ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7537 SENATE LABOR & COMMERCE

Medicaid match through voluntary contributions. You should also consider writing President Bush, Department of Health and Human Services Secretary Louis Sullivan, and HCFA Administrator Gail Wilensky advising them of the importance of these financing options.

*NCSL STAFF CONTACT: JOY JOHNSON WILSON*

* **MEDICAL MALPRACTICE**: The initial component of the Bush Administration's health care reform strategy, a medical malpractice proposal, was unveiled on May 15th. States would be given three years to cap non-economic damage awards, eliminate joint and several liability, eliminate the collateral source rule, require periodic payments, promote alternative dispute resolution mechanisms, and implement procedures to enhance quality of care through enhanced effectiveness research and improved peer review. Beginning in 1995, states that enact a certain number of reforms would be eligible to share in an incentive pool.

A budget neutral pool would be created by (1) withholding 2 percent of the state Medicaid match for salaries and expenses, generating approximately $90 million in FY 1995; and (2) withholding a portion of the annual update for Medicare hospital DRG payments. States that enact reforms would receive enhanced Medicaid matching rates for program administration and their hospitals would receive supplemental payments. States that fail to enact reforms lose the Medicaid administrative matching funds.

*NCSL STAFF CONTACT: JOY JOHNSON WILSON*

* **BELLAS HESS**: On May 17, 1991, North Dakota's Supreme Court upheld the state's right to require out-of-state mail order companies to collect state sales taxes. The decision reached in *North Dakota v. Quill* favorably treated the state's expanded definition of a "retailer" for sales tax purposes. The Court concurred with the state's argument that there was sufficient contact or presence (nexus) in the state by direct marketers to require tax collection under the due process clause. The *Quill* decision followed two recent Tennessee trial court renderings that found that use of government services and modern technology, rather than, strict physical presence, satisfied Due Process arguments for requiring sales tax collections. The *Quill* case is expected to be appealed to the U.S. Supreme Court.

*NCSL STAFF CONTACT: SUSAN WOLFE*

***** All action requests are consistent with NCSL-approved policy. *****

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## . . . FEDERAL UPDATE . . .

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## COMPARISON OF SELECTED HEALTH REFORM PROPOSALS[1]

| FEATURES | PROPOSAL | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AHA | Pepper | Kennedy | AMA | Stark | NGA | USCC | BRT | HLC | NAM | ACP | AFL-CIO | NLC |
| **OVERVIEW OF PLAN** | | | | | | | | | | | | | |
| Approach | | | | | | | | | | | | | |
| pluralistic | X | X | X | X | | X | X | X | X | X | | | X |
| unitary | | | | | X[2] | | | | | | X[3] | X | |
| Access Assured | | | | | | | | | | | | | |
| universal | X | X | X | X | X | X | | X[4] | | | X | X | X |
| not universal | | | | | | | X[5] | | X | X | | | |
| **PRIVATE PROGRAM** | | | | | | | | | | | | | |
| Individual Mandates | X | X | X | | | | | | | | | | X |
| Employer Mandates | X | X | X | X | | | | | | | | X | X |
| phase-in | X | X | X | X | | | | | | | | | X |
| small employers permanently exempt | | | | | | | | | | | | | |
| minimum % of premium paid for full-time employees | 50 | 80 | 80 | | | | | | | | | | 75 |
| minimum % of premium paid for dependents | 50 | 80 | 60 | | | | | | | | | | |
| premium participation for part-time | X | X | X | | | | | | | | | | X |
| Subsidies/Tax Incentives | X | X | X | X | | | X | X | X | X | | | |
| employer | X | X | X | X | | | X | X | X | X | | | |
| individual | X | X | X | X | | | X | X | X | | | | |
| Cap on Tax Deductible Premium | | | | X[6] | | | | | | | | | |

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## COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

| FEATURES | PROPOSAL | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AHA | Pepper | Kennedy | AMA | Stark | NGA | USCC | BRT | HLC | NAM | ACP | AFL-CIO | NLC |
| Insurance Market Reform | X | X | | X | | X | X | X | X | X | | X | |
| reinsurance mechs./pools | X | X | | X | | | X | X | X | | | | |
| elim. pre-existing condition clauses | X | X | X | X | | | X | | | | | | |
| required community rating | | X | X[7] | | | | | | | | | | |
| **PUBLIC PROGRAM(S)** | | | | | | | | | | | | | |
| Organization | | | | | | | | | | | | | |
| single program | X | | | | | | | | | | X | X | |
| separate for different populations | | X | X | X | X | X | X | X | X | X | | | X |
| Eligibility/Basic | | | | | | | | | | | | | |
| everyone | | | | | X | | | | | | X | X | |
| poor | X | X | X | X | | | X | X | X | X | | | X |
| elderly/disabled | X | | X[8] | X | | | X[8] | X[8] | X[8] | X[8] | | | X[8] |
| others on buy-in | X | X | X | | | | X | X | | X | | | X |
| Eligibility/Catastrophic | | | | | | | | | | | | | |
| everyone | X | | | | | | | | | | | | |
| public program enrollees only | | X | | | X[9] | | | | | | | | |
| Funding | | | | | | | | | | | | | |
| federal | X | X | X | X | X | X | X | X | X | X | X | | X |
| state | | X | X | X | X | X | X | X | X | X | X | | X |
| premiums | X | X | X | | X | X | | | | X | X | | X |
| individual income-related | X | X | X | | X | X | | | | X | X | | X |
| service specific | X[10] | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AHA | Pepper | Kennedy | AMA | Stark | NGA | USCC | BRT | HLC | NAM | ACP | AFL-CIO | NLC |
| employer | X | X | | | X | | | | | | | | X |
| Administration | | | | | | | | | | | | | |
| federal | X | X | | | X | | | | | | | X | |
| federal/state | | X[11] | X | X | | | X | X | X | X | | | X |
| private as TPA | X | X[11] | | X | X | | X | X | X | X | | | |
| private as underwriters | | | | X | | | | | | | | | |
| BENEFITS | | | | | | | | | | | | | |
| Federal Definition Of Minimum Benefit | X | X | X | X | X | X[12] | | | X | X | X | X | X |
| applies to public plan | X | X[13] | X | X[13] | X | X | | | X | X | X | X | X |
| applies to private plans | X | X | X | X | | X | | | | | | X | X |
| Preemption or elim. of state mandates | X | X | X | X | | | X | X[14] | X[15] | X[16] | | | |
| Scope | | | | | | | | | | | | | |
| basic | X | X | X | X | X | X | | | X | X | X | X | X |
| catastrophic | X | X | X | | X[17] | | | