set by the authority is. This means presumably that the state will provide a list of doctors, hospitals, and insurers which agree to the rates set by the state. If you use one of these for medical services, you will be fully reimbursed up to the limits of your coverage. The legislation does speak to setting the rates based on "geographic regions, actual provider costs and availability of service."

Even with the estimated potential of 135,000 employees, is the pool large enough to affect the cost of care? Are there enough health care providers to make them want to participate?

2. Alternatives: What is the impact on municipalities and their ability to negotiate with a private insurer if the rates are set by the state but they elect not to participate in the state system? How does the system set up in the legislation affect collective bargaining? Will the "minimum benefit and financial standards" negotiated meet the needs and the budgets of all potential employers that do or want to participate, using the current state health benefits as an example?

3. Representation: Why does the definition of "employer" include "a collective bargaining unit"? The legislation states that the Board of the authority shall be made up of representatives of the executive branch, municipalities, school districts etc. but it does not specify "employers" versus "employees."

4. Getting out of the pool: What is the timeline to "match" the state program when applying for a waiver? Can an employer get an "apples to apples" quote? Should there not be the provision (added to the legislation last year at our request) to at least allow an employer to get out of the pool if it could no longer provide <u>any</u> health care benefit?

Department of Commerce
& Economic Development / POSITION PAPER

SB 74: "An Act relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date."

SB 74 would create the Comprehensive Health Insurance Association, a nonprofit corporation comprised of all licensed hospital or medical service corporations and all insurers writing health insurance in Alaska. Membership would be a condition for license to do business in the state. The Association is a health insurance pool run and subsidized by private insurers for the benefit of uninsured high risk state residents.

SB 74 attempts to resolve the unavailability of adequate health care insurance for "high risk" individuals by creating a pool. This is similar to the approach utilized in other states. While the plans and coverages required in the plan are laudable, there are a number of challenges which need to be considered. These challenges are:

1. The absence of hard data to give substance to the numbers of "high risk" persons needing such access makes quantification of the cost for such a plan very difficult. A recent study by an actuary at Consulting Services, Inc. indicates that state pools have an abysmal experience. Loss ratio for the 13 mature pools are at about 165%.

2. In view of the state role in the structure of this Association, a careful review should be made to assure that the full faith and credit of the state is adequately removed from exposure.

3. Sec 21.55.150 provides that the charges for coverage may not be excessive, inadequate or unfairly discriminatory. Yet, the section requires that the rate can not be higher than 125% of the average premium charge of the top five writers of the same coverage on a "standard risk." In view of the experience of other pools, this could effectively mandate an inadequate premium. We are concerned with the source of the funds for that subsidy. This can only come from increased premiums on standard risks thus further exacerbating the cost of health care insurance. A potential solution to this problem would be to start out at 125% with an allowable range of movement (say 120% to 140%) that can occur if supported with a periodic adequacy review.

4. If the subsidy is severe to the point that the insurers can not recover it through their rate structure, it will encourage insurers to leave the Alaska marketplace. It may also have an impact on their solvency.

5. Under the Alaska Insurance Law, the correct term of art for health insurance is disability insurance which is defined in AS 21.12.050. In Sec. 21.55.500(4), on page 12, line 28, the phrase "'health insurance' includes disability insurance under AS 21.12.050." should read "disability insurance under AS 21.12.050 includes 'health insurance'."

Since the above questions and considerations are not resolved, the department has not adopted a position on this legislation.

Glenn A. Olds, Commissioner

Date: 2-25-91

GAO/DK/dgl8987D
022591a

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 74

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

HIAA has long-supported state uninsurable risk-pools. These risk pools are included as one of the components in our program of "Financing Health Care for All Americans." Uninsurable risk pools address accessible health coverage to those who are otherwise considered medically uninsurable. However, we have serious concerns with a number of the provisions contained in SB-74, which will result in underfunding of the program, inappropriate accessibility to the program. We strongly encourage the committee's consideration and adoption of proposed amendments reflecting the issues discussed below.

During the 1990 Alaska legislative session, then-Senator Coghill sponsored SB-304 and the Senate Labor and Commerce Committee agreed to a committee substitute for the original bill -- CSSSSB-304. The committee substitute was a result of an agreement emanating from negotiations between all interested parties. However, the amendments were provided too late for the bill to complete its journey through the legislative process last year. We encourage the committee to amend SB-74 to duplicate the previously agreed-upon version of CSSSSB-304.

Individuals with severe preexisting conditions may be ineligible to purchase insurance from the private insurance industry. A number of states have enacted uninsurable risk pools to address this need. Historical data of the loss ratios of the "mature" (longest operating) risk pools are:

Connecticut - 200 percent

Florida - Exceeded 200 percent in 1990

Indiana - Close to 200 percent in the last several years

Minnesota - Exceeded 200 percent over the last three years

North Dakota - Over 200 percent in 1986-87 and exceeded 175 percent in 1989

Wisconsin - Was the best controlled, but its loss ratio is now moving over 150 percent

These figures indicate the absolute requirement that additional funding is going to be required to cover the claim losses due to the adverse experience of the uninsurable risk pools. We strongly encourage general fund appropriations be allocated to cover these losses. However, if the committee keeps the current assessment on health insurance companies doing business in Alaska, on a pro rata earned premium basis, we strongly encourage the allowance of a credit against premium taxes imposed against disability insurers. Suggested wording of a new section of the bill to accomplish this purpose would include the following language as AS 21.09.210 (j):

> A member of the Comprehensive Disability Insurance Association created in AS21.55.010 may credit against a premium tax imposed against disability insurance premiums under this section, an amount equal to an assessment against the member under AS21.55.220(d). Any portion of the credit allowed in this subsection that cannot be taken in a tax year without reducing taxable premiums below zero may be

carried forward and credited in successive years until the credit is exhausted.

A new subparagraph should be added to Section 21.55.060 on page 3. The present paragraph should be designated as sub paragraph (a). A new subparagraph (b) should be added to read:

> A member of the Association is entitled to receive a credit against taxes levied by the state on disability insurance premiums as provided in AS21.09.210(j).

The 1990 CSSSSB-304 legislation allowed for such a credit by the inclusion of the above-referenced language.

Most states with uninsurable risk pools either have the losses covered by a broad-based funding mechanism, i.e., general funding, dedicated taxes or allow a premium tax offset as mentioned above. Examples of dedicated taxes imposed by other state uninsurable risk pools include: California -- funding from cigarette and tobacco products surtax fund; Colorado -- funding by imposing a $2.00-4.00 charge on state taxpayers whose federal income tax return indicates an adjusted gross income in excess of $15,000; Louisiana -- funded by a $2.00 service charge on each admitted hospital day and $1.00 charge for admittance to an ambulatory surgery center. Fees are paid by all private payers as a medical expense; Maine -- assessment on all revenues of hospitals in the state.

An adequate premium must be charged to the insured, reflecting the increased risk that will be borne due to their

preexisting medical condition. SB-74, as proposed, permits a maximum premium of 125 percent of the average of five Association members' standard premiums for similar-type benefits. CSSSSB-304 (1990) included a 150 percent premium based on the average of an estimate of five Association members' standard premium for like-type benefits. It is our understanding that Senator Coghill and the group of interested parties had further agreed that the premium would be raised to 175-200 percent of standard risk. Most state insurance risk pool plans allow premiums greater than 125 percent. Therefore, we strongly encourage the committee to increase the premiums to 200 percent of the average of five Association members' plans. Even with a 200 percent premium, the claims experience of these uninsurable individuals will be inadequate to cover all the claims losses.

Deductibles are a mechanism to reduce the cost of the insurance policy premium to the purchaser. CSSSSB-304 called for two alternative deductibles: $1,000 and $5,000. SB-74 has substantially reduced deductibles -- $200, $500 and $1,000. Today, the average private sector deductible for standard policies is considerably higher than $200. In addition, many state uninsurable pools have deductibles substantially greater than those proposed in SB-74. We request the committee consider increasing the deductible to a more appropriate level such as those proposed in last year's CSSSSB-304.

Unlike CSSSSB-304, SB-74 includes Medicare-eligible persons within the uninsurable risk pool, allowing the pool to act as a Medicare supplement plan. We oppose this inclusion, as the

purpose of the uninsurable risk pool is to provide coverage for those without any insurance. People covered under Medicare have coverage and are also eligible to purchase Medicare supplement insurance. Medicare supplement policies are available in Alaska. Congress included in the Omnibus Budget Reconciliation Act of 1990 -- P.L.101-508 -- that Medicare supplementary policies meet specific National Association of Insurance Commissioners (NAIC) standards. The NAIC is actively working on the development of the ten variations which will be before the NAIC for adoption later this year. Therefore, we do not see the need for inclusion of Medicare supplement coverage within the uninsurable risk pool and urge the committee to remove that provision which is 21.55.100(b) on page 3. CSSSSB-304 did not include Medicare supplementary insurance within the uninsurable risk pool.

SB-74 requires a lifetime maximum of $1 million per individual. This coverage is higher than many of the state uninsurable risk pool programs. To further make the pool premium more affordable, we suggest reducing the policy lifetime maximum to $500,000 similar to the amount contained within CSSSSB-304.

CSSSSB-304 allowed for a preexisting exclusion of 12 months. However, SB-74 allows only 3 months for such an exclusion. It is necessary to collect an adequate premium over a period of time in order to cover the losses for expected claims, as for people with preexisting conditions. Therefore, a three-month preexisting exclusion is an inadequate amount of time and will lead to further losses for the pool, especially as the premium charge will be inadequate to cover all claims incurred. Therefore, we

strongly encourage the committee to amend the 3-month preexisting time limit to 12 months.

Section 21.55.220 allows an employer who has one or more eligible persons enrolled in a state plan to pay for the premiums of that person. We are concerned that such a provision will allow employers to "dump" higher risk employees into a state pool which is available only for individuals who are medically uninsurable, i.e., those who have been declined health insurance. The purpose of the uninsurable risk pool is not to reduce the cost of an employer's overall premium for their employees -- by their eliminating a higher risk employee from the group -- but to provide access to health insurance to medically uninsurable individuals. HIAA recognizes that some small employers have been declined insurance because one or more of the employees have proven to be uninsurable. However, SB-242 will preclude that from occurring, and all employees of an employer will be covered. Therefore, provisions in SB-242 negate the need to find high-risk employees an alterative to their group plan. Employers should not be encouraged nor given the opportunity to "dump" higher risk employees into a state uninsurable risk pool.

Section 21.55.300 in SB-74 does not include a listing of persons who are ineligible for coverage, as does Section 21.55.300(b) in CSSSSB-304. It is imperative to list those persons who would not be eligible for coverage, i.e., a person who at the time of application is eligible for medical assistance; a person who terminated coverage under the chapter in the previous 12 months; or that a person on whose behalf the pool

has paid out the maximum lifetime benefits; or for persons who are inmates of public institutions; or persons whose benefits are duplicated under public programs.

The purpose of insurance is to provide coverage for some unexpected, future event. Allowing applicants to pay retroactively for coverage back to when their previous contract was terminated is a violation of the principle of insurance. Coverage should be based on a prospective, not a retrospective basis. Therefore, we strongly encourage Section 21.55.330(b) to be deleted. HIAA is very willing to work with the committee in developing a workable, affordable, uninsurable risk pool that will be to the benefit of Alaskan medically uninsurable residents. Participation by health insurers is required in the uninsurable risk pool, as a privilege of doing business in Alaska. Insurance companies want to support and participate in the risk pool. However, the absence of a broad-based financing mechanism or a premium tax offset for the claims-incurred losses to pay the residual losses will result in a failed system with severe financial implications to the insurers licensed in Alaska.

We thank the committee for its consideration of incorporating the provisions of CSSSSB-304 into SB-74.

Consulting Services, Inc.

C. Keith Powell, ASA, MAAA
Consulting Actuary

10-22
10-29-9

September 28, 1990

Office of the Director
Department of Insurance
Juneau, Alaska 99811

Dear Sir:

I was recently asked to make a presentation to an actuarial meeting on the subject of state pools for people who are uninsurable for health coverages. The larger topic of the meeting was national health insurance, and I was asked specifically to examine the possibility that these state pools (now existing or in the process of implementation in 23 states) may be a backdoor approach to national health insurance.

The survey that I did in preparation for this presentation developed some interesting information on the financial results under those pools, different approaches to funding used by the various states, eligibility requirements, etc.

As the consulting actuary who reviews the pool rates for the Indiana DOI, I have often wished that I had such information available; so I thought you or a member of your staff might be interested in the financial results of these pools.

I am enclosing a summary of these financial results, as well as a copy of my presentation. If you or a member of your staff would like to discuss this material, feel free to contact me. I can usually be reached at 502-245-1459 on Monday through Thursday, or by mail at the address below.

Sincerely yours,

C. Keith Powell

C. Keith Powell, ASA, MAAA
Consulting Actuary

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OCT 09 1990
Department of Commerce
& Economic Development

OCT 22 19[illegible]

9245 North Meridian Street, Suite 206, Indianapolis, Indiana 46260 317-575-3384

STATE POOLS FOR THE UNINSURABLE.

As of 1989 thirteen states had in place relatively mature (operational for two years or more) state pools offering health insurance coverage for residents who can not otherwise get health insurance. Counting the states with newer programs, some authorized but still in the process of becoming active, the total is now 23 states whose populations represent over 50% of the people in this country. This is about four times the number of such pools in force five years ago - a very rapid and surprisingly little publicized development. The ongoing, and worsening, problem of the lack of availability of private sector coverage for large segments of the population seems to be a major force driving this growth of state sponsored pools.

I would like to share with you the results of a recent survey of these programs that I have completed. While I am rambling through the survey results, you might want to keep in mind the following radical thoughts, not original with me:

(i) With the growth of these pools, we might be seeing a form of national health insurance growing right before our eyes.

(ii) Of the approaches to national health insurance with any chance of implementation, this might be the one that is most favorable to the private insurance industry.

Now, to the results of the survey.

(1) Eligibility Requirements.

It is difficult to generalize about eligibility requirements, but the most common one is an individual's status as uninsurable for reasons of health. There are other requirements in several states, and the type of proof of eligibility based on the status of uninsurable for reasons of health varies considerably by state.

(2) Financial Results.

If you look at 1989 results for the thirteen relatively mature plans, there was $68 million of collected premiums and $112 million of paid claims, for a paid loss ratio of 165%. The administrative cost of $9 million was about 8% of claims. If you take out two large states (Connecticut and Minnesota) that are atypical in certain important respects, the "loss ratio" drops from the 165% above to about 139%. Of the remaining eleven states, seven show loss ratios in the 125% to 150% range.

I think that this loss ratio range of 125% to 150% is about where

it should be. This is my conclusion based on looking at commutation functions for health insurance claims and making some guesses about antiselection in the bigger claims. It is also borne out as order of magnitude reasonable by conversion experience, experience on some Blue Cross plans that are not underwritten, and some social insurance experience.

When you look at details, results are, as you would expect, all over the place for reasons such as rate of growth, position in the rating cycle, etc. Within the eleven more normal plans, the paid loss ratios for 1989 range from a low of 72% to a high of 172%.

The low loss ratio of 72% was from Washington, a very fast growing plan that had $122,000 of collected premium in 1988 and $2,065,000 in 1989. Under these conditions a paid claims / collected premium loss ratio understates incurred claim / earned premium experience due to the claims reporting and processing lag and to the failure of collected premiums to reflect the fact that some of the collected premiums are not fully earned. The Washington plan also has a six month / six month preexisting condition exclusion. In the presence of such fast growth, a great deal of the experience will still be driven by the pre-ex period and as such the loss ratios will be considerably lower than ultimate experience should show.

The Iowa plan, with its loss ratio of 112%, is another very fast growth case.

The high loss ratio of 172% for 1989 comes from right here in Indiana. This resulted from some very special circumstances. The Indiana plan tried to get approval for an incredibly large rate increase to be effective 7/1/89. The DOI challenged the rate increase all over the place, and it was finally approved under the Indiana deemer provision effective 12/1/89. The effect of this delay contributed to the high loss ratio in Indiana for 1989. Just as a footnote to this story, as some of the Indiana participants might know, the incredibly high set of rates was rescinded in 1990 and the state plan agreed to make partial refunds of the excessive portion of the premiums.

Again, the purpose of this detail is to present an argument that most of the plans tend to have cash loss ratios in the range of 125% to 150%. As you might expect, the results by state are all over the place due to such factors are rate of growth, the pre-existing condition exclusion provisions, and the plan position in its rating cycle.

On additional thought bridging design and pricing is that there is surprisingly little exclusive provider design in these plans. This could be the one angle that could really contribute to bringing

down the loss ratios somewhat. It should be possible to get some excellent discounts from hospital and physician providers by promising them these very high using populations.

(3) Funding Mechanism.

Premiums are most often set at 125% to 150% of the some version of an average price for underwritten products in the state. This price reason pops up for many reasons.

At the low end of the 125% to 150% range, it is probably a friendly gesture to the insurance industry to try to keep the price above 125% of the average hot selling underwritten rate. By keeping the rate 25% over the average selling rate for underwritten products, it is safe to assume that there will be little or no loss of private sector underwritten business to the pools. Notice that but for this point of wanting to protect the private sector you could logically justify holding the pool rate below 125% of the average selling rate for an underwritten product. Recall that the underwritten rates generally target 50% to 70% loss ratios, so a pool rate based on 125% of the average underwritten selling rate means that the pool is allocating twice as high a percent of premium to benefit costs as the private sector product does.

If you go much higher than this range of 125% to 150% of the average underwritten selling rate a look at claims distributions and almost any reasonable guesses about antiselection show that the product will be priced well above "reasonable" for a very large portion of the people needing the product. This would discourage purchase of pool products by not only a large number of the people who need it but also by the very people who do not tend to contribute large losses to the pool.

The linkage between this 125% to 150% and the emerging loss ratios of 125% to 150% mentioned earlier is very tenuous. There actually might be a little bit of a linkage, but it is pretty far out there and it is probably best to think of them as unrelated concepts.

Remaining costs (in addition to premiums) are usually paid by either (i) the insurance industry in the state or (ii) local health care providers, and there is often some kind of tax offset that ultimately brings it to roost on general revenues.

(4) National Health Insurance Implications.

In 1989, 13 states (representing roughly 20% of the U. S. population) paid $112,000,000 in health benefit costs to providers, $9,000,000 for administration mainly to the insurance industry, for a total cost of $121,000,000. This was offset by $68,000,000 in premiums collected, for a net cost of $53,000,000. With all kinds

of caveats, extrapolating that to the entire U. S. would have cost less than $300,000,000. These numbers relate to programs that are almost exclusively freedom of choice arrangements that have made very little effort to get the savings from exclusive provider arrangements; and proper use of exclusive provider arrangements could introduce an element of savings. Again, with still more caveats, it had no direct impact on the federal deficit.

Note how nicely these pools dovetail with existing public and private health insurance programs.

Medicare and Medicaid are the major social insurance programs in this country. Medicare people generally do not need the pool benefits because the Medicare program itself is so comprehensive. Medicaid people generally already have some kind of half way decent benefits. They are not as generous as those in the state pools, but then Medicaid people generally pay nothing for their benefits.

I am going to try to summarize the value of this concept of national health insurance to the insurance industry, at the risk of getting up on the soap box.

Over the last half century the private health insurance industry has proved itself totally incapable of providing significant medical expense benefits on an individual basis to people with serious health problems, in spite of the fact that these people beg for our products and are willing to pay almost anything asked for the benefits. At least for freedom of choice insurers there is no reason to believe that this is changing, and in fact the problem seems to be worsening each year health care costs grow faster than other costs. While this is a very serious indictment of our industry, it does point out that the people that we are losing to these pools are the very people that we could not handle anyway. In fact, the payments that the health insurance industry receives to administer the benefits for these people probably exceeds aggregate premiums that the industry could collect from them for meaningful medical expense benefits; and absent state legislation making the cost fall directly on insurers, it comes without underwriting losses or significant financial risks.

These pools leave with the health industry the very people that the health insurance most wants and takes the people that they do not want.

With caveats, I would like to suggest that this may be the feasible approach to national health that is kindest to the health insurance industry.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Connecticut					
1983	3134889	3442223	272550	109.80%	7.92%
1984	3473145	4454451	315450	128.25%	7.08%
1985	3285762	4579461	276379	139.37%	6.04%
1986	3532941	4203833	246156	118.99%	5.86%
1987	3186476	6663081	337235	209.11%	5.06%
1988	3460337	7293434	412942	210.77%	5.66%
1989	4495872	10438000	567826	232.17%	5.44%

Comment - These results may not be typical due to the presence of a Blue Cross plan in the process of being phased out.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Florida					
1983	23759	0	0	0.00%	ERR
1984	505798	141430	69114	27.96%	48.87%
1985	1107581	774174	103946	69.90%	13.43%
1986	1770171	1686195	184889	95.26%	10.96%
1987	2858173	3963710	357017	138.68%	9.01%
1988	5294446	8581468	1134991	162.08%	13.23%
1989	12443960	17425025	2810723	140.03%	16.13%
Indiana					
1983	2352179	217878	56512	9.26%	25.94%
1984	6356995	6843691	256462	107.66%	3.75%
1985	7505144	9518759	253524	126.83%	2.66%
1986	7197774	11552494	443791	160.50%	3.84%
1987	6301707	11564602	459462	183.52%	3.97%
1988	5607908	9640519	500643	171.91%	5.19%
1989	6210701	10690610	670565	172.13%	6.27%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Iowa					
1987	164995	56725	16560	34.38%	29.19%
1988	1008691	1249159	82560	123.84%	6.61%
1989	2876251	3232227	339660	112.38%	10.51%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

Uninsurable Pool Data

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Maine					
1988	15179	0	33960	0.00%	ERR
1989	228189	290179	81265	127.17%	28.01%
Minnesota					
1983	4082351	6981967	383741	171.03%	5.50%
1984	6413829	9761835	665100	152.20%	6.81%
1985	9492438	13324992	984514	140.37%	7.39%
1986	10772454	18913879	904886	175.58%	4.78%
1987	11407281	21893358	928773	191.92%	4.24%
1988	14197219	27098596	1340562	190.87%	4.95%
1989	18459482	38373578	2115892	207.88%	5.51%
Montana					
1987	9870	0	9759	0.00%	ERR
1988	97026	65374	14675	67.38%	22.45%
1989	316276	395050	24523	124.91%	6.21%
Nebraska					
1986	8414	0	11558	0.00%	ERR
1987	458857	443238	14600	96.60%	3.29%
1988	1221792	1808813	57097	148.05%	3.16%
1989	2572213	4088816	128223	158.96%	3.14%
New Mexico					
1988	233053	127399	103475	54.67%	81.22%
1989	1222400	1565229	157945	128.05%	10.09%
North Dakota					
1983	138666	345918	25305	249.46%	7.32%
1984	455874	1058694	35904	232.23%	3.39%
1985	894701	1704988	56756	190.57%	3.33%
1986	1321991	2863886	108756	216.63%	3.80%
1987	1626970	3389229	174130	208.32%	5.14%
1988	1937903	3340441	234984	172.37%	7.03%
1989	2261638	3691487	278007	163.22%	7.53%
Tennessee					
1987	556763	17450	0	3.13%	0.00%
1988	3236204	2807338	317930	86.75%	11.32%
1989	8433944	10212644	623744	121.09%	6.11%

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Washington	Earned	Incurred			
1988	124260	74121	78575	59.65%	106.01%
1989	1940334	2543839	204221	131.10%	8.03%
Wisconsin					
1983	1232352	2463703	156964	199.92%	6.37%
1984	2079996	3104604	196338	149.26%	6.32%
1985	2600586	3265492	210646	125.57%	6.45%
1986	7856286	3336087	284500	116.80%	8.53%
1987	[illegible]959861	3956056	366245	133.66%	9.26%
1988	[illegible]056671	5518189	906550	136.03%	16.43%
1989	6676614	9754103	885383	146.09%	9.08%

Comment - Participating insurers are not permitted any kind of credit against premium or income taxes.

State	Prems. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Total					
1983	10964196	13451689	895072	122.69%	6.65%
1984	19285637	25364705	1538368	131.52%	6.06%
1985	24886212	33167866	1885765	133.28%	5.69%
1986	27460031	42556374	2184536	154.98%	5.13%
1987	2953095[illegible]	51947449	2663781	175.91%	5.13%
1988	40490689	67604851	5218944	166.96%	7.72%
1989	68137874	112700787	8887977	165.40%	7.89%
Total - Minus Connecticut and Minnesota					
1983	3746956	3027499	238781	80.80%	7.89%
1984	9398663	11148419	557818	118.62%	5.00%
1985	12108012	15263413	624872	126.06%	4.09%
1986	13154636	19438662	1033494	147.77%	5.32%
1987	14937196	23391010	1397773	156.60%	5.98%
1988	22833133	33212821	3465440	145.46%	10.43%
1989	45182520	63889209	6204259	141.40%	9.71%

DRUE

Alaska State Legislature

3111 C Street, Suite 150
Anchorage, Alaska 99503
(907) 561-2038

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-4993

Senator Drue Pearce
District G

TO: Members
Senate Labor & Commerce Committee

FROM: Senator Drue Pearce, Chair
Senate Labor & Commerce Committee

DATE: February 8, 1991

RE: Health Insurance Legislation

Gordon E. Evans, representative for the Health Insurance Association of America, asked that the enclosed material be distributed to committee members in preparation for hearings that the committee will be holding dealing with health insurance.

DP:rrm

Enclosure

Health Insurance Association of America

April 25, 1990

Dear Colleague:

Every year state legislators present us with an ever increasing amount of legislation important to our business. These proposals are examined and pursued in light of HIAA's policy on any given issue. In order to place the Association in a proactive posture and gain wider understanding of the industry's legislative program, we have developed kits describing the background and explaining our positions on key issues affected by state legislative initiatives.

HIAA is glad to provide you with our new State Health Insurance Issues Kit. Please feel free to request additional copies for legislative and regulatory activities by writing HIAA, P.O. Box 41455, Washington, D.C. 20018. Our goal is to expose legislators, regulatory officials, business leaders and public interest groups to HIAA's state legislative program. Please help us do this by distributing any of the individual issues briefs, or the entire kit, at hearings, meetings or visits with policymakers.

Sincerely,

Woody

Woodrow E. Enb
Senior Associate General
Counsel

WEE/bac

Enclosures

1025 Connecticut Avenue, NW Washington, DC 20036-3998 202/223-7780 Telecopier 202/223-7897

HIAA ON STATE HEALTH INSURANCE ISSUES

ISSUE: ACQUIRED IMMUNE DEFICIENCY SYNDROME
(as of March 1990)

BACKGROUND: The first case of AIDS in the United States was diagnosed in 1980. As of spring 1989, 88,000 cases have been reported to the Centers for Disease Control, which estimates that by the year 1992, 365,000 Americans will have died of AIDS or progressed to the later stages of the disease.

Despite intense biomedical research efforts, there remains no cure, nor is an effective vaccine likely to be developed in the immediate future. Health officials estimate that between 1 million and 1.5 million Americans are infected with the human immunodeficiency virus (HIV). Available data support the view that, absent any effective therapy, virtually all those infected with HIV will eventually progress to AIDS or severe HIV illness.

The human and financial costs of this tragic epidemic have been staggering, with many young adults being stricken during their most active and productive years. Loss of wages resulting from illness and disability and loss of future earnings as a result of premature death are estimated at $7 billion in 1986. An ongoing survey of AIDS-related life and health insurance claims by HIAA-ACLI member companies documents these losses, reporting an estimated $263 million in life insurance death claims in 1987.

Medical care costs for AIDS patients are estimated at $3 billion in 1988, and health insurers have borne a significant portion of this cost. Although 1988 data are not yet available, the HIAA-ACLI survey showed that member companies paid $35.9 million in individual claims and $188 million in group claims in 1987, the latter representing more than twice the amount paid during the previous year.

The cost of AIDS per case has decreased over time, primarily due to the development of alternative outpatient treatments. Health insurers have responded quickly to these innovative approaches, and companies continue to develop methods, through case management programs, that provide appropriate and humane care to AIDS patients while at the same time realizing tremendous cost savings. Home care, a major component of case management, can result in savings of $3,000 to $15,000 per month and allows AIDS patients more independence.

Because there is no AIDS vaccine, effective treatment or cure, and because of the high morbidity and mortality associated with HIV infection, people with AIDS and HIV infection represent medical risks that must be considered uninsurable. For most of the 90 percent of the insured population who receive insurance through the work place, evidence of individual health status is not required. However, for those currently uninsured who seek to obtain individual or small group coverage, health status must be tested to determine insurability. Evidence of HIV infection (like heart disease, diabetes and cancer, for example) would necessarily require some initial restrictions on coverage, or possibly exclusion from coverage. The HIV antibody test, now regarded as a reliable indicator of viral infection, is an essential tool available to insurers to determine medical insurability.

Health Insurance Association of America

1025 Connecticut Avenue N.W., Washington, DC 20036 ▢ 202-223-7780 ▢ FAX 202-223-7897

HIAA POSITION: The health and life insurance industries have paid a significant portion of the costs associated with AIDS and will continue to do so. For those AIDS patients who are now uninsured, HIAA believes that alternatives should be developed that address their health care needs. HIAA has recently adopted an innovative proposal on the needs of all the uninsured, including people with AIDS. Of particular significance is the availability of coverage for the medically uninsurable. HIAA continues to seek legislation that would establish state pools for uninsurable individuals.

On the issue of testing, HIAA believes that legislation that forces insurers to ignore reliable evidence of health status will create underwriting inequities, and continues to voice strong opposition to such laws. Insurers must be permitted to use the results of HIV tests in the underwriting process. HIAA supports the 1986 model guidelines, adopted by the National Association of Insurance Commissioners, that set limits on permissible application questions and establish underwriting guidelines.

HIAA

ON STATE HEALTH INSURANCE ISSUES

ISSUE: HEALTH MAINTENANCE ORGANIZATIONS
(as of March 1990)

BACKGROUND: In slightly more than a decade, health maintenance organizations (HMOs) have become a well-established force in most major American metropolitan areas. Today, HMOs serve approximately 13 percent of the U.S. population and provide effective competition for traditional fee-for-service plans.

Along with consumer acceptance of HMOs have come sophisticated oversight procedures by state authorities. Consumers in all states are covered by a well-developed framework of laws and regulations.

Increasing HMO enrollments, coupled with a few major insolvencies and a competitive climate, have stimulated many state regulators to consider additional HMO solvency requirements. At least five states have enacted legislation that includes HMOs in a guaranty fund.

In 1987, the HIAA's Government Relations Committee established a task force to study HMO issues. The first assignment was to study the problem of solvency.

The National Association of Insurance Commissioners (NAIC) and the National Association of Health Maintenance Organization Regulators recently completed an examination of existing HMO requirements. In December 1988, the NAIC adopted amendments to the model HMO act that provide for increased net worth and deposit requirements, mandatory hold harmless provisions, continuation of benefits and replacement coverage. In December 1989, the NAIC also adopted an assessment provision to be included in the HMO model act, which is in lieu of the HMO guaranty association proposal originally under its consideration.

HIAA POSITION: HIAA supports the position that the goals of the original federal HMO act have been met, and there is no longer a need for a significant federal role. The act should be repealed.

HIAA supports a comprehensive approach to the problems associated with HMO insolvencies. In addition to the approach adopted by the NAIC, the Association supports the use of parental guarantees to meet net worth and deposit requirements.

Moreover, HIAA opposes creation of HMO state guaranty funds or assessments because they do not prevent insolvency, strengthen regulatory oversight or improve standards for licensure. They might even create a false sense of security. The Association believes that guaranty funds or assessments will not assure continued medical services for enrollees. Further, if providers are bailed out of a failed HMO by a guaranty fund or assessment, they may have less incentive to control utilization and costs.

HIAA will actively seek enactment of a comprehensive solution to the problem of HMO solvency and will vigorously oppose guaranty funds or assessments for HMOs.

See also the enclosed position paper on managed care.

Health Insurance Association of America
1025 Connecticut Avenue N.W. Washington, DC 20036 202-223-7780 FAX 202-223-7897

HIAA
ON
STATE HEALTH
INSURANCE
ISSUES

ISSUE: LONG-TERM CARE
(as of March 1990)

BACKGROUND: Long-term care has engendered growing interest among insurers, government policy makers and groups concerned with aging. Common to all is a strong belief that the current financing arrangement, which relies on a welfare program and the private resources of individuals, is inadequate. New solutions are needed, and for many, private insurance coverage is an alternative.

Recently, there has been tremendous growth in private long-term care insurance. Today, more than 100 companies sell such products, and as of June 1989, more than 1.3 million people had purchased a policy. The introduction of employer-sponsored plans is particularly promising. Almost 35 large employers have begun to offer this coverage as of June 1989. Despite rapid growth, there remains great uncertainty as to how large a role the private sector can play in paying the nation's long-term care bill.

More than 50 bills on long-term care financing have been introduced in Congress, the focus of which include incentives to stimulate the private market and federalization of long-term care financing.

Initiatives with strong private sector orientation include tax clarifications and changes necessary for continued growth in the private market. For example, several bills would clarify the tax status of long-term care insurance regarding premiums paid and benefits received under individual and group contracts. Other private market approaches and incentives should be encouraged, especially given the nation's many pressing budget priorities. Other congressional proposals seek to establish a federal oversight role in the sale of private long-term care insurance. Sponsors of these bills do not believe that states can regulate this new product adequately. However, since adoption of the long-term care insurance model act in December 1986 by the National Association of Insurance Commissioners (NAIC), 26 states have passed legislation based on this model statute. Another 11 states have passed legislation or adopted regulations more stringent than the NAIC model act. And, as of the end of 1989, legislation is pending in several other states.

HIAA POSITION: HIAA strongly believes that government's role in financing long-term care should be targeted to those who are in greatest need. To the extent possible, individuals of all ages should be encouraged to use their own resources to purchase private insurance. Private coverage offers the elderly and their families the greatest flexibility in determining individual needs and is also the most appropriate vehicle for allowing families to preserve financial assets. The latter is not the proper role of government. HIAA also believes that the rapid growth of the private market should be encouraged, especially given the nation's many pressing budget priorities.

Action at the state level has been significant. HIAA strongly believes that, as for other types of insurance, the states are the responsible body for governing the sale of long-term care insurance. Further, the Association believes that the states have acted with unprecedented speed in setting standards for this new product.

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HIAA supports the provisions of the NAIC long-term care insurance model act and regulation and has made its passage in those remaining states a top priority in 1990.

HIAA supports the following:

- o An expanded uniform public program to provide coverage for people who cannot provide for themselves;
- o Appropriate and adequate state consumer protection to ensure that consumers have access to high-quality long-term care providers and fair and affordable insurance policies;
- o Greater consumer education efforts to promote the public's understanding of their potential need for long-term care and its costs; and
- o Legislative and regulatory initiatives to promote the public interest and the availability of long-term care policies, and to encourage flexibility and innovation in developing long-term care coverage.

HIAA ON STATE HEALTH INSURANCE ISSUES

ISSUE: MANAGED CARE
(as of April 1990)

BACKGROUND: The high cost of health care is a major problem for the United States. All who pay – employers, individuals, and government – are burdened by continual increases in health expenditures. Moreover, escalation of health costs greatly complicates the task of finding ways to provide coverage for the large number of Americans who are without either public or private health insurance.

Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Some get care that is more intense and expensive than necessary. Others receive care that is not beneficial and may even be harmful. Eliminating such inefficiencies – which may account for 25 percent or more of medical expenditures – is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Payers of health care are aware of such inefficiencies and are demanding more accountability and better performance from those who make health care decisions in order to assure that patients receive good value for money spent. Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients receive appropriate care, that is, high quality care efficiently provided in the least costly setting.

DEFINITION: Because it is still evolving, managed care embraces a variety of existing and developing structures. It may be defined as systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- Explicit standards for the selection of health care providers;
- Formal programs for ongoing quality assurance and utilization review; and
- Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care organizational structures are evolving in response to marketplace demands and will continue to do so. Today's structures include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), as well as mixed arrangements that combine elements of HMOs, PPOs and indemnity plans to accommodate employer and operating environment requirements.

Managed care plans arrange with selected providers to furnish health care services to plan members. Explicit criteria are used for the selection of providers, and formal programs for ongoing review of the quality and appropriateness of services are incorporated into the plan.

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Plans provide financial incentives for covered individuals to use providers who deliver appropriate quality care. In some managed care plans, the cost of services is covered only when health care is received from selected providers. Other managed care plans provide individuals more latitude in the choice of providers. Out-of-pocket costs, however, are usually higher when out-of-plan providers are chosen.

Some state legislators are concerned that managed care, including both contracting arrangements with providers and utilization review techniques, could adversely affect the quality of health care. Their concerns have been encouraged by some associations of providers representing hospitals, physicians, dentists, pharmacists and allied health professions. These groups have drafted and advocated state legislative proposals that would restrict or prohibit the operation of managed care programs.

HIAA POSITION: HIAA is firmly committed to the expansion of managed care programs and techniques in order to assure high-quality, cost-effective health care. Managed care systems have the means to avoid unnecessary and inappropriate care.

Therefore, HIAA is opposed to legislation or regulations that would impose barriers to the development and implementation of managed care in its current and evolving forms. Legislation or regulation that unduly limits insurers' ability to carry out rigorous utilization review is one such barrier. Legislation that opposes utilization review takes many forms, but generally seeks to put inappropriate restrictions on who can conduct reviews and what can be reviewed.

HIAA is also opposed to legislation that would restrict an insurer's freedom to form networks or contract selectively with providers. Legislation that opposes networking also takes many forms, but generally seeks to put restrictions on the ability to pay providers anything but their usual and customary fees, or to contract with a limited number of providers.

HIAA believes:

- Insurers should be free to negotiate whatever price they can with providers. One important way to reduce costs is to be able to buy provider services at lower prices, and managed care systems need to have freedom to negotiate lower prices. On the other hand, in some instances plans may wish to offer higher-than-usual fees to especially efficient providers.
- Insurers should be able to pay providers in ways that create appropriate incentives. If provider reimbursement systems reward high-cost medical practice, it will be very difficult to reduce costs. Managed care systems need to be able to alter reimbursement incentives to reward efficient providers. Severe restrictions on capitation payment, for example, are inappropriate and unwarranted.
- State laws should not place artificial limits on the amount of consumer cost sharing that can be imposed on PPO plan enrollees who choose to get care from off-panel providers. If a PPO has a panel of providers that can provide needed high-quality services more efficiently than other providers, it is entirely appropriate to require consumers who choose not to use these efficient providers to pay the extra costs. HMOs, which all states allow, do not pay anything when consumers receive care from non-HMO providers.

- Legislation should not establish inappropriate barriers to insurer efforts to establish effective utilization review programs and should require providers to make available, at a reasonable cost, patient records and other information necessary to monitor cost and quality of care. Monitoring medical practice patterns is critical to managing care. If reviewers cannot get access to medical records at reasonable cost, or if excessive restrictions are put in place to limit who does utilization review or what the process will be, managed care plans cannot accomplish the critical task of encouraging providers to become more efficient.
- Insurers who are negotiating to form provider panels should not be compelled to enroll every provider who wishes to be included. A key mechanism that managed care plans use to constrain costs is to contract only with efficient providers. If plans are required to include on their panels all willing providers, this critical element of control is eliminated.
- States should not mandate that insurers cover services and categories of care, since doing so often adds to costs and limits the plan's ability to develop cost-effective benefit packages. Research evidence shows that legislation that requires coverage of certain provider categories or particular services generally causes a net increase in costs. The buyers of insurance plans, not state government, should be the ones who decide what services and provider groups should be covered. Legislation mandating coverage of particular provider groups is often simply a reflection of that group's desire to create demand for their own services as a way of enhancing income.

HIAA supports the concept of physician peer review as a method of determining appropriateness of care. In doing peer review, however, it is not appropriate to rely solely on local peer assessment. Studies of differences in patterns of medical practice from area to area within a state demonstrate that the typical method of treatment in one community is often significantly different from that in another community even though the conditions of the patients are essentially identical. The differences, in other words, are not medically justified. Thus, local habit or customary practice is not necessarily the best standard for assessing medical appropriateness or necessity for a given treatment.

The collective judgment of physicians who are experts in a given field and who have done a systematic study of the scientific research must ultimately form the basis for determining what is appropriate care in a given situation. It is for this reason that HIAA supports the development of medical practice guidelines and protocols. When developed, these can form a rigorous, scientifically defensible standard for educating physicians about the best medical practice and for judging the appropriateness of care.

GLOSSARY: Below is a list of some of the current managed care structures now available:

Health Maintenance Organization (HMO): This was the original managed care arrangement, first emerging as prepaid group practices in the 1930s. The name "health maintenance organization" was coined in the early 1970s, and was given to 1973 federal legislation promoting its development. HMOs provide:

- An organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care;
- An agreed-on set of basic and supplemental health maintenance and treatment services; and
- A voluntarily enrolled group of people

In exchange for a set amount of premium or dues, HMOs provide all the agreed-on health services to their enrollees; there are generally no deductibles and no or minimal copayments. The HMO bears the risk if the cost of providing the care exceeds the premium received. There are now several types of HMOs

- o The staff model, where providers are directly employed by the HMO;
- o The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- o The independent practice association (IPA), where the HMO contracts with physicians in independent practice, or with associations of independent physicians. IPA physicians frequently have arrangements with more than one HMO; and
- o The network model, which contracts with two or more independent group practices.

Preferred Provider Organization (PPO). A PPO consists of groups of hospitals and providers that contract with employers, insurers, third-party administrators or other sponsoring groups to provide health care services to covered persons and accept negotiated fee schedules as payment for services rendered. There are different sponsoring arrangements:

- o Hospital-sponsored PPOs, which often include a network of institutions in order to cover a wider geographic area, as well as many of the physicians on their medical staffs;
- o Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- o Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- o Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- o Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- o Other provider-sponsored PPOs, which are developed by nonhospital and nonphysician providers, such as dentists, optometrists, pharmacists, chiropractors and podiatrists, through their professional associations, local groups or clinics.

Exclusive Provider Organization (EPO). People belonging to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

Point-of-Service Plans. Also known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan at any time yet are designed to encourage the use of network providers. If a provider is affiliated with the HMO or PPO, the service is covered (perhaps after a modest copayment). If an out-of-network provider is chosen, reimbursement may be significantly reduced.

A number of managed care techniques are used to assure quality and appropriate care. These include, but are not limited to, quality assurance, utilization review, case management and use of a primary care physician. Although the combination of elements will differ among plans, each managed care plan operates as an organized system where patient services are subject to review and coordination by health professionals.

- o Quality assurance is a process by which a managed care plan monitors and takes action as necessary to assure that quality care is delivered by selected providers. The process measures the extent to which quality has been attained and periodically reevaluates health care to assure that established standards are being met.

- Utilization review is a system of reviewing the medical necessity and appropriateness of patient services within guidelines developed by physicians. Performed by health care professionals, it is comprised of several processes and may be used for both inpatient and outpatient services. Processes may include preadmission certification, application of practice guidelines, continued stay review, discharge planning, second surgical opinion and retrospective review. Because of the explosion of costs in all aspects of ambulatory care in recent years, programs to require preauthorization of ambulatory procedures are now evolving.
- Preadmission certification is a process in which a health care professional (such as a registered nurse) evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.
- Continued stay review, also called concurrent review, is a process whereby a review organization continues to examine medical information during a patient's hospital confinement to determine the need for continued hospitalization.
- Discharge planning is a process in which a health care professional from a review organization works with an attending physician and hospital staff to arrange for appropriate discharge of a patient from the hospital, including a plan for the patient's subsequent care. Its purpose is to determine when patients are ready to go home, perhaps with the support of a nurse or other home health provider, or are able to be transferred to a nursing home.
- Second surgical opinion programs require patients to seek a second surgeon's opinion if elective surgery is recommended for certain conditions. Elective surgery is defined as that which can be avoided or delayed without undue risk to the patient and which allows sufficient time to seek another opinion.
- Retrospective review provides for the establishment of a utilization profile of inapproppriate care for monitoring trends and addressing excessive use or cost.

Other managed care techniques include case management, which is a process that provides a comprehensive plan of care and rehabilitation for people suffering from severe conditions such as trauma, premature birth or AIDS. Through flexible interpretation of plan provisions, case management coordinates the use of all appropriate types of therapy and equipment in the most appropriate setting. Case management often supports alternatives to institutional care, such as physical therapy and other services delivered in the home, that achieve better patient outcomes at lower cost.

In many managed care plans, a primary care physician serves as the initial screening, testing, treatment and referral source for a patient. This physician oversees health care services rendered to patients by other providers and assumes continuing responsibility for the overall course of treatment.

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HIAA

ON

STATE HEALTH

INSURANCE

ISSUES

ISSUE: McCARRAN-FERGUSON ACT
(as of March 1990)

BACKGROUND: In 1945, after the U.S. Supreme Court ruled that insurance is interstate commerce and therefore subject to federal regulation, including antitrust laws, Congress passed the McCarran-Ferguson Act to exempt the business of insurance from some federal antitrust laws. Cooperative efforts among insurance companies (e.g., collection of industrywide loss data, ratemaking and establishment of risk pools) were exempted, provided they were regulated by the states. Insurers were not exempted from the federal prohibition against boycott, coercion or intimidation.

The perceived crisis over the availability and affordability of commercial liability insurance and concern about insurance rates has focused renewed attention on the McCarran-Ferguson Act. Federal legislation was reintroduced in the 1989-1990 session, which would modify the insurance antitrust exemptions provided by the act.

The insurance industry is subject to the laws and regulations of a variety of state and federal agencies, but for the most part, insurance regulations are a state matter and Congress has been reluctant to involve the federal government in regulating it more actively.

HIAA questions the public benefits to be gained by abandoning the limited antitrust exemption and stresses the dynamic nature of the insurance regulatory process and the ability of each state to respond efficiently to its residents' needs.

HIAA POSITION: The McCarran-Ferguson Act makes the system of state regulation of insurance workable, and the law should not be repealed or amended to eliminate or restrict the already narrow exemption the act provides.

Repeal or amendment could be detrimental to the public interest by creating unnecessary and duplicative regulation and might give the federal government unwarranted supremacy over the states on this issue.

The health insurance industry is already highly competitive, and there is no evidence that repeal of McCarran-Ferguson would enhance competition. On the contrary, economic disruption, with consequent premium price increases, might ensue.

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ISSUE: MEDICARE SUPPLEMENT POLICIES
(as of March 1990)

BACKGROUND: Title XVIII of the Social Security Act, otherwise known as Medicare, was enacted in 1965 and provides hospital and other health care services to people age 65 and over and to disabled individuals.

To a large extent, the health insurance needs of older Americans are borne by the federal government, but because of Medicare's deductibles, copayment provisions and benefit limits, older people are not fully protected against the possibility of large unexpected medical expenses. These limitations in Medicare's benefit structure have prompted development of private supplementary insurance policies (known as Medigap).

There are more than 33 million people in the United States over age 65 – approximately 13 percent of the total population. The number of elderly, most of whom are not employed, is expected to increase well into the next century. The vast majority of these individuals no longer have access to a health care plan provided by an employer, and except for those who are part of a retiree health plan, the elderly must rely on Medicare and private insurance to pay their health care expenses.

Since the health insurance industry will be called on to help find a solution to the growing problem of meeting the health care needs of the elderly, the Medicare program presents an important issue for private industry.

The Medicare Catastrophic Act of 1988 went into effect Jan. 1, 1989, and substantially increased Medicare benefits, but it was repealed on Dec. 31, 1989. The repeal was largely due to the outrage of consumers over age 65 because of cost increases and the surtax placed on high-income individuals age 65 and older.

The National Association of Insurance Commissioners (NAIC) was forced to respond immediately to the repeal by enacting transition requirements at its December 1989 meeting. Basically, these requirements returned policies issued prior to Jan. 1, 1989 to their original benefit levels and required insurers to offer to former policyholders, who dropped their medical policies during 1989, the opportunity to reinstitute their old policies without penalty.

During the December 1989 meeting, the NAIC also adopted consumer protection amendments to the existing model Medicare Supplement Act and Regulation. The amendments require insurers to issue guaranteed renewable policies, limit insureds to one Medicare supplement policy, provide more extensive reporting of this line of business and increase penalties for violations.

These actions will once again require all 50 states to establish a regulatory format equal to or more stringent than standards established by the NAIC model act and regulation covering Medicare supplement policies. This format defines such a policy, regulates policy provisions and loss ratios, sets rules for replacement of such policies and establishes minimum benefit standards.

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HIAA POSITION: The Association encourages the states to adopt the NAIC regulatory format for Medicare supplement policies. It opposes federal government intrusion into the private insurance market. HIAA's position is that private insurance meets the needs of Medicare recipients for supplementary coverage and that current state regulations are sufficient to protect purchasers of Medicare supplement policies.

ISSUE: RISK CLASSIFICATION
(as of March 1990)

BACKGROUND: Health insurance companies use risk classification methods to set premium rates commensurate with the level of risk an individual or group represents. The use of such techniques by insurers has expanded the availability of health insurance, as well as consumer options, since premiums are set at levels that represent the relative risk of insuring a given group or individual.

Risk classification also helps to form a direct link between health care expenditures and the cost of coverage. Since employers who self-insure avoid subsidizing other higher-cost employer groups, insurers must be able to classify risk in order to offer reasonable prices to clients preferring traditional insurance. Moreover, if insurers were prevented from charging a client the true cost of coverage, a major incentive for employers to hold costs down would be diminished. Employers would have less reason to provide safe work environments, establish wellness programs or seek efficient providers of care. Without risk classification, every group would pay the same in premiums, regardless of its true health care costs.

The process of risk classification depends on fairness. Discrimination by insurance companies against individuals seeking coverage is governed by federal civil rights statutes as well as state laws and regulations. The National Association of Ir. urance Commissioners (NAIC) model regulations on discrimination on the basis of sex or blindness have been adopted by a majority of states, and they serve as a basis of resolving claims of unfair treatment by insurance companies. HIAA also has developed a model risk classification bill for use in states considering actions in this area.

Some state regulators have urged equal, rather than equitable, treatment of insureds and have attempted to ignore the difference in projected health care expenses among people. For example, HIV testing of insurance applicants has become the focus of special interest groups that want to prevent insurers from testing applicants, despite the fact that HIV-positive individuals represent a risk that is 26 times greater than average.

Without the ability to use risk classification, insurers may encounter adverse selection, which is the tendency of consumers to buy health insurance only after the onset of illness or when a likelihood of major illness has become apparent. Adverse selection can seriously threaten insurers' financial stability.

HIAA POSITION: In order to ensure the financial soundness of the industry, health insurers must be permitted to classify their policyholders according to expected risk of loss. This necessarily includes the use of readily available data about applicants' age, sex, occupation and health status.

HIAA recognizes the need to make affordable coverage available to all, and has developed proposals for reinsurance and risk pools for high-risk employers and individuals.

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The Association opposes legislative interference with legitimate and necessary risk clas-sification and ratemaking procedures and believes that insurers should be allowed to col-lect and use information that has a statistically demonstrable relationship to the cost of providing coverage.

Insurers do not seek to stereotype or discriminate unfairly against individuals or groups. However, to ignore data that ties the cost of claims to a fair premium cost is to invite financial failure.

HIAA

ON

STATE HEALTH

INSURANCE

ISSUES

ISSUE: STATE MANDATED BENEFITS

(as of March 1990)

BACKGROUND: Over the years, the list of state mandated benefits and providers has grown dramatically. In all, there about 800 different state mandated benefit laws nationwide, ranging from such disparate services as acupuncture and Chinese medicine, pastoral counseling, chiropractic and podiatry, to a variety of mental health benefits.

While the merits of any particular benefit or provider group can be vigorously defended by its proponents, the cumulative effect is a hodgepodge of state laws that increase the cost of health insurance, particularly to small employers who are most in need of relief from the high cost of health care.

One negative effect of the myriad mandated benefit laws that increases the cost of coverage is that multistate insurers must monitor and comply with many different state laws. They are precluded from developing lower-cost prototype plans which they can market across state lines.

More importantly, many of these benefits are expensive in their own right. Substance abuse treatment, coverage for psychiatric hospitals and psychologists' visits substantially increase the cost of both individual and group coverage. With few exceptions, mandates raise the price of insurance coverage.

Taken together, the mandated benefits in some states provide a comprehensive benefit package that many small employers simply cannot afford. Studies indicate that approximately 16 percent of small businesses that do not offer health benefits to their employees would offer them in a less heavily mandated setting. This creates a serious problem for the health insurance industry, which is trying to develop lower cost health plans for small employers in its efforts to increase coverage to the 31 million Americans without health insurance, many of whom are full-time workers or their dependents and employed by small firms.

Furthermore, state mandated benefit laws do not apply equally to all health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws. Thus, mandated benefits have encouraged firms to self-insure and thereby escape state oversight from mandated benefits, reserve and financial solvency requirements and premium taxes.

In general, only large employers can afford to self-insure, which not only allows multi-state employers to save administrative costs, it also allows them to pick and choose the benefits that are most desirable and cost-effective for their employees. Employers too small to self-insure, however, do not have this flexibility, thus making it less likely that they will offer health insurance at all. In 1984, 37 percent of all workers and their families were covered by self-insured plans. This places the burden of mandated benefits on small employers.

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HIAA POSITION: HIAA opposes all mandated benefit laws. When an employer cannot afford all benefits that may be beneficial for its employees, the choice of which benefits to buy should be made by the purchaser.

The existing preemption of state mandated benefit laws that currently applies to self-insured employee health plans should be extended to insured plans. Small employers should not be forced to choose between a "Cadillac" plan and none at all.

ISSUE: STATE POOLS FOR UNINSURABLES
(as of March 1990)

BACKGROUND: State risk pools are designed to guarantee the availability of private health insurance to all Americans under age 65 who want to purchase protection, who are willing to pay for it but who are not considered medically insurable. Without guaranteeing such access to health insurance, the industry risks government intrusion into the health insurance market.

The commercial health insurance industry has actively supported such initiatives since the late 1960s. However, the Association's chief concern about state pools is that they be equitably funded.

Funding mechanisms vary. While the majority of state pools for uninsurables are supported through direct payments from the state or by tax credits allowed against insurer assessments, some states use other mechanisms, such as imposing the cost of pool losses entirely on insurers (Wisconsin) or imposing a hospital use tax (Maine).

HIAA POSITION: Insurers should be allowed to retain their ability to underwrite. We support state legislation to establish voluntary risk pools for individuals who are denied insurance coverage because of poor health or medical conditions, as well as federal legislation encouraging states to take such action.

HIAA believes that funding for these pools should be broadly based, preferably from general tax revenues. Assessing only commercial insurers for pool losses drives up the cost of private insurance and gives self-funded plans a competitive advantage over insured plans. In addition, HIAA maintains that cost controls and managed care should be incorporated into pool administration.

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HIAA

ON
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ISSUE: THE UNINSURED
(as of March 1990)

BACKGROUND: Approximately 31 million Americans have no public or private health care coverage. Commentators have stated that the uninsured population has increased significantly in the past decade for the following reasons: the economic downturn of the early 1980s and its effect on employment; Medicaid cutbacks; a probable decline in employer-based coverage of dependents in what may be a response to rising health care costs; an increase in state mandated benefits; and increasing numbers of workers in industries less likely to offer health insurance.

The uninsured have greater problems gaining access to the health care system than do those who have insurance. Therefore, they often forego necessary care or delay getting care until it is either too late or more costly. For all these reasons, it is incumbent on policy makers to devise ways to fill the gaps in the health financing system.

Contrary to popular belief, the uninsured are not mainly poor and unemployed. In fact, fewer than one-third have incomes below the federal poverty line, although a significant number are in the near-poor category. Most uninsured people (approximately 62 percent) are either full-time workers themselves or family members of such employees.

Data have shown that it can be difficult for small employers to obtain group health insurance, although there are a number of insurance companies and mechanisms through which such coverage can be purchased. One of the principal barriers for small employers is the cost of health insurance, and HIAA's program on the uninsured calls for tax subsidies for financially vulnerable groups to encourage the purchase of coverage.

In addition, policy makers have stated that certain underwriting and rating practices in the small employer market exacerbate the problem of the uninsured. A portion of HIAA's program also addresses these concerns.

A number of bills have been introduced at the federal level to require or encourage employers to offer coverage. At the state level concern over the uninsured has received widespread attention, and by the end of 1989, more than 40 states were studying and/or considering legislation on the uninsured.

HIAA POSITION: HIAA believes that neither a private nor a public effort, by itself, will adequately meet the needs of the uninsured. However, a cooperative effort can help solve the problem.

HIAA is faced with the ever-increasing need to respond to a growing number of state proposals for the uninsured. Many of these initiatives have their own characteristics, reflecting the special interest groups behind the proposal and the state's political atmosphere, collective social consciousness and financial resources.

HIAA's state policy on the uninsured needs to be consistent with federal policy, but allow more room to incorporate a variety of ways to meet its objectives. To best serve these needs, HIAA has not adopted a specific proposal on the uninsured, but instead supports

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state legislation that aims to improve access for some or all of the state's uninsured and that is consistent with the following six points.

- **State programs must be expanded to cover the poor and near-poor populations.** States should expand their Medicaid programs to cover all mandatory and optional categorical groups up to the federal poverty line.

  For those poor individuals who do not fall into a federally defined Medicaid categorical group, states have the obligation to provide similar coverage using their own funds.

  For near-poor individuals (those between 100 percent and 150 percent of poverty), and possibly some of the noncategorical poor, states should establish a public buy-in program, which would cover a range of primary and preventive services (no inpatient hospital or major outpatient surgery) in exchange for an income-related premium.

  If public funds are limited, states should give first priority to low income children and pregnant women.

  States should take advantage of recent federal welfare reform legislation that allows Medicaid to pay low income workers' share of employer-based premium contributions in order to help such individuals participate in available employer-based coverage for a transitional period when returning to work. They should also extend this notion to pay employees' share of premium even after the transition period for all workers whose family incomes are below poverty, whether or not federal matching funds are available for this purpose. HIAA recommends federal Medicaid matching funds when states elect to implement such a buy-out program.

  States should urge the federal government to break the income and categorical links between cash assistance and eligibility for Medicaid so that federal Medicaid matching funds are available to all poor individuals regardless of family structure or work status. States should also urge the federal government to make federal funds available to cover the near-poor population through Medicaid buy-in and other similar programs. Finally, the federal government should be urged to expand welfare reform to apply to all poor and near-poor workers for a transitional period.

- **HIAA is opposed to employer mandates or a compulsion on employers to provide health insurance to employees and their dependents, including tax penalties for failure to provide coverage.** HIAA has developed a separate position paper on employer mandates which is available on request.

- **There are several fundamental tenets of the health insurance industry that HIAA should actively pursue to shape the outcome of any state proposal on the uninsured.**

  They include: essential underwriting freedom; appropriate rate latitude; noncompetition between private and public programs; maintenance of a private market, including the agent distribution mechanism (e.g., no state fund); meaningful cost containment; and elimination of state benefit mandates

- **Small employers should have reliable premium levels and access to group health insurance.** HIAA has developed a set of standards dealing with small group reforms in connection with the establishment of a reinsurance mechanism, including making coverage available to entire employer groups, and not subjecting employees to new preexisting conditions when they change jobs or their employer changes carriers. These reforms are intended to help assure a viable private marketplace and place meaningful limits on the rate of premium increases, on renewal of coverage and on the degree to which rates vary for groups that are similar with respect to their plan design, geography, demography and industry

- **Uninsurable individuals (as defined by HIAA policy) who are also ineligible for private group coverage, should have access to coverage through high-risk pools.**

  Even with Medicaid expansions and increased employer-based coverage, uninsurable individuals will remain without coverage. High-risk pools should be established to make coverage available to them, but participation should be limited as defined by HIAA policy. Measures should be included in legislation that prevent risk pools from competing with existing private coverage, such as capping premium rates at a multiple of standard rates (e.g., 150 percent). Pool losses should be funded by general revenues or similar sources, which spread the cost across virtually all citizens.

- **Individuals and groups unable to afford coverage should receive subsidies to purchase it. Whenever possible, such coverage should be sold in the private sector.**

  Some individuals and businesses are insurable but cannot afford to buy coverage. Publicly funded subsidies for private coverage should be available to them but should be limited to truly hardship employers. Subsidies can be direct public funds used to purchase coverage, or incentives such as tax credits to individuals, employees or employers. In
  addition, alleviation of a premium tax on coverage that insurers sell to those eligible for subsidies further reduces the cost of coverage.

  If an individual or business is both uninsurable and unable to afford coverage, subsidies should be available through the high-risk pool. But subsidies should not be available
  exclusively to pool participants.

- **Cost is a key barrier to access to health care. In order to make coverage more affordable, it must be free from mandated benefit requirements, and payers must be permitted to use managed care techniques to control cost and maintain quality of care.**

  Health care cost containment principles and techniques should be incorporated into any reform package as an essential element of an affordable and comprehensive proposal for the uninsured. State law should permit the delivery of quality health care coverage tailored to the needs and resources of employers and consumers, but it should not impair the ability of third-party payers to use appropriate managed care techniques, including prepaid funding, selective contracting, provider networks, utilization management and fee schedules.

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

PROPOSAL ON PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

In Brief

I. Adopt reforms to assure the availability and reliability of private health insurance in the small employer market.

A. Enact small-employer market reforms to assure that coverage is available on a continuing basis for all small employers and that individual high-risk employees are not denied coverage. If an employer changes insurers or an employee changes jobs, new preexisting condition restrictions would not be imposed. Limits would apply to variations in premiums and premium increases.

Accepts ENTIRE GROUP

B. Authorize a private reinsurance mechanism for the small-employer health benefit market. This would allow insurers to implement market reforms by permitting insurers to spread losses for high-risk people equitably across the market. Under the HIAA proposal, no employer would have to pay more than 150 percent of the relevant market averages for basic coverage.

C. Establish state pools for medically uninsurable individuals who are not part of an employer group. Losses should be financed by state general revenues or other broad-based funding. If a state does not act, the U.S. Department of Health and Human Services should be authorized to set up a federally funded pool in that state to pay for losses. The funds for the pool would come from funds that HHS would otherwise spend in that state.

II. Allow insurers to offer more affordable coverage to small employer groups.

Allow insurers to market lower-cost prototype plans through exemptions to costly state provider and service coverage mandates (given to self-insured plans) to insured employer plans.

III. Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage.

MANDATED COVERAGE DRIVE UP COSTS.

A. Help small businesses afford coverage by extending to the self-employed the 100 percent tax deduction that is available to other employers (as long as they provide equal coverage for their employees).

B. Target new tax subsidies to financially vulnerable groups. Subsidies should be directed toward financially fragile employers and low-income employed individuals.

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IV. Expand public coverage for the poor and the near poor.

A. Expand Medicaid to cover all those below the federal poverty level, regardless of family structure, age or employment status. Eliminate Medicaid's link to welfare categorical restrictions.

B. Extend the Medicaid "spend-down" program to all states and set eligibility thresholds so that no one is impoverished by medical expenses.

C. Allow low-income individuals above the poverty level to "buy into" an income-related package of primary and preventive health care services.

D. Establish an optional "buy out" program for employed individuals who are Medicaid-eligible; that is, allow states to reduce government costs and provide a transition to self-sufficiency by paying the employee share of available employer group insurance.

A more detailed discussion of this proposal is available.

October 1990

HIAA

ON

HEALTH CARE

FINANCING

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AMERICANS

PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

PROPOSAL

Today, more than 30 million Americans have neither public nor private health care coverage. These Americans often have greater problems gaining access to the health care system than do those who have coverage. They may forgo necessary care or delay getting treatment until their problems worsen—and become more costly.

These individuals represent the widening gap in our nation's health care financing system. The Health Insurance Association of America (HIAA) believes that policy makers must devise ways to close the gap. More precisely, government action is needed to provide the legislative and fiscal base that will enable both public and private providers of health care coverage to meet the health care financing needs of all Americans.

HIAA's proposal focuses on expanding health care coverage through the workplace and expanding public coverage for the poor and the near poor. As a complement to its proposal, HIAA also is recommending ways to curtail the relentless rise in health care costs that has contributed to the increase in the numbers of the uninsured. **The four essential elements of HIAA's proposal are:**

- **Adopt reforms to assure the availability and reliability of private health insurance in the small employer market;**
- **Allow insurers to offer more affordable coverage to small employer groups;**
- **Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage; and,**
- **Expand public coverage for the poor and the near poor.**

These objectives can be achieved through carefully crafted policy, embodied in responsible legislation. In addition, efforts to expand the nation's health care coverage must be coupled with meaningful cost-containment measures, since improved access largely depends on reducing the rate of increase in health care costs while maintaining quality of care. Thus, action to halt the rise in health care costs will also help stem the rise in the numbers of the uninsured. Such actions include promoting managed care, medical malpractice reform, assessment of new medical technologies and their uses, and wellness and preventive activities.

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DISCUSSION

The early 1980s were marked by a significant increase in the numbers of people without health care coverage. This increase has been attributed to many causes: the economic downturn and increased unemployment of the early 1980s, a decline in Medicaid's coverage of the poor, a small decline in employer-based coverage of dependents, a rise in health insurance costs due to the proliferation of state-mandated benefits, and the growing number of workers in industries less likely to offer health insurance. Not the least important factor has been the steady rise in the cost of health care.

Since the mid-1980s, the number of people without health care coverage in the United States has remained high but relatively constant. While estimates vary, the U.S. Bureau of the Census figure of 31.5 million is the most frequently cited. This population is demographically diverse. And, while three out of ten are poor, four out of ten have incomes of more than twice the federal poverty level.

The low-income individual under age 65 is less likely to have health coverage or to be covered through public programs. On the other hand, the individual whose family income rises above 150 percent of the federal poverty level is far more likely to have private health care coverage and less likely to have no coverage or coverage obtained from a public source. (Figure 1)

The vast majority of the non-elderly (approximately 150 million people) obtain health coverage through an employment-based plan. Yet most individuals without health care coverage still have some association with the work force. In fact, 66 percent of the uninsured are full-time workers or belong to families of full-time workers. Another 14 percent either work part-time (18 to 34 hours a week) or belong to families with one or more working members. (Current Population Survey, U.S. Dept. of Health and Human Services, March 1988 tabulations)

The relationship of health care coverage to income level and workplace to has important policy implications.

First, in order for expanded public coverage to be cost effective, it should be targeted to the poor and the near poor. Extending public coverage to higher income individuals inevitably will lead to costly and unnecessary substitution of public coverage for private coverage.

Second, efforts to make coverage more available and more affordable should reflect that most Americans receive their health care coverage through employment. Thus, a realistic approach should focus on improving the ability of financially vulnerable employers to offer health insurance to their employees—who, for the most part, have low incomes. In addition, some low-income employees—who may or may not work for small employers—need direct government assistance so that they can meet their share of premiums.

Finally, HIAA also believes that efforts to expand the nation's health care coverage system must be complemented by responsible cost-containment measures. HIAA's policy on cost containment includes an emphasis on the development of managed health care systems including health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other effi-

cient networks. It also calls for greater scrutiny of one of the major causes of high costs—the use of new, often unproven technologies and procedures. Once again, HIAA recommends a mechanism for assessing the cost effectiveness of such technologies and the adoption of medical practice guidelines and protocols. HIAA also strongly supports wellness and prevention activities, as well as economic incentives for the consumer to be 'cost conscious' in the use of medical resources and in choosing health plans.

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HIAA

ON

HEALTH CARE

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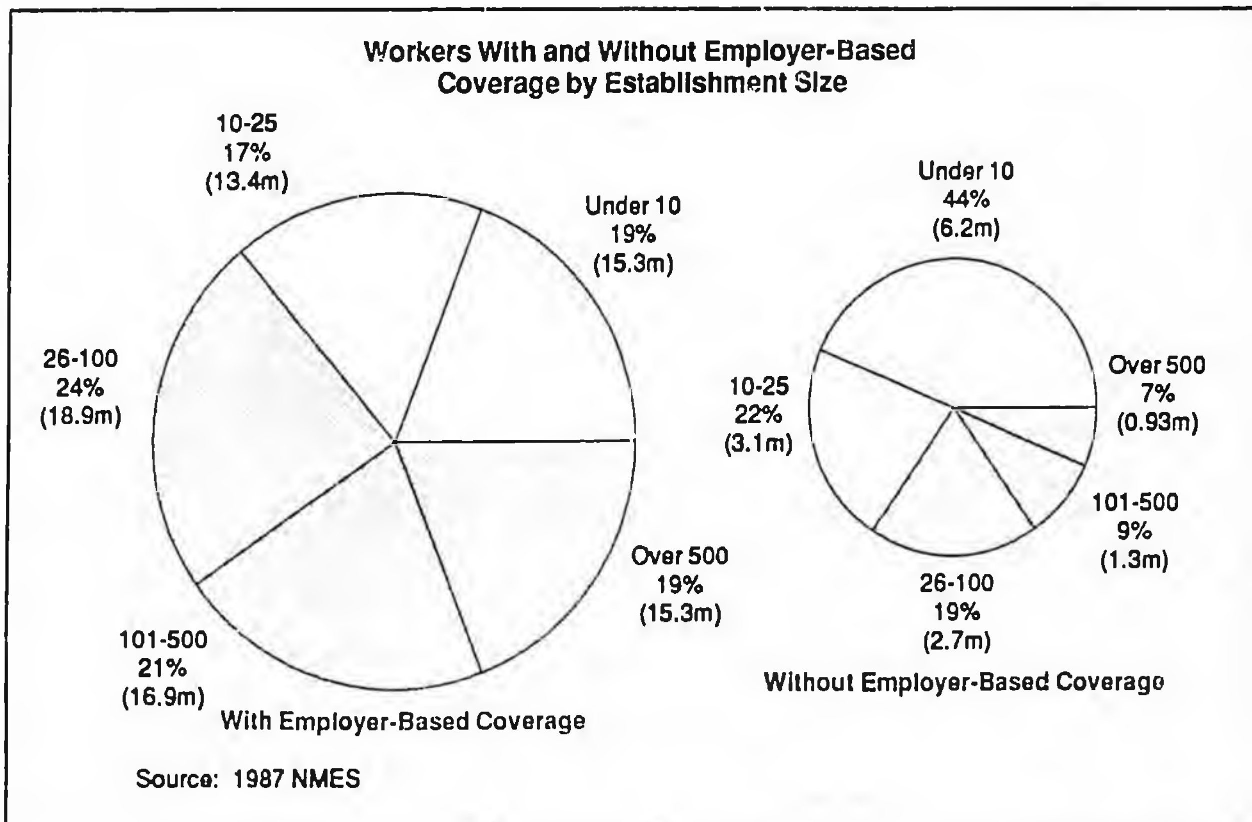
PROPOSAL ON PROVIDING HEALTH CARE FINANCING FOR ALL AMERICANS

In Detail

I. Adopt reforms to assure the availability and reliability of private health insurance coverage in the small employer market.

The small employer health benefit market is receiving increasing attention. This is largely because, as shown below, a high proportion of workers without health care coverage—fully two-thirds—work for business establishments with 25 or fewer employees. This is not surprising since only one in three firms with fewer than 10 employees offers health benefits.

Increasingly, small employers seek relief from rising health care costs by an aggressive search for the lowest possible price for health care coverage. Those with healthy employees are more



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likely to seek, and obtain, coverage at prices that reflect their low risk. This has made it more difficult for insurers to spread risks as broadly as in the past.

In general, small employers have greater difficulty than large employers in affording and sometimes even obtaining health coverage. This is particularly true for those employers with employees at high-risk of incurring medical expenses. Furthermore, the greater frequency with which small employers change carriers and their workers change jobs exposes individuals in this market to greater risk of being left out of the system. Finally, small employers are generally highly sensitive to very large, unanticipated premium increases and may fail to initiate or retain coverage in a marketplace where individual employer experience is highly unpredictable.

- ***Small Employer Market Reforms***

HIAA has developed market reforms and reinsurance recommendations that would ensure fair access to, and continuity of coverage for, small employers and their employees. These reforms would introduce a greater degree of predictability and stability to the small employer health benefit marketplace.

- **Guaranteed Availability**. All small employer groups would be able to obtain private health insurance regardless of the health risk they present.
- **Coverage of Whole Groups**. Coverage would be made available to entire employer groups; neither an employer nor an insurer would be able to exclude from the group's coverage individuals who present high medical risks.
- **Renewability of Coverage**. At renewal time, employer groups and/or individuals in these groups would be assured that their coverage would not be cancelled because of deteriorating health.
- **Continuity of Coverage**. Once a person is covered in the small employer market and satisfied a plan's preexisting condition restrictions, he or she would not have to meet those requirements again when changing jobs or when the employer changes carriers.
- **Premium Pricing Limits**. Insurance carriers would be required to limit how much their rates could vary for groups similar in geography, demographic composition and plan design.

  More specifically, a carrier's premiums for similar groups could not vary by more than 35 percent from the carrier's midpoint rate (halfway between the lowest and highest rate). There would also be a 15 percent limitation on how much a carrier could vary rates by industry. Finally, carriers would have to limit a group's year-to-year premium increases to no more than 15 percent above the carrier's "trend" (the year-to-year increase in the lowest new business rate). Separate trends should be allowed for managed care and non-managed care to reflect health care cost/efficiency differences in these structures.

  In order for the reforms to succeed, the implementing legislation will have to pertain to all competitors in the small employer market. If any one company or segment of the market pursues such reforms independently, without rules for marketplace behavior spelled out in legislation, it might invite financial ruin. Within the scope of these rules, insurers would be allowed to assess risk, set rates, and determine which individuals for whom to purchase reinsurance.

- ***Private Reinsurance***

A private marketwide reinsurance system would make these small employer reforms possible. Reinsurance means to "insure again." Under reinsurance, an insurance company, called the ceding or direct-writing insurer, purchases insurance from the reinsurer to cover all or part of the loss against which it protects its policyholder. The reinsurer is, in a sense, a silent partner of the original insurer. Reinsurance enables an insurer to accept a greater variety of risks. By sharing these risks with a reinsurer, the ceding insurer obtains an adequate spread within which the law of averages can operate.

Reinsurance will allow individual insurers (or other small employer health plan entities) to implement reforms without facing high financial losses. Reinsurance will assure that small employer groups that present a high health risk may obtain a basic set of benefits from private carriers at a rate no higher than 50 percent above the applicable average market premium. For groups already covered by an insurance carrier, the premium pricing limits described above would pertain, and would in many cases limit a high risk employer's rates to a level below the guaranteed marketwide maximum level of 50 percent above average.

Under the approach developed by HIAA, carriers could: (a) reinsure entire high-risk small employer groups at a reinsurance premium price of 150 percent of average market costs or (b) reinsure high-risk individuals within groups at 500 percent of average market costs. To reduce the volume of reinsured claims, reinsurance would be on a three-year basis. (If reinsurance were permitted annually, carriers would declare more groups or individuals high-risk and utilize reinsurance more often increasing reinsurance losses to unacceptable levels.)

The reinsurer would cover the costs associated with reinsured cases. The process of reinsurance is invisible to employers and employees and is purely a transaction between the ceding insurer and the reinsurer.

Because reinsurance would be aimed at employer groups and employees known to be high risk, and because the premium price would be capped in order to encourage carriers to participate in the small employer market, in the aggregate the cost of the reinsured persons will exceed the reinsurance premiums. Under the HIAA proposal, the reinsurer losses would be spread equitably across all competitors in the private marketplace.

The losses would be covered first through contributions from all carriers in the small employer market. If losses were significantly higher than expected, a second "safety valve" of private financing will be made available from health benefits plans in general. In the highly unlikely event that the first and second financing tiers were inadequate, governmental assistance might be sought.

HIAA will continue to pursue reinsurance and related small employer market reform in the states. HIAA will also recommend Federal legislation to give states the authority to assure compliance with the market reforms outlined here and to finance the reinsurance system.

- ***Establish State Pools for Uninsurable Individuals***

Even with increased employer-based coverage and with Medicaid expansions (see below), medically uninsurable individuals who are not part of an insured employer group would remain without coverage.

High-risk pools should be established to make coverage available to such individuals. Pool losses should be funded by general revenues or similar sources, which spread the cost broadly across society.

As of December 1990, 25 states have enacted broad-based pools for uninsurable individuals.

II. Allow insurers to offer more affordable coverage to small employer groups.

Over the years, the list of state laws mandating that insurance cover specific services and providers has grown dramatically. There are about 800 such laws nationwide—and they mandate coverage of such disparate services as chiropractic, podiatry, acupuncture, pastoral counseling, and mental health. The cumulative effect of this hodgepodge of state laws is to increase the cost of health insurance, particularly to small employers who are most in need of relief from the high cost of health care and who are too small to self-insure and thus escape these mandates.

One reason that mandated benefit laws increase the cost of coverage is that multi-state insurers must monitor and comply with so many different state rules and regulations. Insurers are precluded from developing lower-cost prototype plans that would be marketable across state lines. Instead, they are often forced to offer only "Cadillac" plans based on a multitude of mandates from many states.

Many of these benefits, such as those for mental health, are expensive in their own right. Taken together, mandated benefits in many states provide a package that many small employers simply cannot afford.

A 1989 study conducted by Gail Jensen, then a University of Illinois health care economist and now at the University of North Carolina, concluded that 16 percent of small employers not now providing health insurance would offer benefits in the absence of state mandates.

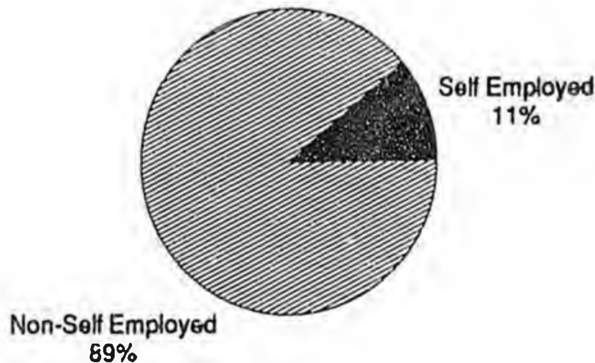
Furthermore, state-mandated benefit laws do not apply equally to all health plans. The Employee Retirement Income Security Act of 1974 (ERISA) exempts self-insured plans from state mandated benefit laws and other forms of state insurance regulations. In general, only large employers have the financial resources or the risk-spreading base to self-insure; self insurance allows multi-state employers not only to save administrative costs through plan uniformity but to pick and choose those benefits that are most desirable and cost effective. Employers too small to self-insure do not have this flexibility, and they are thus less likely to offer health insurance at all.

In 1985, the U.S. Supreme Court ruled that to put employee health benefit plans on the same footing as self-insured plans required congressional action. Moreover, in recent years, there also has been a proliferation of state actions that obstruct or hinder private sector managed care efforts that would make health care coverage more affordable. These state bills are aimed at limiting contractual arrangements with cost-effective provider networks, as well as preventing or limiting insurers' ability to carry out effective utilization review programs. Again, small employers should be able to benefit from the same cost-management approaches as do larger employers.

III. Provide targeted tax assistance so that small employers and their financially vulnerable employees can afford health insurance coverage.

Small businesses tend to be younger, financially less stable and employ a lower wage work force. Thus, health benefits often represent a greater financial burden to small businesses, who are far less likely to offer them than are other employers. A 1989 HIAA survey found that only 33 percent of firms with fewer than 10 employees offer health benefits. Conversely, over 96% of firms with more than 25 employees offer health benefits.

Percentage of Uninsured Workers Who are Self-Employed



Source: HHS Tabulations of the March 1987 Current Population Survey

Percentage of Firms That Offer Health Benefits by Numbers of Employees

Source: HIAA

Eleven percent of uninsured workers are self-employed. They are uninsured in part because self-employed workers receive only a 25 percent income tax deduction for the cost of health benefits. Other (incorporated) businesses receive a full 100 percent deduction.

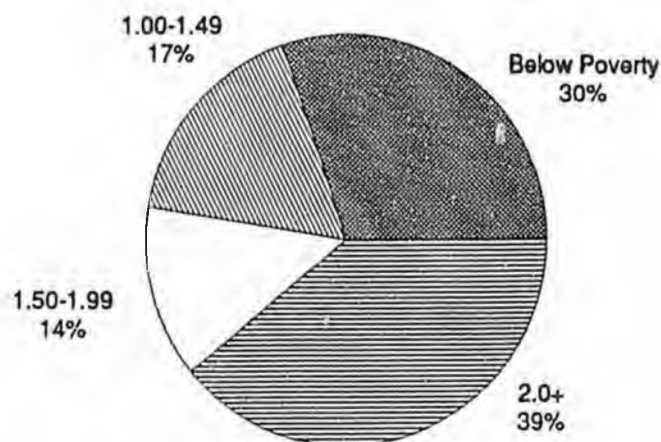
The financial vulnerability of small employers and uninsured workers, as well as government fiscal realities, suggest that additional tax assistance should be carefully targeted to those populations most in need. For instance, government should:

- Direct new tax subsidies to assist employers and individuals with inadequate financial resources (e.g., certain small employers) in purchasing private coverage; for example, firms with 25 or fewer employees, and that pay low average wages, could be subsidized on a sliding scale. Employees with low incomes could be assisted in paying their share of premiums.
- Extend to the self-employed the 100 percent tax deduction enjoyed by other employers (as long as they provide equal coverage for their employees, if they have any).

IV. Expand public coverage for the poor and near poor.

Thirty percent of the uninsured have family incomes below the federal poverty level ($10,560 for a family of three in 1990). Another 17 percent have family incomes between one and one and a half times the federal poverty level. The current federal/state Medicaid program covers only four out of ten poor Americans. Many states do not have a medically needy program, and Medicaid income eligibility thresholds for the non-elderly generally fall far below the poverty level.

Persons Without Health Care Coverage
By Family Income as a Percentage of Poverty



Source: Tabulations of the March 1988 Current Population Survey

Because the poor and many of the near poor do not have the means to purchase coverage on their own, the health care financing responsibility for these populations rests largely with the government. HIAA proposes the following actions:

- The Medicaid program should be extended to cover all poor Americans regardless of age, family structure or employment status. To carry out this recommendation fully, Medicaid eligibility will have to be independent of cash assistance programs such as Aid to Families with Dependent Children (AFDC.) Recent congressional action to phase in coverage for all poor children under age 19 over the next ten years is a good start.

- For poor workers with access to employer-based private coverage, states should be given the authority to buy out employed individuals and their families from the Medicaid program. States should pay the poor employees' premium contributions and cost sharing (copays and deductibles) associated with available employer plans. This approach would be used for all Medicaid eligible employees of employer plans that, if used, would reduce net government costs. It would build upon existing private plans and would ease individuals' transition into economic self-reliance. In determining whether this approach will yield savings to the state, attention should be focused on the characteristics of the employer plan (coverage levels, amount of employer premium contribution) and on its value to a typical employee rather than on the characteristics of the individual employee. (Recent congressional action requires states to implement a "buy-out," but is vague as to how cost-effectiveness will be determined.)

- Near-poor individuals with family incomes between one and one-and-a-half times the federal poverty level should be allowed to "buy in" to a lower cost package on a sliding scale related to their income. This package should cover primary and preventive care services only. Such a limited buy-in package would target government assistance to the primary and preventive services the near poor most often forgo and for which cost-sharing sometimes presents a financial obstacle; adopting this approach would also avoid the costly substitution of comprehensive public coverage for existing private coverage.

- To assure that no American falls beneath the poverty level as a consequence of medical expenses, all states should deduct medical expenses from income when determining eligibility for Medicaid. "Medically needy" or "spend-down" programs (and many states have already adopted such programs) constitute a last-resort financial safety net covering a full range of health services.

Raising eligibility standards for Medicaid to 100 percent of the federal poverty level will give an estimated 9.5 million to 11 million uninsured Americans access to Medicaid coverage. (The Medicaid program currently pays for the care of over 21 million people annually.) While costly, these reforms would increase Medicaid costs by only about 25 percent while more than doubling the population served by the program. This is because three quarters of Medicaid spending now goes for long-term care and other services for the elderly and disabled. Medicaid coverage for poor uninsured populations is far less expensive on a per capita basis.

December 1990

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COUNTING THE UNINSURED

Estimates of the number of uninsured Americans can be derived from a number of different government based sources. The most frequently cited figures are generated from the Census Bureau's Current Population Survey (CPS). This survey source is popular primarily because it is conducted every year, it allows general short-term trend analysis, and because the data is easy for researchers to work with. In 1988, the number of uninsured individuals, according to the CPS, was 31.5 million.

Other data sources sometimes used are the Health Interview Survey (HIS), the Survey of Income and Program Participation (SIPP) and the National Medical Expenditure Survey (NMES). Each of these sources has produced slightly different estimates of the number of uninsured Americans. For example, preliminary tabulations of NMES have determined uninsured counts for 1987 to be in the neighborhood of 37 million. This number, however, is expected to be revised downward in future NMES estimates. In addition, part of the discrepancy between the NMES and CPS estimates may be the result of different survey designs. For example, the two surveys ask somewhat different questions regarding individuals' health insurance status.

Much larger uninsured counts have been cited recently from the SIPP data. The fundamental difference between the recent SIPP estimates and the CPS and NMES estimates is that the SIPP estimates are measuring the number of individuals who were uninsured at any time during a 28-month period. This survey's data find that over a 28-month period (1986-88), 62 million individuals were without health coverage at some time. The same data show that at any time, roughly 31 million are without coverage (close to estimates based on the CPS). This suggests that lack of health coverage is a transitory phenomenon in many cases, but a core of uninsured remains.

It should be noted that in 1988 the Census Bureau redesigned its questionnaire. In doing so, the estimates of uninsured Americans dropped from roughly 37 million to 31 million. Most of this adjustment can be attributed to a more discrete classification of the coverage status of children. The questionnaire change led to a reduction in the number of children counted as uninsured, and hence, an increase in the number of insured children.

October 1990

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HEALTH CARE ACCESS LEGISLATION BY STATE

ALASKA

House Bill 581

Creates a Universal Health Care Task Force to design a cost efficient program allowing access to a basic level of health care for all state residents. Members appointed by the governor to include a representative of the insurance division. The task force is charged with soliciting advice and information from all interested groups, including the insurance industry and includes consideration of state health insurance for low income indigent residents, an uninsurable risk pool, reestablishing the state catastrophic illness insurance program, mandated employer coverage and virtually every other aspect of and option for health care coverage. Specifies delivery options. Chapter 179-90. Effective February 1, 1991.

Senate Bill 326

Creates a grant program for community health care planning in municipalities and rural areas. Chapter 107-90. Effective July 1, 1990.

Senate Bill 334

Directs the U.S. Department of Health and Social Services to seek options and receive waivers under the federal Medicaid program for the cost of home or community-based services for developmentally delayed or disabled children and adults. Chapter 90-26. The bill became effective 5-4-90.

ARIZONA

House Bill 2249

Expands coverage for pregnant women and infants under the Arizona health cost containment system and increases the maximum allowable qualifying family income to 133 percent of the federal poverty level. Chapter 90-27. The bill became effective 4-6-90.

CALIFORNIA

Senate Bill 1412

Establishes a state health care for the indigent program and appropriates money from Proposition 99 funds for allocation to counties that do not contract with the State's Department of Health Services for the provision of health services to the indigent. Chapter 90-50. The bill became effective 4-17-90.

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COLORADO

House Bill 1305

Creates the Colorado Uninsurable Health Insurance Plan, designed to provide health insurance coverage for eligible Colorado residents. Coverage is available for those residents considered medically uninsurable because they had been denied health insurance coverage or because such coverage is available to them only at prohibitively high rates. The initial premium rates for coverage under the plan shall not exceed 150 percent of the standard risk rate established pursuant to subsection (2) of §10-8-512. Subsequent premium rates shall provide fully for expected costs of claims, including recovery of prior losses and operating expenses. However, subsequent premium rates shall not exceed 175 percent of the standard risk rate determined pursuant to subsection (2) of §10-8-512. Funding for losses of the uninsurable pool will be met by imposing a $2.00 charge on Colorado taxpayers whose federal income tax return indicates an adjusted gross income in excess of $15,000 for a single return, or a $4.00 charge on a joint return. This law becomes effective July 1, 1990 and will remain in effect until July 1, 1993. The bill was approved 5-31-90.

Senate Bill 63

Creates the Colorado Uninsurable Pool to provide health coverage for Colorado residents who are medically uninsurable. Rates for coverage shall be between 150 percent and 175 percent of the standard risk rate. Pool losses will be funded through premiums paid by insured participants and by monthly assessments on each employed person. The assessment amount would range between 10 cents per employee per month up to a maximum of 25 cents per employee per month. This bill authorizes employees who are not eligible for an employer's group health insurance program to participate under the uninsurable pool with funding provided by the employer in an amount equal to that paid by the employer for other employees. Employers may pass assessments on to each employee and qualify for a tax credit equal to the amount of their assessments. Adds a new 39-22-117 to impose an additional tax on individuals whose federal tax return indicates adjusted gross income in excess of $5,000, in the amount of $1.20 per single/separate returns and $2.40 for every joint return. Such amounts will be transmitted to the state treasurer and credited to the Colorado Uninsurable Health Insurance Cash Fund.

CONNECTICUT

House Bill 5936

Alters the income eligibility for Medicare assignment by increasing limit on annual income from 150 percent to 175 percent of the qualifying income level established in the ConnPACE program. Chapter 90-185. The bill was approved 6-6-90.

Senate Bill 342

Implements the recommendations of the Blue Ribbon Commission on Health Care Access to, among other things, (1) provide medical assistance to children from low-income families; (2) authorize Medicaid to "buy-in" to employment-based plans for low-income persons and pay COBRA continuation premiums; (3) authorize a new program for pregnant women whose income is within 250 percent of the federal poverty level; (4) provide a grant program for providers serving the uninsured in low-income communities; and (5) require the development of a plan to lower Medicare cost shifting. In addition, this bill requires the Colorado Health Reinsurance Association to develop a special policy for small employers with employees who have incomes below 200 percent of the federal poverty level. This proposal substantially reforms the small group market by (1) requiring insurers to accept all applicants in the small employer

market; (2) making such policies guaranteed renewable with few exceptions; and (3) imposing limits on experience rating/durational rating and preexisting conditions. The bill establishes a reinsurance pool to support the new guaranteed issue requirements funded by assessments not exceeding 6 percent of the small employer premium base. The bill was approved 5-17-90. Chapter 90-134.

FLORIDA

Senate Bill 2794

Authorizes certain groups of small employers to sell "basic" policies but the bill remains ambiguous about which mandated benefits may be omitted. Among the allowable exclusions are: co-insurance options, midwives and birthing centers, mastectomy prostheses, ambulatory surgical benefits, home health care, and acupuncture. Furthermore, it alters required mental benefits. This bill has been sent to the governor.

GEORGIA

House Bill 1696

Establishes the Indigent Care Trust Fund in order to, among other things, expand Medicaid eligibility and provide primary health care to indigent citizens. Chapter 90-738. The bill became effective 3-6-90.

Senate Bill 434

Among other things, provides that the profiles of groups of 50 or fewer members who are separately covered under group accident and sickness insurance must be fully pooled for rating purposes. It requires that insurers issuing individual major medical policies make available to applicants optional cash deductible amounts of at least $5,000. Senate bill 434 also allows insurers to offer higher optional deductibles to existing policyholders as a means of reducing the cost of such policies or offsetting premium increases. Chapter 90-1338. The bill became effective 10-1-90.

HAWAII

House Bill 2908

Places a ceiling on the personal care services program expenditures, limiting total expenditures to not more than 75% of the annual medical assistance cost to maintain recipients at their appropriate level of institutional care. The medical assistance cost, which shall be the basis for the expenditure ceiling, shall be determined by the department of human services. Act 145-90. Effective June 15, 1990.

Senate Bill 3079

Raises the state general fund expenditure ceiling. Rates of payment to individual practitioners shall be based upon the most current profile available of usual and customary fees and the percentage of the profile in proportion to the funds appropriated by the legislature. The director shall submit a report to the legislature on or before January 1 of each year indicating an estimate of the amount of money required to be appropriated to pay providers at the maximum rates permitted by federal and state rules in the upcoming fiscal year. Act 263-90. Effective July 1, 1990.

IDAHO

House Bill 582

Creates a medical assistance program for low-income persons not eligible under the state plan for Medicaid. The program shall be a payer of last resort. Regulatory standards will be developed for the eligibility requirements for participation in this program and for payment of medical claims for eligible persons. Chapter 90-87. The bill was approved 3-23-90.

Senate Bill 1377

Amends section 39-5602, Idaho Code, to include "personal care services" in the Medicaid program. Defines "case management" and other terms related to personal care services. Establishes standards for personal care services. Chapter No. 90-326. The bill was approved 4-9-90.

ILLINOIS

House Bill 3339

Appropriates $18,779,200. from the general revenue fund to the Board of the Comprehensive Health Insurance Plan. Act 86-1059. Effective July 1, 1990.

House Bill 3528

Establishes a program whereby small employers may obtain affordable "no frills" group health insurance to increase access to health care, assist in the reduction of the amount of uncompensated care, and reduce the amount of uninsured state residents. Act 86-1407. Approved September 11, 1990.

IOWA

House Bill 2496

Requires insurers, upon request, to provide information to policyholders, including number of claims processed to date, cost of such claims, and average cost per claim. This bill limits the cost reporting requirements for group health insurance to once in a 12-month period and limits the requirement to groups of more than 100 persons; it deletes the reporting of reserves. The bill became effective 7-1-90.

KANSAS

House Bill 2610

Enacts new section in the Insurance Statutes and State Income Tax Statutes to provide income tax credits for employers contributing to a health benefit plan for employees. Allows different variables in coverage offered by employers to employees in order to obtain tax credits. The bill was approved 4-12-90.

KENTUCKY

Senate Bill 239

Establishes a health care delivery network system. Among other things, this bill would (1) permit Medicaid reimbursement of networks and practitioners and increase payments to family practice physicians in certain underserved areas; (2) encourage employers to provide health insurance; and (3) allow premiums paid for health insurance to be treated as an income tax credit for state income tax purposes. The bill is effective 7-13-90.

Senate Resolution 81

Urges the President of the United States and the U.S. Congress to develop a comprehensive system to adequately address the health care needs of Americans. Adopted 2-21-90.

LOUISIANA

House Bill 2030

Creates the Louisiana Health Insurance Association to make health insurance coverage available to persons otherwise unable to obtain coverage due to health conditions. The program is similar to the HIAA and NAIC model uninsurable pooling mechanism bills, requiring all companies doing business in the state to become an association member; limits premium rates to not less than 150% nor more than 200% of rates applicable for comparable standard risks. Coverage shall consist of comprehensive benefits with specified optional deductibles. Excess losses are funded through hospital admission charges. Policies are not required to be issued by the association until the later of year July 1, 1991 or the date on which the association accumulates service charges for an amount equal to the minimum capital and surplus requirements of domestic stock insurers regarding a certificate of authority to transact health insurance business. Act 131-90. Approved June 29, 1990.

MAINE

House Bill 1509

Establishes a third mandated care insurance plan demonstration program in one urban, one rural, and one undetermined site for individuals without health insurance. This bill would continue two established sites until December 31, 1992. Chapter No. 90-905. The bill became effective 4-24-90.

MARYLAND

Senate Bill 388

Provides comprehensive medical and other health care under the Maryland Medical Assistance Program for: (1) pregnant women and children under the age of 1 whose family income falls below 185% of the federal poverty level; (2) children 1 through 5 years of age whose family income falls below 133% of the federal poverty level; and (3) children 6 and 7 years of age whose family income falls below 100% of the federal poverty level. Chapter 90-418. Effective July 1, 1990.

MINNESOTA

House Bill 2343

Among other things, provides that (1) certain data on eligible persons and enrollees of the State Comprehensive Health Plan be classified as private; (2) a person may enroll in the Plan with a waiver of preexisting condition limitations provided certain requirements are met; (3) every insurer which rejects or applies underwriting restrictions to an applicant for accident and health insurance must provide the applicant with written notice of rejection or the underwriting restrictions applied; and (4) under certain conditions, employers be liable to the Comprehensive Health Association for the costs of any preexisting conditions of the employers' former employees or their dependents during the first 6 months of coverage under the Plan. Employers are required to pay a special assessment to the Association for the costs of the preexisting conditions. Chapter No. 90-523. The bill was approved 4-26-90.

House Bill 2521

Substitute for SBN 2286 to add ten members to the commission currently studying the uninsured situation in the state. Chapter No. 90-373. The bill became effective 8-1-90.

Senate Bill 1696

Includes the Commissioners of Human Services, Commerce and Health in the design of the demonstration project for uninsured low-income persons. Revises enrollee eligibility and participation requirements. Chapter 454. Effective April 17, 1990.

Senate Bill 2621

Establishes demonstration projects to allow health insurers and nonprofit health service plans to extend coverage for health services to individuals or groups currently unable to afford coverage. An insurer or health service plan corporation electing to participate in a demonstration project may apply to the commissioner for approval. Chapter No. 90-568. The bill was approved 5-3-90.

MISSISSIPPI

House Bill 1269

Authorizes the Department of Health to contract with the state medical association to establish a statewide program to provide medical services at no charge to uninsured persons unable to pay for the services. Chapter No. 90-544. The bill became effective 7-1-90.

House Bill 1467

Among other things, defines Medicaid eligibility and expands Medicaid reimbursement to include periodic screening and diagnostic services. Chapter No. 90-548. The bill was approved 4-4-90.

House Bill 2769

Increases the statutory limit on the annual appropriation to the state Medicaid program to $160,000,000. Chapter No. 90-390. The bill became effective 6-30-90.

MISSOURI

House Bill 998

Establishes a pooling program for individuals (except those having coverage, Medicaid recipients, a person having terminated coverage in the pool unless 12 months have lapsed, any person receiving $1,000,000 in pool benefits, and inmates of public institutions) requiring participation by all insurers and self-insurers in the state. Pool losses will be borne by participants according to premium volume (110 percent of claims for self-insurers) with assessments allowed as an offset against premium and other taxes. Coverage to be determined by the pooling board, with rates of not less than 150 percent nor more than 200 percent of average individual standard rates. This bill has been sent to the governor.

NEW HAMPSHIRE

House Bill 1348

Continues the process started by the committee on access to health care established in 1989, 332:2 by arranging for and overseeing an actuarial study for a benefits package, designing the

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Continues the process started by the committee on access to health care established in 1989, 332:2 by arranging for and overseeing an actuarial study for a benefits package, designing the

final benefits package, designing, but not implementing, a pilot program, and evaluating and identifying funding needs and sources for an ongoing program. Chapter No. 90-227. The bill became effective 7-1-90.

Senate Bill 403

Establishes a committee to study the problem of uninsurables in the state and the possibility of establishing a comprehensive risk pool for the uninsurables. The committee shall report its findings to the legislature on or before December 1, 1990. Chapter No. 90-159. The bill became effective 4-19-90.

NEW MEXICO

House Bill 133

Expands the Indigent Hospital Claims Act to include any community-based public health program operated by a political subdivision or other non-profit health organization that provides prenatal care delivered by New Mexico licensed or certified health care practitioners. Chapter No. 90-37. The bill became effective 5-16-90.

Senate Bill 293

Creates the Indigent Catastrophic Illness Hospital Funding Act to reimburse hospitals for eligible claims incurred by the "medically indigent." "Medically indigent" is defined as a state resident not eligible for Medicaid or Medicare whose income does not exceed 250 percent of the federal poverty level. Chapter No. 90-93. The bill became effective 5-16-90.

OKLAHOMA

Senate Bill 346

Enacts the "Health Insurance Opportunities for Employed Uninsured Oklahoman's Act." Establishes the Oklahoma Basic Benefits Board charged with approving and implementing the terms and conditions of a state certified basic health benefits plan for those employers and employees eligible for participation. Effective July 1, 1990.

RHODE ISLAND

House Bill 7815

Memorializes the United States Congress to support the enactment of a national health insurance act. Resolution 105-90. Adopted March 29, 1990.

Senate Bill 1746

Provides for a basic health care plan to certain eligible persons delivered through managed health care systems. The basic health plan shall be exempt from all mandatory benefits which insurers are required to provide to their insureds but shall include, at a minimum: (1) inpatient hospital care up to 20 days per year; (2) certain outpatient hospital care; (3) emergency room care; (4) physician care and well baby exams with up to 6 visits in a child's first year and childhood immunizations through age 8; (5) physician office visits or community health center visits for primary or sick care (up to 4 visits per year) and laboratory fees; (6) maternity care; (7) psychiatric and substance abuse care; (8) home nursing care up to 20 visits per year; and (9) newborn metabolic and sickle cell screening, mammography and pap tests. Effective July 10, 1990. Chapter 90-271.

SOUTH CAROLINA

Senate Bill 689

Creates the Health Benefit Plan Demonstration Project to develop test models for providing health insurance coverage to state residents currently uninsured with an emphasis on the working uninsured. Requires the Health and Human Services Finance Commission to develop, implement and administer the project, which is exempt from the insurance code and insurance regulations. Requires model programs tested by the project to generate funds from employers and employees participating in the program to be utilized in securing the health insurance offered through the program. Sunsets on May 15, 1993. Act 561-90. Effective May 15, 1990.

Senate Bill 1332

Makes technical changes to the South Carolina Health Insurance Pool Act (Act 127, Laws 1989) to, among other things, permit a person paying a premium for health insurance comparable to the pool plan in excess of 150% of the pool rate, or has received notice that the premium for a policy would be in excess of 150% of the pool rate, to make application for coverage under the pool. Effective June 5, 1990. Act 697-90.

UTAH

House Bill 67

Establishes the Utah Comprehensive Health Insurance Pool Act with premiums between 125 percent and 200 percent of individual standard rates. The pool shall be funded through general revenue funding, by premiums paid by pool enrollees, and by employers of employees enrolled in the pool. Employers shall contribute the same dollar amount that such employer would pay for health insurance for similar employees not covered by the pool policy. Dependents of the employee also are eligible for coverage under the pool. The bill was approved 3-12-90.

VERMONT

Senate Joint Resolution 57

Memorializes Congress to enact a national health program. The bill was approved 4-25-90.

VIRGINIA

Senate Bill 480

Allows insurers to issue limited mandated benefit policies, i.e., policies exempt from existing mandates. Such policies may be offered to certain individuals, families, or groups of less than 50 members. Under the proposed law, certain managed care provisions to control costs are required and others are considered optional. This bill would provide for a minimum level of basic benefits of primary, preventative, and hospital care including, but not limited to, a minimum of thirty days of inpatient hospitalization coverage, prenatal care, obstetrical care, and well-baby and well-child care up to age six. The insurance policy must meet disclosure requirements and is subject to prior rate approval and certain actuarial standards. The provisions of this act are scheduled to sunset on July 1, 1994. Chapter 90-795. The bill was approved 4-9-90. (Same as VA HBN 1108)

WASHINGTON

House Bill 2410

Extends current Medicaid coverage of hospice services until June 1991. Chapter 90-25. The bill became effective 3-13-90.

House Bill 2603

Creates a Children's Health Program to provide medical care to children under 18 who live in households with an income at or below federal poverty level and who are not eligible for medical assistance. The health care provided shall be equivalent to that provided to children under medical assistance. Chapter 90-296. The bill became effective 7-1-90.

House Bill 2959

Authorizes school districts to require uninsured students to purchase health insurance coverage from the school district and allows school districts to reduce or waive premiums for low-income students. Chapter No. 90-74. The bill became effective 6-7-90.

Senate Bill 6418

Establishes a health professional substitute resource pool to provide short-term physician, physician assistant, pharmacist, and advanced registered nurse practitioner personnel to rural communities where such health care professionals are unavailable due to provider shortages. Such short-term assistance should complement active health provider recruitment efforts by rural communities where such shortages exist. Chapter 90-271. The bill became effective 3-29-90

Senate Bill 6834

Authorizes the development of basic group disability policies and health care service contracts for employers with less than 25 employees. Under this bill, all forms, policies and contracts shall be submitted to the Commissioner for approval. Chapter No. 90-187. The bill became effective 6-7-90.

WEST VIRGINIA

House Bill 4128

Changes the termination date for the Task Force on Uncompensated Health Care and Medicaid Expenditures from 1990 to 1993. The bill was approved 3-19-90.

WISCONSIN

Assembly Bill 644

Increases the Medicaid income eligibility level for pregnant women and children under six years of age to 133 percent of the poverty level. Also authorizes the state to impose a monthly premium of Medicaid coverage of pregnant women and children under six years of age whose family income exceeds 133 percent of the federal poverty level. Chapter No. 90-351.The bill was approved 4-27-90.

Assembly Bill 822

Creates, in two counties, a pilot volunteer health care provider program for licensed health care providers who make available certain services to low-income uninsured persons ineligible for any aid program. Chapter No. 90-206. The bill was approved 4-13-90.

Senate Bill 397

Expands the state medical assistance program to include coverage for podiatrists' services and appropriate additional money to fund that coverage. Chapter No. 90-333. The bill was approved 4-26-90.

Senate Bill 542

Among other things, increases Medicaid eligibility for pregnant women and children, requires the Health Department to establish and administer a program to subsidize health insurance premiums for AIDS patients, and requires that a health insurance plan that provides coverage for dependent children also provide coverage to a limited extent for adopted and adoptive children. Chapter No. 90-336. The bill was approved 4-27-90.

WYOMING

House Bill 86

Raises Medicaid's income allowance level Medicaid in cases where a covered spouse is institutionalized. That spouse's income will not be considered available to him for Medicaid eligibility purposes as long as it does not exceed two-thirds of the maximum income allowed by federal law. Chapter No. 90-65. The bill became effective 7-1-90.

House Bill 150

Patterned after the National Association of Insurance Commissioners' model, this bill creates a health insurance risk pool for the uninsurable with losses funded by assessments against health insurers. Pursuant to this section, for the total amount of assessments due up to one million dollars from all members in any one calendar year, 100 percent of each member's proportionate contribution to the one million dollars shall be allowed as a credit. This credit shall be applied against any premium tax owed by the member in the year for which the assessment is payable. Chapter No. 90-58. The bill became effective 7-1-90.

THE FOLLOWING STATES HAVE HIGH-RISK POOLS FOR UNINSURABLE INDIVIDUALS

California
Colorado
Connecticut
Florida
Georgia
Illinois
Indiana
Iowa
Louisiana
Maine
Minnesota
Missouri
Montana
Nebraska
New Mexico
North Dakota
Oregon
Rhode Island
South Carolina
Tennessee
Texas
Utah
Washington
Wisconsin
Wyoming

December 1990

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HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unbeknownst to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

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SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.

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SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1990

(1) **Typical Employer**[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate which amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

ow Risk Employer - While a second employer has similar demographic, area and industrial mposition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

(3) **High Risk Employer** - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1991

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1990 to 1991) is 12 percent.

(4) **Typical Employer** - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1990 and submitted major claims. From 1990 to 1991, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be no more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

(5) **High Risk Employer** - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1991 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1991 mid-point rate of $224), which amounts to an increase from 1990 to 1991 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer

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[1] By "typical" we mean a small employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

[2] This is believed the best measure of a carrier's general yearly increase in premiums.

HIAA SUMMARY RESPONSE TO CANADIAN-STYLE PUBLIC HEALTH INSURANCE

Many groups are advocating the adoption of Canadian-style public health insurance. In Canada, public health insurance plans run by the provinces cover all residents and are the sole payers for hospital and physician care. Patients have free choice of doctors and hospitals and face no out-of-pocket costs at the time of service. Financing comes almost entirely from taxes.

Public health insurance advocates like Canada's universal coverage, and they claim that Canada has controlled health care costs more effectively than the United States because Canada spends only 9 percent of its gross national product (GNP) on health care, as compared to 11 percent of GNP spent in the United States.

- **Despite these claims, Canada has not controlled health care cost escalation.**

If trends in health care costs per capita are analyzed, it becomes clear that Canada has not fared better than the United States at controlling cost escalation. Over the past 10 years (1977 to 1987), real health care costs per capita grew at an average rate of 4.3 percent per year in Canada, compared to 3.9 percent per year in the United States. The percent of GNP devoted to health care grew more slowly in Canada than in the United States not because Canada controlled health care spending, but because Canada's economy grew faster than ours. Between 1977 and 1987, Canada's GNP per capita grew an average of 2.1 percent per year in real terms, compared to the 1.6 percent per year growth in the United States.

- **Government is bigger in Canada.**

Canadians pay a high price for their public health insurance system and other government-funded services. Excluding defense, the public sector consumes a 30 percent larger share of the total economy in Canada than in the United States (36.7 percent of GNP compared to 28.3 percent of GNP). The net government deficit (across all levels of government) is almost 50 percent larger in Canada when compared to total economic output (Canada's is 3.6 percent of GNP, while the United States' is 2.4 percent of GNP). These statistics are from 1987 figures.

- **Canadians endure long waits for major surgery, and the standard of care is beginning to fall behind current available technologies.**

More importantly, Canadians have to put up with the health care consequences of government attempts to control costs. Because there are no charges to patients, access to care for "sniffles, sneezes, and splinters" is no problem in Canada, but some patients in need of serious surgery have to wait many months for their operations, due to lack of facilities. Modern diagnostic equipment is also in short supply in some provinces, which leads to long waits for such tests as computerized

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tomography scans and mammograms. Provincial authorities tacitly have admitted that waiting lines for heart surgery are too long, since they agree to pay for Canadians to have surgery in U.S. hospitals.

This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, bureaucratic budget control discourages innovation, perpetuates existing inefficiencies, and leads to obsolescence.

The strength of the American health care system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness. Such responsiveness is clearly not possible when all major resource allocation decisions are made by a government, particularly a government concerned primarily with cost control.

- **Controlling health care budgets does not eliminate unnecessary care and waste in the health care system.**

While arbitrarily restricting access to expensive high-technology procedures, Canada's provincial health plans make no attempt to determine whether care ordered by physicians is really necessary, despite the large volume of evidence (in the U.S. and elsewhere) that a significant proportion of services ordered by physicians are unnecessary, ineffective, or actually counter-indicated. Inappropriate care, which may constitute as much as 25-30 percent of all care rendered according to some estimates, is the real cause of waste and excess expense in the health care system.

- **Canadians are stuck with a "one size fits all" system.**

Canadians lack choices—not of specific doctors and hospitals, but of the overall delivery system and the extent of coverage. In the United States, if an employment-based group chooses to reduce its current outlays for insurance premiums and protect themselves only against very major medical bills, for example, they can buy lower-cost insurance.

These choices are not available to Canadian citizens. All must belong to the same system and accept its deficiencies as well as its benefits, unless they choose to be restricted to the very few private hospitals and physicians or to seek care outside the country. Thus, if the government seeks to control costs by restricting the availability of hospital beds or new equipment, citizens who need care must either wait for service or pay privately to go outside the system.

- **The Canadian system would be in worse shape if it did not have the U.S. health care system right next door.**

First, Canadians need not spend large sums developing new medical technology—they can wait for the United States to develop it and reap the benefits when it is ready.

Second, the United States relieves the pressures that would otherwise build requiring expansion of the Canadian system and additional spending. For example, with few exceptions (e.g., cataract surgery), it is almost impossible for individuals to shorten their waiting periods for surgery within Canada because there are virtually no private hospitals; but Canadians who are willing and able to pay privately to obtain care sooner can come to U.S. hospitals and clinics. The provinces had no other short-term alternative for reducing surgical waiting lists. If the United States were to adopt the Canadian system, this safety valve for Canadians would no longer exist, nor would there exist one for Americans.

• Conclusion

Clearly, the United States must work to assure access to health care for all Americans. Equally clearly, we must do a better job of containing health care cost increases, while we also maintain quality of care. But public insurance based upon the Canadian model is not an approach that would work well in the United States.

The U.S. private market is responding to the growing demand for cost containment and quality assurance and is moving aggressively to implement and improve managed care systems that will meet this dual need. Private insurers also recognize the need for universal availability of health care coverage and have developed specific proposals to make coverage available to the broad spectrum of Americans who currently are without.

June 1990

Health Insurance Association of America

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HIAA SUMMARY RESPONSE TO S. 768; THE BASIC HEALTH BENEFITS FOR ALL AMERICANS ACT

HIAA agrees that proposals to address the uninsured must include significant expansion of public coverage. Such expansion should be targeted to those populations most in need — the poor and near poor populations.

- **HIAA agrees that special tax subsidies and exceptions for small employers are necessary and appropriate.** HIAA supports providing financial assistance to small employers who face a substantial burden when they try to provide private coverage. We also support extending the 100 percent income tax deduction to self-employed individuals. Finally, HIAA supports the concept of making lower cost tailored plans available to very young firms.
- **HIAA supports the concept of assisting low income workers in their achieving the cost sharing and premium contributions associated with employer-based coverage.**
- **HIAA supports an Employee Reduction Income Security Act (ERISA) preemption of state benefit mandates.**
- **HIAA opposes employer mandates or other efforts to compel employers to provide health benefits through tax penalties.** We are concerned with the negative employment effects associated with employer mandates and believe that large scale expansion of the employer-based system must be met with successful efforts to contain rising health care costs.
- **HIAA believes that the uniform regional/state rates envisioned under the bill would create major market distortions and would prove to be poor economic policy.** This structure would (a) create tremendous cross-subsidization from areas with lower health care costs to areas with higher health care costs; (b) break the link between costs generated by health care use and health care premiums, thereby eliminating incentives for employers to seek out the most efficient local financing and delivery systems and also to maintain a safe work environment; and, (c) reduce employer economic incentives to locate in lower cost, nonmetropolitan regions. We recommend another approach, which is outlined under HIAA policy.
- **HIAA believes that the current structure of the public program would result in an undesirable, unnecessary, and costly shift of individuals from private to public coverage.** When fully phased in, the public coverage under S. 768 would be available to anyone who does not have employer-based coverage, regardless of income or whether coverage is available through a private source. Further, the open-ended structure would, in all likelihood, exacerbate enrollment problems and create fiscal difficulties (due to adverse selection). It will also instigate perverse incentives for states to make fiscal decisions based

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upon actions by neighboring states. In other words, if voters perceive that they are subsidizing the public coverage of neighboring states (indirectly through federal matching funds), they may be inclined to expand their own program beyond what is believed to be necessary or financially prudent. This phenomenon would be more likely under the broad-based program envisioned by the Act than under the current Medicaid program.

- **While HIAA recognizes the need for appropriate reform of the insurance marketplace, we oppose the responsibilities delegated to the U.S. Secretary of Health and Human Services under the bill.** There already exists, at the state level, a highly developed regulatory structure which carries out many of the functions which would be placed under the control of the U.S. Secretary of Health and Human Services.

Initiatives to address the access to health care coverage issue should build and improve upon the existing public/private system without promoting large scale and unnecessary substitution of existing sources of coverage. Proposals to expand private coverage should not hastily mandate or compel employers to provide health benefits, but should instead focus on making coverage more available and affordable. Such efforts should include introducing a range of small employer insurance market reforms; establishing a reinsurance mechanism to guarantee availability of coverage and making the small employer market reforms feasible; making lower cost prototype benefit plans possible; and assisting financially needy employer groups and individuals with their purchase of private coverage. For more details regarding the above, see the HIAA Summary of Recommendations on Expanding and Improving the Health Care Financing System.

HIAA

ON

HEALTH CARE

FINANCING

FOR ALL

AMERICANS

HIAA SUMMARY RESPONSE
TO THE PEPPER COMMISSION'S RECOMMENDATIONS
FOR THE UNDER 65 POPULATION

The Bipartisan Pepper Commission released a series of recommendations for reforming our nation's health care system. The report makes a number of positive recommendations which HIAA supports.

For instance, HIAA supports the Pepper Commission proposals to expand government coverage to poor and near poor individuals and to target tax subsidies to small employers. HIAA also supports targeted government assistance to low income workers to help them pay the premium contributions and cost sharing associated with their health plan. HIAA supports the concept of a federal preemption of state benefits and provider mandates and many of the underlying concepts for reform of the small employer health benefit market. HIAA also supports a number of the suggestions for constraining growth in health care costs and for assuring the delivery of quality care through managed care and other initiatives aimed at establishing better practice guidelines and standards of care, including the study and demonstrations on medical malpractice reform.

However, the report also includes elements which are politically and economically unfeasible, elements that HIAA cannot support.

- It is HIAA's belief that scarce public funds and assistance should go first and foremost to the needy. The proposal unnecessarily makes public coverage available on a very broad scale.

  The program's structure would likely lead to costly substitution of public coverage for existing private coverage. One would expect employers in high cost regions and higher cost employers to buy disproportionately into the public plan (since under the public plan the employer's costs are capped at a defined percentage of payroll). For employers buying into the public plan, the plan eliminates any linkage between the cost of coverage and the true health care costs incurred by the employer (which therefore eliminates incentives to increase efficiency and to maintain healthy work environments). Further, the concentration of high cost employers in the public plan would lead to large public sector losses which would necessitate either (a) an infusion of public dollars funded by increasing tax revenues to subsidize the high cost employers, or (b) efforts to enlist lower cost employers in the public plan (e.g., by lowering the payroll tax). The problem with alternative "a" is that the American public appears unwilling to accept a major tax increase (particularly when revenues will assist other individuals). A major problem with alternative "b" is that it would institute an inflexible public program for a larger segment of the population, something that neither employers nor the American public wants.

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In almost any scenario, employers located in regions with lower health care costs would wind up cross subsidizing, through public funds, those employers in higher cost regions that have opted into the public plan.

Employers in many cases would find it advantageous to provide private coverage for higher income employees and cover lower income employees (e.g., part-time or temporary) with the public plan. From a labor standpoint this may be viewed as unfair and discriminatory.

Employees' preferences and needs would be subject to an arbitrary decision by the employer, who would determine whether it was more advantageous to pay for public or private coverage.

HIAA statistics strongly suggest that the public program will severely limit its provider payment rates, thereby forcing a cross subsidy from other payers.

- While HIAA supports the general direction being taken in small employer market reform, specific requirements that coverage be sold on "the same terms to all employers" are troubling. This implies a crude form of community rating, which is highly problematic for a number of reasons. One, it would lead to more employers that pay higher premiums. Their number would be substantially greater than the employers that received lower premiums. Two, making coverage substantially more costly for the majority of small employers may cause many employers to drop coverage or seek refuge in self insurance. Three, it entirely breaks the link between an employer's true health care costs and the premiums which employers pay. This mitigates an employer's incentive to seek out more efficient financing and more efficient delivery systems in order to maintain a safe and healthy work environment.

- The "basic" benefit package identified in the Commission's proposal needs to be more basic. Perhaps most importantly, the "limited" mental health benefit could prove to be very costly.

HIAA SUMMARY RESPONSE TO THE HERITAGE FOUNDATION PROPOSAL FOR HEALTH SYSTEM REFORM

The Heritage Foundation proposal for health system reform and cost containment makes several valid points. Perverse incentives (though not just consumer incentives) are a main cause of cost escalation. Consumers do need incentives to be concerned about costs of care. Government price and budget controls can produce undesirable consequences. A market-based strategy must be a major part of the solution.

On the other hand, the Heritage Foundation proposal is inadequate in several important ways.

- The proposal places far too much reliance on the individual consumer's ability to solve their coverage problems and unwisely eliminates employer-based coverage. Employers, unlike consumers, have the clout to negotiate with providers to change the system. Because they have both the incentive and the leverage to bring about system changes, employers are critical actors in the effort to bring costs under control. Moreover, the administrative and marketing costs for employment-based plans are much less than if all plans were sold to individuals. Simply giving individual consumers incentives to choose a low-cost plan will not control costs. With so many different plans and the complexity of many benefit structures, most consumers would not have the time or the skill to make reasoned judgments about the level of benefits that would best suit them, about the adequacy of coverage, about the value of the benefits relative to the price, and about the quality of providers' services. The screening process that employers now provide to help decide which plans to offer employees greatly reduces the complexity of the task.
- The proposal totally ignores the critical role that providers, especially physicians, play in determining resource mix and cost of care. The assumption is that if consumers have proper incentives, then that will be enough to force providers to become more efficient and less costly. Given the highly technical nature of medicine, the cost-increasing incentives of fee-for-service physician reimbursement, and the natural reluctance of physicians to change the way they deliver care, this assumption is unrealistic.
- The proposal offers no details of any kind to illustrate the process by which consumer incentives will be translated into efficient delivery systems designed to produce high-quality, low-cost care. The argument assumes that making consumers cost-conscious will produce the desired outcome. Yet, major structural changes are required if costs are to be contained; these changes do not just happen. We believe that managed care systems are a major part of the answer. Attention must be addressed to the conditions and mechanisms that are necessary to produce managed care systems and the other system changes that are necessary.

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- The proposal vastly underestimates the problems of adverse selection. If consumers have a choice of many different plans, rather than just a few, competitive pressures will force the plans to compete not by trying to provide services more efficiently, but by trying to attract healthy individuals. Healthy individuals, with low probability of high expenses, will naturally want to join a plan that insures similar low-risk individuals, since the cost will also be much lower. The advantage to be gained by underwriting low-risk individuals will overwhelm any savings that could be realized through providing services more efficiently. Even with the tax-credit subsidy, the high-risk people will find the cost of insurance very burdensome. If the Heritage approach is not the answer to cost control, what is? The solution is to be found in the development of improved managed care. Managed care systems, of which HMOs and PPOs are the best-known examples, are designed to monitor treatment decisions to assure that care is appropriate and efficiently provided. They provide comprehensive, integrated care through selected panels of providers who are chosen because they are known to be cost-effective, and who agree to practice within defined constraints to assure quality and efficiency. The closed nature of the provider panel and the incentives for consumers to use panel providers creates an environment where standards to assure appropriate cost-effective care can be developed, implemented, and accepted by both providers and patients. For physicians, the attraction of managed care systems is an assured supply of patients. For purchasers, the attraction is high-quality, less costly care. The insurance industry has made a major commitment to the development of such systems and believes that they must be a major part of any plan for health system reform.

HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

MANAGED CARE

BACKGROUND: The high cost of health care is a major problem for the United States. All who pay—employers, individuals, and government—are burdened by continual increases in health expenditures. Moreover, escalation of health costs greatly complicates the task of finding ways to provide coverage for the large number of Americans who are without either public or private health insurance.

Although cost escalation has many causes, research shows that one key problem is that patients receive much care that is not appropriate for their condition. Some get care that is more intense and expensive than necessary. Others receive care that is not beneficial and may even be harmful. Eliminating such inefficiencies—which may account for 25 percent or more of medical expenditures—is clearly a critical objective, both as a way of reducing costs and improving quality of care.

Payers of health care are aware of such inefficiencies and are demanding more accountability and better performance from those who make health care decisions in order to assure that patients receive good value for money spent. Increasingly, managed care is recognized as the best mechanism for carrying out such improvements. The key objective of managed care is to assure that patients receive appropriate care, that is, high quality care efficiently provided in the least costly setting.

DEFINITION: Because it is still evolving, managed care embraces a variety of existing and developing structures. It may be defined as systems that integrate the financing and delivery of appropriate health care services to covered individuals by means of the following basic elements:

- Arrangements with selected providers to furnish a comprehensive set of health care services to members;
- Explicit standards for the selection of health care providers;
- Formal programs for ongoing quality assurance and utilization review; and
- Significant financial incentives for members to use providers and procedures associated with the plan.

Managed care organizational structures are evolving in response to marketplace demands and will continue to do so. Today's structures include health maintenance organizations (HMOs), preferred provider organizations (PPOs), and exclusive provider organizations (EPOs), as well as mixed arrangements that combine elements of HMOs, PPOs and indemnity plans to accommodate employer and operating environment requirements.

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Managed care plans arrange with selected providers to furnish health care services to plan members. Explicit criteria are used for the selection of providers, and formal programs for ongoing review of the quality and appropriateness of services are incorporated into the plan.

Plans provide financial incentives for covered individuals to use providers who deliver appropriate quality care. In some managed care plans, the cost of services is covered only when health care is received from selected providers. Other managed care plans provide individuals more latitude in the choice of providers. Out-of-pocket costs, however, are usually higher when out-of-plan providers are chosen.

Some state legislators are concerned that managed care, including both contracting arrangements with providers and utilization review techniques, could adversely affect the quality of health care. Their concerns have been encouraged by some associations of providers representing hospitals, physicians, dentists, pharmacists and allied health professions. These groups have drafted and advocated state legislative proposals that would restrict or prohibit the operation of managed care programs.

HIAA POSITION: HIAA is firmly committed to the expansion of managed care programs and techniques in order to assure high-quality, cost-effective health care. Managed care systems have the means to avoid unnecessary and inappropriate care.

Therefore, HIAA is opposed to legislation or regulations that would impose barriers to the development and implementation of managed care in its current and evolving forms. Legislation or regulation that unduly limits insurers' ability to carry out rigorous utilization review is one such barrier. Legislation that opposes utilization review takes many forms, but generally seeks to put inappropriate restrictions on who can conduct reviews and what can be reviewed.

HIAA is also opposed to legislation that would restrict an insurer's freedom to form networks or contract selectively with providers. Legislation that opposes networking also takes many forms, but generally seeks to put restrictions on the ability to pay providers anything but their usual and customary fees, or to contract with a limited number of providers.

HIAA believes:

- Insurers should be free to negotiate whatever price they can with providers. One important way to reduce costs is to be able to buy provider services at lower prices, and managed care systems need to have freedom to negotiate lower prices. On the other hand, in some instances plans may wish to offer higher-than-usual fees to especially efficient providers.
- Insurers should be able to pay providers in ways that create appropriate incentives. If provider reimbursement systems reward high-cost medical practice, it will be very difficult to reduce costs. Managed care systems need to be able to alter reimbursement incentives to reward efficient providers. Severe restrictions on capitation payment, for example, are inappropriate and unwarranted.
- State laws should not place artificial limits on the amount of consumer cost sharing that can be imposed on PPO plan enrollees who choose to get care from off-panel providers. If a PPO has a panel of providers that can provide

needed high-quality services more efficiently than other providers, it is entirely appropriate to require consumers who choose not to use these efficient providers to pay the extra costs. HMOs, which all states allow, do not pay anything when consumers receive care from non-HMO providers.

- Legislation should not establish inappropriate barriers to insurer efforts to establish effective utilization review programs and should require providers to make available, at a reasonable cost, patient records and other information necessary to monitor cost and quality of care. Monitoring medical practice patterns is critical to managing care. If reviewers cannot get access to medical records at reasonable cost, or if excessive restrictions are put in place to limit who does utilization review or what the process will be, managed care plans cannot accomplish the critical task of encouraging providers to become more efficient.
- Insurers who are negotiating to form provider panels should not be compelled to enroll every provider who wishes to be included. A key mechanism that managed care plans use to constrain costs is to contract only with efficient providers. If plans are required to include on their panels all willing providers, this critical element of control is eliminated.
- States should not mandate that insurers cover services and categories of care, since doing so often adds to costs and limits the plan's ability to develop cost-effective benefit packages. Research evidence shows that legislation that requires coverage of certain provider categories or particular services generally causes a net increase in costs. The buyers of insurance plans, not state government, should be the ones who decide what services and provider groups should be covered. Legislation mandating coverage of particular provider groups is often simply a reflection of that group's desire to create demand for their own services as a way of enhancing income.

HIAA supports the concept of physician peer review as a method of determining appropriateness of care. In doing peer review, however, it is not appropriate to rely solely on local peer assessment. Studies of differences in patterns of medical practice from area to area within a state demonstrate that the typical method of treatment in one community is often significantly different from that in another community even though the conditions of the patients are essentially identical. The differences, in other words, are not medically justified. Thus, local habit or customary practice is not necessarily the best standard for assessing medical appropriateness or necessity for a given treatment.

The collective judgment of physicians who are experts in a given field and who have done a systematic study of the scientific research must ultimately form the basis for determining what is appropriate care in a given situation. It is for this reason that HIAA supports the development of medical practice guidelines and protocols. When developed, these can form a rigorous, scientifically defensible standard for educating physicians about the best medical practice and for judging the appropriateness of care.

GLOSSARY: Below is a list of some of the current managed care structures now available:

Health Maintenance Organization (HMO): This was the original managed care arrangement, first emerging as prepaid group practices in the 1930s. The

name "health maintenance organization" was coined in the early 1970s, and was given to 1973 federal legislation promoting its development. HMOs provide:

- An organized system for providing health care in a certain geographic area, as well as responsibility for providing or otherwise assuring delivery of that care;
- An agreed-on set of basic and supplemental health maintenance and treatment services; and
- A voluntarily enrolled group of people.

In exchange for a set amount of premium or dues, HMOs provide all the agreed-on health services to their enrollees; there are generally no deductibles and no or minimal copayments. The HMO bears the risk if the cost of providing the care exceeds the premium received. There are now several types of HMOs:

- The staff model, where providers are directly employed by the HMO;
- The group model, where medical groups contract with the HMO (Kaiser plans are the best-known example of this type);
- The independent practice association (IPA), where the HMO contracts with physicians in independent practice, or with associations of independent physicians. IPA physicians frequently have arrangements with more than one HMO; and
- The network model, which contracts with two or more independent group practices.

Preferred Provider Organization (PPO). A PPO consists of groups of hospitals and providers that contract with employers, insurers, third-party administrators or other sponsoring groups to provide health care services to covered persons and accept negotiated fee schedules as payment for services rendered. There are different sponsoring arrangements:

- Hospital-sponsored PPOs, which often include a network of institutions in order to cover a wider geographic area, as well as many of the physicians on their medical staffs;
- Physician-sponsored PPOs, which are developed by local medical societies, other local professional associations or clinics, or groups of physicians;
- Third-party payer-sponsored PPOs, which include those initiated by commercial insurers and Blue Cross and Blue Shield plans;
- Entrepreneur-sponsored PPOs, which create a broker relationship with the entrepreneur acting as an intermediary between the provider and payer of service;
- Employer- or labor-sponsored PPOs, which contract directly with providers on behalf of their employees or members;
- Other provider-sponsored PPOs, which are developed by nonhospital and nonphysician providers, such as dentists, optometrists, pharmacists, chiropractors and podiatrists, through their professional associations, local groups or clinics.

Exclusive Provider Organization (EPO). People belonging to an EPO must receive their care from affiliated providers; services rendered by unaffiliated providers are not reimbursed.

Point-of-Service Plans. Also known as open-ended HMOs or PPOs, these plans permit insureds to choose providers outside the plan at any time yet are designed to encourage the use of network providers. If a provider is affiliated with the HMO or PPO, the service is covered (perhaps after a modest copayment). If an out-of-network provider is chosen, reimbursement may be significantly reduced.

A number of managed care techniques are used to assure quality and appropriate care. These include, but are not limited to, quality assurance, utilization review, case management and use of a primary care physician. Although the combination of elements will differ among plans, each managed care plan operates as an organized system where patient services are subject to review and coordination by health professionals.

- Quality assurance is a process by which a managed care plan monitors and takes action as necessary to assure that quality care is delivered by selected providers. The process measures the extent to which quality has been attained and periodically reevaluates health care to assure that established standards are being met.
- Utilization review is a system of reviewing the medical necessity and appropriateness of patient services within guidelines developed by physicians. Performed by health care professionals, it is comprised of several processes and may be used for both inpatient and outpatient services. Processes may include preadmission certification, application of practice guidelines, continued stay review, discharge planning, second surgical opinion and retrospective review. Because of the explosion of costs in all aspects of ambulatory care in recent years, programs to require preauthorization of ambulatory procedures are now evolving.
- Preadmission certification is a process in which a health care professional (such as a registered nurse) evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.
- Continued stay review, also called concurrent review, is a process whereby a review organization continues to examine medical information during a patient's hospital confinement to determine the need for continued hospitalization.
- Discharge planning is a process in which a health care professional from a review organization works with an attending physician and hospital staff to arrange for appropriate discharge of a patient from the hospital, including a plan for the patient's subsequent care. Its purpose is to determine when patients are ready to go home, perhaps with the support of a nurse or other home health provider, or are able to be transferred to a nursing home.
- Second surgical opinion programs require patients to seek a second surgeon's opinion if elective surgery is recommended for certain conditions. Elective surgery is defined as that which can be avoided or delayed without undue risk to the patient and which allows sufficient time to seek another opinion.

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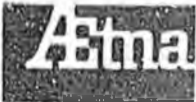
- Retrospective review provides for the establishment of a utilization profile of inapproppriate care for monitoring trends and addressing excessive use or cost.

Other managed care techniques include case management, which is a process that provides a comprehensive plan of care and rehabilitation for people suffering from severe conditions such as trauma, premature birth or AIDS. Through flexible interpretation of plan provisions, case management coordinates the use of all appropriate types of therapy and equipment in the most appropriate setting. Case management often supports alternatives to institutional care, such as physical therapy and other services delivered in the home, that achieve better patient outcomes at lower cost.

In many managed care plans, a primary care physician serves as the initial screening, testing, treatment and referral source for a patient. This physician oversees health care services rendered to patients by other providers and assumes continuing responsibility for the overall course of treatment.



Corporate Affairs
151 Farmington Avenue - MA64
Hartford, CT 06156

Judith T. Hyfield-Starr
Manager
(203) 636-2259

June 1989

Dear Editor:

You're hearing a lot these days about a new concept in health care called *managed care*. It's basically a simple concept -- bringing together the doctor, patient, employer and insurer to manage the use of health care. But it's revolutionary compared to the traditional view of health care.

No longer does a patient rely solely on the doctor for a course of treatment. That treatment today might be influenced by a second opinion, or other cost-saving alternatives established by the employer or the insurance company. It's a true <u>partnership</u> guiding the use of health care resources.

This kit explains the driving forces behind managed care, as well as its many facets. You may want to use elements of it for individual stories, or just keep it on file for future reference.

Aetna is a responsive and knowledgeable news source on health-related issues. Our medical claims data base is the largest in the world (we insure 10 million Americans), and we frequently provide journalists with extensive information on topics ranging from treatment trends to medical costs.

When you need more information on this or any other health care topic, please give us a call.

Sincerely,

Judith Hyfield-Starr

Judith T. Hyfield-Starr
(203) 636-2259

NEWS

For Release:

MANAGED CARE: THE PARTNERS

Aetna's managed care effort brings together its strength as one of the largest private health insurers with the resources of a national not-for-profit hospital system in a unique partnership.

***

AETNA is one of the 15 largest U.S. corporations and is the nation's largest investor-owned insurance company underwriter and administrator of group insurance benefits, based on premiums of $11 billion.

Providing health insurance coverage for 11 million Americans, Aetna has been providing employee benefits since 1913.

***

PARTNERS National Health Plans is a joint venture developed in 1985 between Aetna and VHA Enterprises, Inc., the equity arm of Voluntary Hospitals of America, Inc., to develop a national managed health care system.

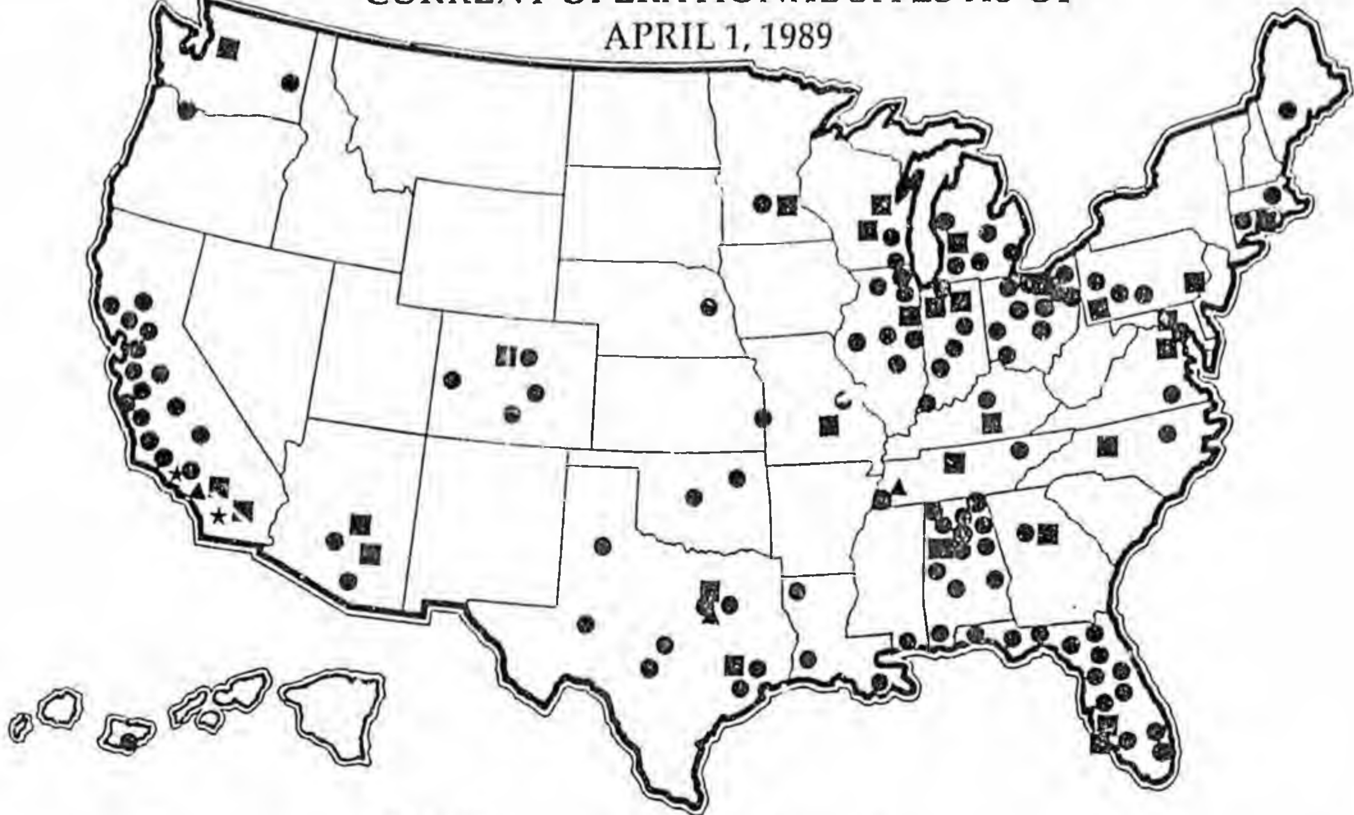
PARTNERS provides employers and their employees with preferred provider organizations (PPOs), health maintenance organizations (HMOs) and other managed health care programs, marketed through Aetna employee benefit representatives, their local brokers and agents and PARTNERS representatives. At the end of 1988, more than 1.7 million members were enrolled in PARTNERS programs.

***

VOLUNTARY HOSPITALS OF AMERICA, INC., founded in 1977, is the largest alliance of not-for-profit hospitals in the nation, with 662 hospitals and their 172 affiliates operating in 47 states and the District of Columbia.

VHA hospitals generally are grouped into 29 regional health care systems built around one or more VHA shareholder hospitals. These regional health care systems, organized into six divisions across the U.S., are licensed by VHA and operate as independent not-for-profit corporations.

CURRENT OPERATIONAL SITES AS OF APRIL 1, 1989



● PPO ■ HMO ▲ TPCM Claims Center ★ CHAMPUS

ALABAMA
Anniston - PPO
Birmingham - HMO, PPO
Bridgeport/Centre/Fort Payne - PPO
Cullman - PPO
Fayette - PPO
Florence - PPO
Gadsden - PPO
Huntsville/N. Alabama - PPO
Jasper - PPO
Mobile - PPO
Montgomery - PPO
Phenix City - PPO
Tuscaloosa - PPO

ARIZONA
Phoenix - HMO, PPO
Tucson - HMO, PPO

CALIFORNIA
Central Valley
(Fresno/Bakersfield/Modesto) - PPO
Greater Los Angeles
(Anaheim/Santa Ana, Long Beach, Oxnard/Ventura, Riverside/San Bernardino, Santa Barbara/Santa Maria/Lompoc) - HMO, PPO, TPCM Claims Center, CHAMPUS
Northern California
(Oakland, Sacramento, San Francisco, San Jose, Santa Rosa/Petaluma, Stockton, Vallejo/Fairfield/Napa) - PPO
San Diego - CHAMPUS, HMO

COLORADO
Colorado Springs - PPO
Denver
(Boulder/Longmont) - HMO, PPO
Grand Junction/Montrose - PPO

CONNECTICUT
New Britain - PPO
Southern New England
(Hamden) - HMO

FLORIDA
Brevard County - PPO
Daytona Beach - PPO
Fort Myers - PPO
Gainesville - PPO
Inverness - PPO
Jacksonville - PPO
Martin County - PPO
Ocala - PPO
Orlando - PPO
Panama City - PPO
Pensacola - PPO
Tallahassee - PPO
Tampa - Two HMOs, PPO
West Palm Beach/Boca Raton - PPO

GEORGIA
Atlanta - HMO, PPO

HAWAII
Honolulu - PPO

ILLINOIS
Champaign - PPO
Chicago
(Aurora/Elgin, Lake County) - HMO, PPO
Joliet - PPO
Kankakee - PPO
Peoria - PPO
Rockford - PPO

INDIANA
Evansville - PPO
Fort Wayne - PPO
Gary/Munster - HMO, PPO
Indianapolis - PPO
South Bend - HMO
Terre Haute - PPO

KANSAS
Kansas City - PPO

KENTUCKY
Louisville - HMO, PPO

LOUISIANA
Lake Charles - PPO
New Orleans - PPO
Shreveport - PPO

MAINE
Lewiston - PPO

MASSACHUSETTS
Boston
(Brockton, Fitchburg/Leominster, Lawrence/Haverhill, Lowell, New Bedford, Salem/Gloucester, Worchester) - PPO

MICHIGAN
Detroit/Port Huron - PPO
Grand Rapids - HMO, PPO
Lansing - PPO
Muskegon - PPO
Saginaw/Bay City - PPO

MINNESOTA
Minneapolis/St. Paul - HMO, PPO

MISSISSIPPI
Biloxi/Gulfport - PPO

MISSOURI
Kansas City - PPO
St. Louis - HMO, PPO

NEBRASKA
Omaha/Council Bluffs - PPO

NORTH CAROLINA
Raleigh-Durham - PPO
Winston-Salem - HMO

OHIO
Akron - PPO
Cincinnati
(Hamilton/Middletown) - PPO
Cleveland - HMO, PPO
(Lorain/Elyria) - PPO
Columbus - PPO
Dayton/Springfield/Xenia - PPO
Toledo - PPO
Youngstown - PPO

OKLAHOMA
Oklahoma City - PPO
Tulsa - PPO

OREGON
Portland - PPO

PENNSYLVANIA
Johnstown - PPO
Philadelphia - HMO
Pittsburgh - HMO, PPO
(Beaver County) - PPO

TENNESSEE
Knoxville - PPO
Memphis - PPO, TPCM Claims Center
Nashville - HMO

TEXAS
Amarillo - PPO
Austin - PPO
Dallas
(Fort Worth/Arlington) - HMO, PPO, TPCM Claims Center
Houston - HMO, PPO
(Brazoria) - PPO
Midland - PPO
San Antonio - PPO

VIRGINIA
Fairfax - HMO
Norfolk/Virginia Beach/Newport News - PPO

WASHINGTON
Seattle - HMO
Spokane - PPO

WASHINGTON, D.C. - HMO

WISCONSIN
Appleton - HMO
Kenosha - PPO
Milwaukee - HMO, PPO

PHP 1217 (3/89)

NEWS

For Release:

Immediate

Contact: Judith Hyfield-Starr
(203) 636-2259

Background on Managed Care

Just 10 years ago, a new employee received a booklet of benefits, glanced at it briefly and tucked it away, safe in the knowledge that it was a standard package.

Today, the employee faces a wide array of alternatives -- PPO or HMO? Which one? Maybe a traditional indemnity plan? What level of coverage?

Just 10 years ago, the employee visited the family doctor for an ailment and followed that doctor's advice without question.

Today, that employee seeks advice from his employer, his insurance company and possibly another doctor before the best course of treatment is determined.

Just 10 years ago, an employee with a catastrophic illness or a psychiatric problem spent months or years in a hospital or institution, with bills often mounting into the millions.

Today, that patient is evaluated by a group of professionals, and treatment -- possibly in an alternative setting -- is customized for the individual medical problem.

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Patient knowledge and responsibility are at the core of this new approach to health care -- called *managed care*. Managed care is a partnership of the patient, doctor, employer and insurer working together to make effective use of health care resources.

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Today, 74 percent of people with employer-sponsored health insurance are covered by at least some form of cost management, up from virtually none at the beginning of the decade, according to the Health Insurance Association of America.

The concept has its roots in the late 1970s and early 1980s, when employers began facing seriously escalating health care costs due to the frequent use of inpatient care and the advent of new and costly procedures.

The health care service industry responded quickly to the cost spiral, offering an array of cost-management strategies, including second surgical opinions, preadmission certification and the encouragement of outpatient services for many procedures once done in the hospital.

While these strategies worked in reducing inpatient stays and surgeries, the cost balloon bulged in other areas. Outpatient costs jumped dramatically and hospital beds began filling up with mental health and substance abuse cases. And, second surgical opinions too frequently confirmed the original opinion and didn't appear to avert unnecessary surgery or reduce costs.

Health care costs continued to soar, with the U.S. health bill at 11.4 percent of GNP in 1988, up from 6 percent in 1965. Costs rose 50 percent just from 1982 to 1987, implying there might have been significant overutilization.

Insurers began to play a far bigger role, using their own nurses, doctors and software systems to help employees identify unnecessary, inappropriate or overly costly procedures. More and more, they began suggesting that some operations not be performed, that alternative care be explored. In addition, insurers began organizing networks of competent and cost-efficient hospitals and doctors, ensuring steady patient flow in return for a reasonable cost structure. It was the advent of managed care.

Managed Care Options

An integral component of managed care involves the use of Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) -- networks of health care providers who supply medical care for a set fee.

Under a typical HMO arrangement, the employee pays a set premium in return for complete care from physical exams to hospital coverage. In an HMO, the patient must use participating health care providers; in a PPO, the patient is free to use providers outside the network, but benefits are reduced.

The HMO agrees to limited fees in return for a steady flow of patients. Operating on fixed payments then, they have a strong incentive to study ways to weed out wasteful practices.

Aetna, for example, has a managed health care partnership with Voluntary Hospitals of America (VHA). Using VHA's more than 800 hospitals in 48 states, the partnership has developed an enrollment of more than 1.8 million people through its joint venture, PARTNERS National Health Plans.

Most recently, there has been an effort to integrate the cost-saving advantages of PPOs and HMOs in what is known as a Triple-Option or Integrated Multiple Option (IMO). In an IMO plan, employers can purchase a combination of an indemnity plan, a PPO and an HMO for one experience-rated premium.

Case Management

As inpatient costs soared in the early 1980s, employers paid high prices for hospital care when, many times, employees could have been treated as effectively, and more humanely, in less expensive settings. But they weren't, either because an alternative setting wasn't covered by the benefit plan or because no one was available to arrange the alternative care.

Case management programs solved both issues by identifying cases that could appropriately be treated outside of the hospital, by providing coverage for that care and by counseling patients and their families as to the most appropriate setting.

A typical case management program might involve a patient with a catastrophic illness who could be given skilled nursing care at home -- a more comfortable and less expensive setting. A nurse would act as liaison between the insurer and the policyholder to monitor the quality of care and would get second opinions on medical procedures and case support from an independent team of physicians and specialists.

Aetna, for example, saved its customers almost $122 million in 1987 through its Individual Case Management program, and arranged for customized care for more than 3,000 patients in the form of specialized medical equipment and care, home modifications, nurses, attendants and training for patients' families.

Mental Health Care

Employers today spend $44 billion a year -- or up to 15 percent of their health care dollars -- on mental health care. Drug abuse,

alcoholism and stress-related claims are all on the rise. And, the average hospital stay for these cases is nearly four times longer than the average for all other admissions.

Mental illness no longer carries the stigma it once did, and employees today are more open about seeking treatment and often are encouraged to do so by their employers.

But mental health treatment is expensive and complex, and the duration of treatment has always been difficult to predict. As a result, many employers and insurers once believed costs also were difficult to assess. They thought the only way to control costs was to limit benefits. In efforts to maintain control yet provide what they thought was meaningful coverage, many began to offer full coverage for inpatient care but little or no coverage for the less-costly outpatient services. As a result, inpatient care -- and costs -- soared.

In response, many employers have redesigned their benefits packages to cover the appropriate treatment and to help employees find quality treatment opportunities. And some insurance companies are offering new and custom-tailored plans to employers, like Aetna's Focused Psychiatric Review, which encourages use of alternatives to traditional hospital confinement -- day hospitals, halfway houses, intensive outpatient treatment and residential treatment centers.

These new programs frequently feature a case management approach, in which the case manager monitors patient programs, helps the employee locate appropriate treatment and works with the physician to identify and evaluate treatment options.

Precertification Programs

Most Americans with group insurance now are covered by some type of precertification arrangement -- programs that offer the patient a financial incentive to seek review of a procedure before it is performed. This process frequently points out the possibility of outpatient treatment as a cost-effective alternative to hospital admission.

Although the programs have worked well to reduce the number of inpatient procedures, they have boosted the use of outpatient care substantially.

To control these costs and maintain quality care, a few precertification programs have expanded to cover outpatient procedures. Aetna, for example, offers employees financial incentives to seek review of 18 of the most expensive and frequently performed outpatient procedures. The Aetna program is expected to reduce use of inappropriate outpatient services by up to 15 percent.

In further efforts to reduce unnecessary surgery, Aetna also has started a managed second opinion program.

Traditionally, second surgical opinion programs have failed because the confirmation rate has been about 97 percent, despite the fact that research shows up to 30 percent of surgeries may be unnecessary or even harmful. The savings from the averted procedures barely covered the costs of the second opinion.

Managed second opinion uses computer-based standards to determine whether a procedure would benefit from a second opinion. The program is expected to cut down on nonproductive second

opinions since physicians will be aware that patients are being referred because the procedure is being questioned.

Utilization Management

One of the critical ingredients tying together managed care programs is effective utilization management. Utilization management allows an employer to monitor costs and quality of care while providing employees with medical care counseling before, during and after treatment.

The programs have been successful since their inception in the early 1980s, and the use of utilization controls has risen fourfold since 1984.

In a typical utilization review program, a patient anticipating a procedure calls a toll-free number and talks to a registered nurse. The nurse may work with the patient's physician in recommending the best and most cost-effective course of treatment.

Aetna's HEALTHLINE, a toll-free hotline people can call with their questions, covers precertification of procedures, review of emergency admissions, continued-stay review, discharge planning, second surgical opinion, individual case management and retrospective review and analysis.

Conclusion

Managed health care is an evolution whose time has come. In today's environment of choices -- which provider and which procedure, what's covered and what isn't -- employees need the proper tools with which to make the correct decisions.

Managed care helps give employees those tools so they can obtain quality health care at an affordable cost.

The rising costs of health care in America has rapidly become one of our Nation's most important social and economic issues. In 1980, total health care expenditures in the United States was $248.1 billion. By 1986, expenditures had increased to $458 billion. If this trend continues, total annual dollars spent on health care will be $1.5 trillion by the year 2000, or an astounding $5,550/yr per person.

Numerous studies have been done to document the causes for this dramatic increase in cost. The principal inflationary factors include:

* Increases in the cost of hospital personnel and medical equipment;
* Over building of hospitals resulting in low occupancy rates;
* Increases in health care consumption;
* Increases in malpractice suits resulting in higher malpractice insurance costs;
* Increase in the median age of the U.S. population;
* Provision of unnecessary medical services;
* Cost shifting from the federal government to state, municipal and private employers;

No where in the country has the cost of health care services risen as quickly as the State of Alaska. Of All fifty states, Alaska:[1]

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[1] Statistics from 1989 Source Book of Health Insurance Data and Health United States 1988

	U.S.	Alaska
1) Has the highest average cost per day for hospital care (60% higher than national average)	$538.96	$892.02
2) Has the second highest cost per hospital stay (76% higher than national average)	$3,850.16	$5,056.92
3) Has the fourth highest cost for semi-private room (77% higher than national average).	$254.87	$330.66
4) Has highest percentage of male smokers in the country.		
5) Is among the top five states in per capita expenditures for mental health care.		

6) Has significantly higher than average costs for most medical and dental services.

	Seattle	Juneau	Anchorage
(a) dental exam	$22	$40	$35
(b) dental cleaning	$48	$85	$80
(c) dental filling	$50	$80	$80
(d) appendectomy	$975	$1400	$1450
(e) Hernia Repair	$900	$1400	$1325

Alaska also leads the country in alcohol and substance abuse, the treatment for which is expensive due to the length of treatment programs.

Other related trends which have been observed in Alaska by Aetna's Cost Containment Unit include confinements extended for social or family reasons when not medically necessary, extended juvenile confinements for behavioral problems, alcohol and drug abuse patients who return to dysfunctional families which do not provide the necessary support to end the abuse, increase in the use of preventative (i.e., naturopathic) services and over use of diagnostic procedures and durable medical equipment.

As a result of these rapidly increasing expenses, the cost of healthcare insurance is also rising quickly. The cost of a fully insured healthcare program is based on the cost of claims

actually paid in the prior year plus administrative expenses to provide for claim processing, financial reconciliation, and the various administrative tasks required to run the plan. The cost is then increased or decreased based on the projected volume of claims expected for the coming year. Nationally the cost of medical claims is currently increasing at a rate of 20%-25%.

Using the State of Alaska health care policy as an example, the payment for claims filed by active state employees has risen from $25 million in 1983 to $48 million in 1988. The number of claims transactions has increased from 264,854 to 338,889 during the same period and the claim cost per employee has jumped from $2,238 to $3,615. The consequence of this upward trend was a proportional increase in health care insurance cost to the State, and there is no evidence that the trend will end in the near future.

The financial impact of the increasing cost of health care insurance is of great concern to employers, employees and insurers. While it will be extremely difficult to control many of the inflationary factors cited herein, there are some factors which can be modified to achieve lower insurance costs.

The Cowper Administration, The Alaska State Employees Association (ASEA), and the legislature have been working with Aetna to identify changes in the existing health care benefits

package for State employees which will result in lower insurance costs without significantly reducing the benefits to employees. An agreement was recently signed by the Department of Administration and ASEA which will result in a $42.00 per employee/per month reduction in insurance premiums beginning in December, 1989. Some of the cost containment measures included in the agreement are:

Health Care Utilization Review Including Hospital Pre-certification. Offers a financial incentive to the patient to seek review of medical procedures before they are performed.

Second Surgical Opinions. Requires a second opinion in cases where national research indicates that the proposed surgery may be unnecessary or harmful.

Onsite Health Care Review. An onsite nurse in Anchorage monitors a patient's progress to assure an appropriate length of hospital stay and to help arrange out patient care.

Substance Abuse Counseling. Professional Pretreatment guidance to help direct people into the most appropriate treatment that is available.

Co-Insurance in Dental and Vision Services. Insured persons assume a greater share of the cost above certain limits.

Incentives for Use of Generic Drugs. Requires additional payment for brand name drugs where less expensive certified generic drugs are available.

Outpatient Pre-certification. Requires a review of the most expensive and frequently used outpatient procedures to reduce the use of inappropriate services (i.e., tonsillectomy).

Home Health Care. Assistance to provide home vs. hospital care where appropriate.

Skilled and Private Duty Nursing. On staff nurses are available to assist patients in obtaining information, evaluating alternatives, and arranging the appropriate level of care. Aetna currently maintains five registered nurses on staff for this purpose.

A primary thrust of these changes is to permit Aetna to consult with employees prior to treatment to assure that proposed medical care is the most appropriate available. This requires the full cooperation of both employees and medical service providers. Aetna is a leader in these cost containment techniques, and cost containment results, where already implemented for other clients, are very encouraging. Nationwide, Aetna saved its employee benefits customers $1.64 Billion in 1988 or 18.2% of total medical and dental payments.

A "Health Care Cost Containment Task Force" comprised of members of the Alaska State Legislature, the Department of Administration, and representatives of several state and municipal employee unions, is at work to find further acceptable means of reducing the cost of health care insurance to the public sector in Alaska. Senator Tim Kelly is the chairman of the task force and is joined by Senator Jim Duncan, Representative Mike Navarre, and Representative Mark Boyer in representing the Legislature. Executive Branch officials include representatives from the Division of Retirement Benefits, Risk Management, and the Department of Health and Social Services. The Task Force is reviewing Aetna's administration of the State of Alaska health care contract and is considering Aetna's proposed alternatives for cost containment along with advice it has solicited from independent health insurance consultants. Cooperation from the employee unions such as ASEA has been extremely important in adopting the cost saving measures.

Aetna, through its professional staff located in Anchorage and its claims administration unit in Seattle, administers a large number of public and private health care insurance contracts in Alaska. It is proud of its successful record in Alaska, and looks forward to a continuing partnership with the public and private sectors to achieve the best possible coverage for medical services.

NEWS

For Release:

Immediate

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MEDIA BACKGROUNDER

TRENDS IN MENTAL HEALTH TREATMENT:
A NATION OF SICK CHILDREN?

Trends in Mental Health Treatment: A Nation of Troubled Children?

The cost of mental health and substance abuse treatment is the number one benefits concern for many employers today, and with good reason. More employees are using their mental health benefits than ever before and the financial impact on employers is alarming. Consider:

- In 1986, mental health care cost the nation $24 billion, according to the National Mental Health Association. (1)

- Large employers spend between 7 percent and 15 percent of their health care dollars on mental health and substance abuse treatment. (2)

- From 20 percent to 30 percent of all claims processed by insurers today are mental health related. (3)

- General spending for psychiatric care is rising at least 10 percent a year. (4)

- Up to 80 percent of all mental health dollars are spent on inpatient hospital care, which can conservatively cost $500 a day (5) and, in many cases, more.

A recent and disturbing trend is the disproportionate use of mental health services by children and adolescents. In general, youngsters under age 19 receive longer treatment and more expensive treatment than other age groups.

Adolescent Psychiatric and Substance Abuse Care

In 1988, Aetna Life Insurance Co., one of the nation's leading administrators of group health benefits covering more than 11 million Americans, examined 1987 psychiatric and substance abuse hospital claims for employees and dependents up to age 65. Here is what it found:

•Persons 18 and younger represented approximately 26 percent of all claimants and accounted for 24.7 percent of all mental health admissions. And, this same group used 39.9 percent of all inpatient mental health days and accounted for 41.8 percent of all inpatient mental health costs.

•The average length of mental health inpatient stay for persons 18 and younger was 40.2 days. This was considerably more than the next highest average length of stay -- 22.1 days for the 19 to 34 age group. It was more than double the average 18-day lengths of stay for age groups 35 to 49 and 50 to 64.

•For every 1,000 persons 18 and younger, there were 5.6 mental health admissions. This rate is consistent with other age groups. But -- for every 1,000 persons ages 18 and younger, 225 hospital days were used, and this rate is much higher than other age groups. The 19 to 34 age group used 158 days per 1,000 persons and the 35 to 49 age group used 120 days per 1,000 persons.

•For persons 18 and younger, psychiatric and substance abuse hospitalizations accounted for 30.6 percent of Aetna's total inpatient expenses (includes medical, surgical and psychiatric) for this age group.

•Of all hospital days used by those 18 and younger, 43.8 percent were for psychiatric and substance abuse confinements.

What does this mean? In general, it means that youngsters are admitted to mental health facilities on a par with other age groups -- but once in treatment, they stay longer and their treatment costs more than other age groups.

Two major questions emerge from these data. Is Aetna's experience similar to other insurers, and if so -- why?

The National Experience

Comparatively little claim data is available that separates the use of psychiatric and substance abuse treatment by youngsters

from other age groups. What is available generally supports Aetna's experience -- more extensive service and higher costs for adolescent treatment.

For example, one large Southern California public utility company reported a fourfold increase in adolescent psychiatric admissions between 1984 and 1985 alone. (6) A California defense contractor found that 66 percent of its hospital claims related to psychiatric disorders and that adolescent stays accounted for a large portion of the total. (7)

A Maryland-based self-funded company paid psychiatric costs of $2.2 million in 1986, representing 21 percent of its health care benefits that year. Of that total, $1.5 million was incurred by 69 teenagers, many of whom were treated extensively for drug abuse. The cost of inpatient care at some psychiatric facilities used was as high as $25,000 a month, almost $1,000 a day. (8)

Nationwide, the picture looks the same, with inpatient admissions for youngsters under age 18 rising 450 percent between 1980 and 1984. (9) Despite this alarming increase, the Congressional Office of Technology Assessment maintains that three quarters of the 7.5 million children who need mental health treatment do not receive it. (10) The American Psychiatric Association estimates that fully 12 percent of all schoolchildren show some level of clinical maladjustment and says the figure is unlikely to change. (11)

In Minnesota, where the youthful population is decreasing, admission of adolescents to hospital psychiatric units increased 25 percent in five years. Ira M. Schwartz of the Humphrey Institute at the University of Minnesota said many of these admissions were youngsters with behavioral or family problems. He noted that it was easy to admit them to a psychiatric unit on only the signature of a parent and an admitting physician. "Juveniles have been spending much longer in the hospital than adults, but there was no evidence that it takes longer to cure juveniles," says Schwartz. (12)

Are We a Nation of Troubled Children?

Why do youngsters receive more care than in the past? Are they more seriously ill, or do social and developmental factors sway their fate?

Today's youth, characterized by some media as living "flat" and colorless lives, are often described as lethargic, unmotivated youngsters who float through days and weeks as "episodes" of life without underlying continuity or purpose. Surrounded by pollution, national debt, homeless families and the possibility of nuclear war, they are publicly acknowledged as a troubled generation.

Troubled, perhaps -- but are they sicker than their predecessors? Growing sentiment among utilization reviewers and third-party payers suggests that a number of youngsters in psychiatric facilities are not mentally ill, but are being treated for behavioral or family problems in psychiatric settings. The spokesman for a large, nationwide provider of health benefits has said, "....children and adolescents were often admitted to psychiatric hospitals for custodial purposes. Now insurers are clamping down because, in some cases, these kids have behavioral problems, but aren't sick enough to need extensive hospitalization." (13)

Then how did the extensive hospitalization trend begin? Experts speculate, but no one seems to know for sure. In general, experts agree that our rapidly changing social environment has a great influence on adolescents, and often cite three specific areas:

Community supports: The demise of community supports -- extended families, church associations, civic clubs and youth affiliations -- means greater isolation for many youngsters. But some of these youngsters are used to isolation, coming from one-parent families due to divorce or intact families where both parents work. With less adult guidance at home, fewer adult role models in the community and less structured group activity, some young people

may have trouble developing social behavior that works favorably with peers and adults both.

Schools: Increasingly, parents want schools to play a larger role in guidance and development issues, but schools may not be equipped to expand their educational mission. Behavioral problems acted out at home are easily tranferred to school during the day. While it's not the role of schools to correct disruptive behavior, they must manage it to carry out their daily educational duties. Encouraging professional help for the problem child is a way to do that.

The courts: Today's judicial system is more willing to recommend mental health treatment for antisocial, delinquent or illegal behavior than the courts of 20 years past. In part, the growth of the mental health treatment sector has provided a resource for the judicial system that simply didn't exist two or three decades ago.

Legally, young people have little recourse. Psychiatric treatment need not be court-ordered. In many states, authorization from the child's parent or legal guardian, together with the treating physician, is enough to get the youngster admitted for, at least, clinical evaluation. Once in the system, these youths find abundant resources to treat them.

The Business of Mental Health

More mental health care is available today than ever before. The number of mental health treatment professionals rose from 50,000 in 1981 to 250,000 in 1986, according to the American Psychiatric Association. (14) Psychiatric beds in hospital systems increased 37 percent in 1985 alone. (15) The number of private psychiatric hospitals nationwide increased by almost 40 percent in 15 years, from 180 in 1970 to nearly 250 in 1985. (16)

Past generations avoided psychiatric treatment because of the attached social stigma. But yesterday's stigma is today's red badge of

courage. Now, a generation of babyboomers willingly seeks professional help for a variety of life's problems -- work-related stress, family and financial problems, divorce, death -- viewing it more as a commitment to personal well-being than as a sign of weakness. (17) Supporting the increased utilization is widespread benefits coverage for emotional problems, offered by 95 percent of employers responding to a recent survey on mental health benefits by the International Foundation of Employee Benefit Plans. (18)

But not everyone treated by the mental health system needs mental health treatment. A National Institute of Mental Health (NIMH) study in the early 1980s showed that one-third of all people who seek mental health treatment lack any symptoms that fit a mental health diagnosis, concluding that people now seek treatment for problems once discussed with family members or friends. Similarly, a 1986 poll of therapists by USA Today showed that marital problems are the most frequent reasons people seek treatment, followed by depression, relationships with co-workers and family members, low self-esteem and insecure feelings. More than 90 percent of responding therapists identified stress at home or at work as the key problem (19), indicating that the population at large sees the problems as significant reasons to consult a mental health professional.

Like all businesses, the mental health field has untapped "specialty markets" offering the best potential for attracting new customers. Providers of mental health care openly acknowledge that children and adolescents are a specialty market with high growth potential.

One company that recognized it was the Nashville-based Hospital Corp. of America (HCA), which increased the percent of its youthful inpatient population in 41 hospitals nationwide from 25 percent in 1983 to a full 50 percent three years later. Other provider systems, aware that insurers are working to contain extensive and possibly unnecessary hospitalizations, have begun

developing continuum of care services for youngsters that include inpatient, outpatient, partial hospitalization and residential programs. (20)

Psychiatric treatment for youth can be profitable. The president of an independent McLean, Va., mental health management firm estimated that psychiatric programs for children and adolescents can yield margins of up to 30 percent, compared to 20 percent margins for adult programs, due to higher occupancy levels and lengths of stay. Also, reimbursement may be less of an issue with youngsters, since many parents pay their children's treatment costs out of pocket. (21)

What Are the Alternatives?

No general consensus exists in the psychiatric community that longer lengths of inpatient stay produce better results. In fact, since the "deinstitutionalization" thrust of the '70s, when state mental health agencies began mass discharging of patients from state hospitals into community services, the trend in mental health care has been toward using the "least restrictive environment" suitable for a patient's needs.

Unlike the medical/surgical arena, where procedures are performed either inpatient or outpatient, the mental health arena offers more options for less restrictive settings.

Partial hospitalization programs that provide day care or evening care can be effective therapeutic environments for youngsters who need acute care but not 24-hour hospitalization. In many cases, residential treatment centers offer adolescents a 24-hour care environment but in a setting less restrictive than a psychiatric hospital. Group homes and halfway houses are two other residential alternatives to hospital settings. Extensive outpatient treatment, possibly including individual, group and family therapy, can also be arranged for youth who need mental health attention.

While youngsters' behavioral and family problems should be addressed and resolved, many do not require 30-day or 40-day hospital confinements. Increasingly, insurers are working with psychiatric practitioners to identify and use non-hospital settings for these youngsters when appropriate. This makes efficient use of employers' mental health dollars, which often carry annual maximums, stretching them farther and, in effect, getting more care for the dollar. It also promotes using the most appropriate level of care and mental health specialty for each patient instead of across-the-board hospitalization for all. In some cases, insurers use programs like Aetna's Individual Case Management to arrange coverage for treatment alternatives that wouldn't be included under the employer's existing benefit plan.

Many employers also use employee assistance programs (EAPs) to address the emotional or substance abuse problems of employees and their families. There are more than 10,000 existing EAPs today and the number is rising, according to the Association of Labor-Management Administrators and Consultants on Alcoholism. Many EAPS provide initial assessment and evaluation, as well as short-term professional counseling, thus avoiding use of mental health benefits altogether. When referral beyond the EAP is needed, company health benefit plans usually cover the services. But evidence suggests that up to 80 percent of problems can be resolved directly by an EAP when it offers professional counseling. (22)

Whether employers will continue to pay for psychiatric treatment for youngsters' behavioral and family problems remains to be seen. Aetna's claim experience with the under-19 age group shows that employers should be concerned about costs and about the services their dollars buy. Some employers have applied annual limits, higher copayments and lower coverage levels to their mental health benefits, and others have reduced psychiatric benefits where they are not mandated by state legislatures.

To protect and restore youngsters who require mental health care, psychiatric benefits in employer-sponsored plans must be preserved. To preserve them, employers' costs must be kept manageable. To do this, insurers, employers and practitioners must work together to identify and use the most efficient treatment for the individual patient.

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1987 Psychiatric and Substance Abuse Confinements
Total Population (males, females/employees, dependents)
Complete and Incomplete Confinements

Ages	# lives	% adms	Days/1,000	ALOS	% days	% Exp.
00-18	2,124,158	24.7	225.1	40.2	39.9	41.8
19-34	2,139,537	31.7	158.3	22.1	28.3	27.1
35-49	1,880,649	25.3	119.6	18.4	18.3	18.7
50-64	1,305,013	13.8	91.6	17.9	10.0	9.9
65+	723,418	4.5	50.4	16.7	3.0	2.5
Total	8,172,775	100.0	146.6	24.8	100.0	100.0

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NEWS

For Release:
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FACTS: EXAMINING HEALTH CARE COSTS

Health care costs are skyrocketing. People are living longer. They have access to more -- and costlier -- medical procedures than ever before. Their doctors, afraid of being sued, prescribe more tests and procedures. Diseases such as AIDS take their toll.

What's being done about the resulting cost spiral? One answer is a concept called managed care -- a partnership of the patient, doctor, employer and insurer working together to guide the use of health care resources.

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WHAT'S HAPPENING?

• Americans now spend $500 billion a year on health care. That's 11.4 percent of the GNP, and nearly twice what the U.S. military spends.

• Last year, the annual medical inflation rate hit 7.3 percent, while general inflation was only 4.6 percent.

• Per capita health care costs were $2,135 in 1988, up from $822 in 1978.

WHY IS IT HAPPENING?

Scientific breakthroughs and technological advances. They've improved the quality of life but carry a steep price tag. Just one premature birth treatment or liver transplant is $150,000; a heart bypass - $40,000.

Governmental limits on Medicare and Medicaid health benefits. Providers make up the difference caused by such cost-shifting by charging higher fees to non-Medicare/Medicaid patients.

A recent surge in use of outpatient services. Outpatient care is encouraged, when possible, to decrease inpatient care costs. As a result, outpatient costs have jumped 25 percent.

Increased psychiatric admissions. As hospitals experienced a reduction in patients, they increased the number of psychiatric beds to accommodate growing mental health utilization.

AIDS. The average medical claim for AIDS is about $50,000 per person. By 1991, the number of new AIDS cases will be five times as great as in 1986, according to the Health Insurance Association of America.

WHAT ELSE IS CONTRIBUTING?

Health care fraud adds at least $50 billion to our nation's health care bill every year, according to the National Health Care Anti-Fraud Association.

A rapidly aging population means more people than ever will require medical care.

Increased diagnostic testing has resulted from the increases in malpractice judgments.

A nursing shortage has forced hospitals to raise salaries to attract and retain staff.

HOW DO WE SOLVE IT?

Managed care -- programs that bring together the doctor, patient, employer and insurer to guide the use of health care resources -- helps keep costs under control while maintaining quality care.

These programs encourage employees, providers, employers and insurers to work as partners in care, help employees become more educated health-care consumers and eliminate unnecessary treatment and hospitalization.

Aetna's managed care effort focuses on health care networks, primarily a partnership with Voluntary Hospitals of America, the nation's largest not-for-profit hospital system. It also includes various utilization review, case management and precertification programs, as well as a HEALTHLINE, a toll-free line that assists employees in making health care decisions.

NEWS

For Release:

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HARTFORD, Conn. -- Aetna Life & Casualty has introduced an outpatient precertification program designed to reduce health benefits costs for employers while improving the quality of patient care.

Similar to the standard inpatient hospital precertification, the program reviews the need for 18 expensive and frequently performed outpatient tests and procedures. It also offers financial incentives to employees to seek review of the procedures.

The program aims to reduce costs and decrease the number of unnecessary medical procedures by providing patients and their doctors with timely, expert information, according to Constance M. Winslow, M.D., medical director of Aetna's Employee Benefits Division. The program is expected to reduce use of the outpatient procedures 10 percent, resulting in benefits cost-savings for employers, she said.

"Outpatient costs are increasing dramatically," Winslow said. "Utilization management in the outpatient setting is problematic, but we believe this is a great first step."

Equally important, she said, is the wealth of medical information and expertise the program places at the doctor's fingertips.

(MORE)

2-2-2 Outpatient Precert

"There are many medical procedures available today and in far too many cases, a procedure is not appropriate for the situation," Winslow said. "A cross-checking system managed by nurses and doctors raises a patient's comfort level."

Under the program, employees call an Aetna nurse on the toll-free HEALTHLINE number if they are scheduled for one of the 18 outpatient procedures. The nurse obtains clinical information from the patient and attending physician, asking questions based on a computerized model of established medical standards. The system then either certifies the procedure or indicates that it may not be medically appropriate and warrants further review.

Cases requiring further review are discussed by the patient's doctor and an Aetna-designated physician, and most are resolved at this level. If agreement is not reached, however, the case is sent to an Aetna regional medical director for final review.

Review for each procedure is based on indications for use set forth in the medical literature and established by expert physicians or medical societies. Academically based consultants developed the review guidelines for each procedure.

The 18 procedures include: cataract removal, knee arthroscopy, inguinal hernia repair, septoplasty, tonsillectomy/adenoidectomy, hammertoe repair, colonoscopy, carpel tunnel, coronary angiography, laparoscopy, bunionectomy, upper GI endoscopy, tympanostomy, cystocopy, CT scan (lumbar), CT scan (head), D&C (dilation and curettage) and strabismus repair.

NEWS

For Release:

Immediate

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HARTFORD, Conn. -- Aetna Life Insurance Co.'s health care cost-management programs saved its employee benefits customers $1.64 billion in 1988.

The savings -- representing 18.2 percent of medical and dental benefit payments -- are up nearly 12 percent over the 1987 total of $1.47 billion.

"We're pleased that our efforts to manage health care costs are paying off in so many areas and improving every year," said Burton E. Burton, president of Aetna's Employee Benefits Division.

The cost-management programs and their savings are as follows:

• Coordination of benefits, $1.15 billion in savings, up 3.5 percent. COB limits total benefit payments to no more than the total cost of health services when a patient is covered under more than one group benefit plan.

• Individual case management, $181 million in savings, up 49 percent. ICM seeks cost-effective alternatives to hospitalization, particularly for catastrophic cases requiring intense management.

(MORE)

5/89

 Cost Savings

- Dental consultant review, $70 million in savings, up 20 percent. In this program, Aetna's dental consultants review cases before treatment or after claims are submitted to determine whether such treatment is necessary and whether less expensive alternate treatment is appropriate.

- Medical necessity retrospective review, $69 million in savings, up 68 percent. Under this program, claims are reviewed to ensure treatment was actually required, and was appropriate, for a specific condition. Coverage is denied for medically unnecessary treatment.

- Surgical profiles, $60 million in savings, up 28 percent. Reimbursement is limited to reasonable charges for surgery, based on prevailing fees for various procedures in 250 geographical areas around the country.

- Medical profiles, $49 million in savings, up 26 percent. This program is similar to surgical profiles, but covers certain medical treatment.

- Dental profiles, $28 million in savings, up 13 percent. Reimbursement is limited to reasonable charges based on prevailing fees for various dental procedures in 250 geographical areas around the country.

- Fraud investigations, $19 million in savings, up 68 percent. Aetna's fraud investigation unit targets potential cases of health care fraud and, when appropriate, refers them to law enforcement agencies for prosecution.

(MORE)

3-3-3 Cost Savings

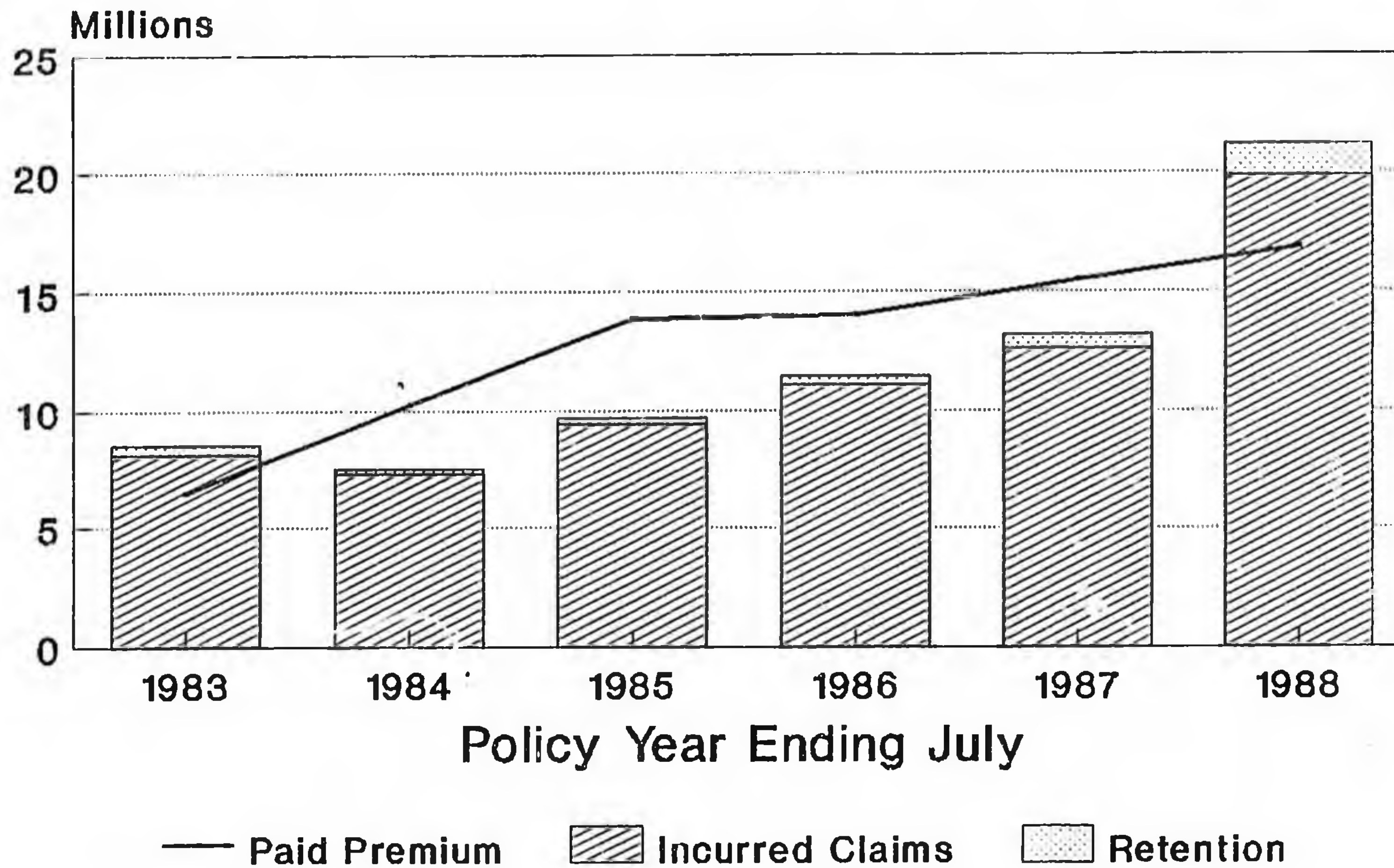
• Fast track, $9 million in savings, up 10 percent. In exchange for expedited claim handling, health care providers give Aetna a discount on payments.

• Hospital audits, $3 million in savings, up 29 percent. Using independent specialists, Aetna audits hospital bills to see that services on the statements were actually ordered by the physician, delivered by the hospital and used by the patient.

# # #

STATE OF ALASKA

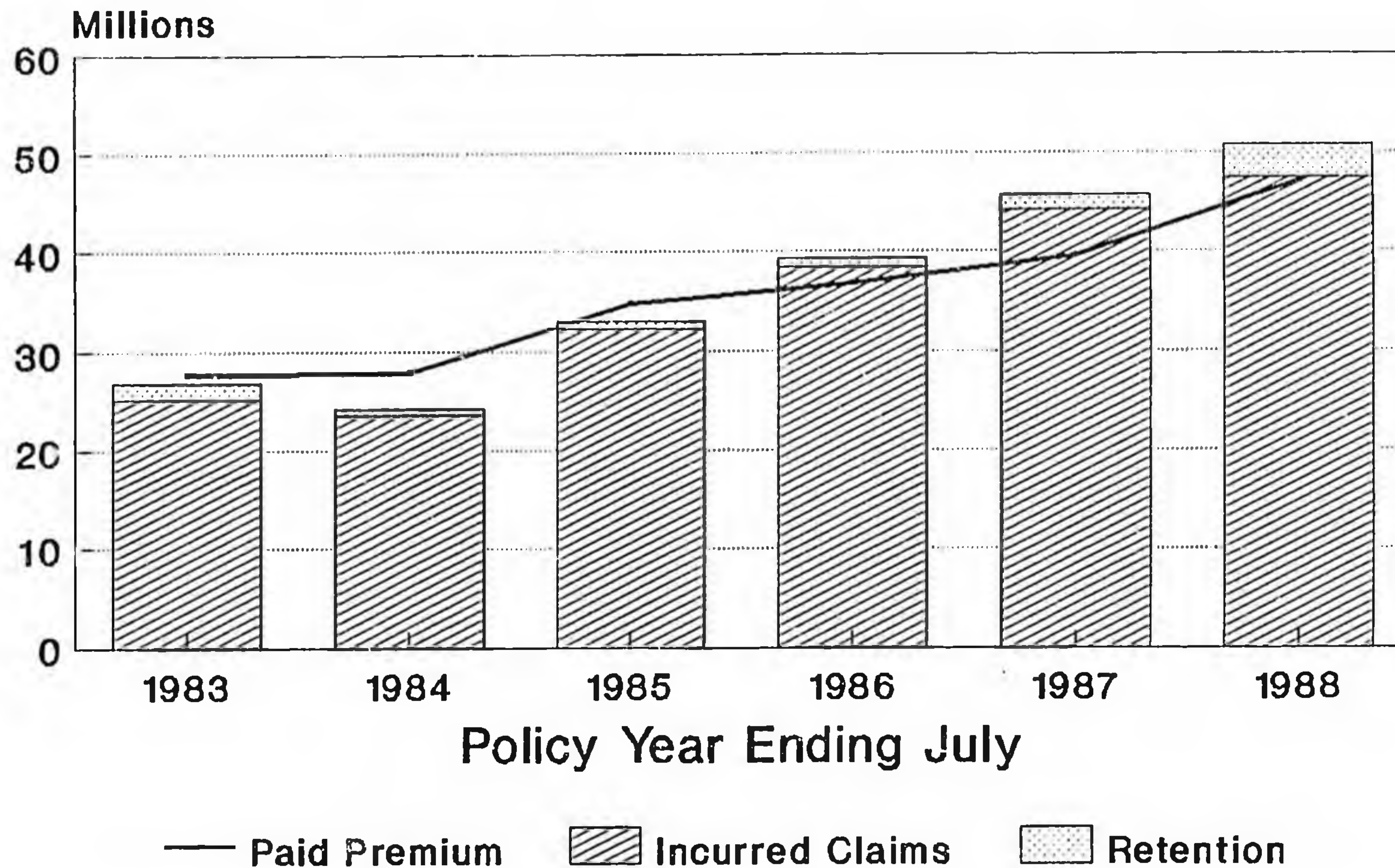
PREMIUM VS. INCURRED CLAIMS + RETENTION



RETIREES

STATE OF ALASKA

PREMIUM VS. INCURRED CLAIMS + RETENTION



ACTIVES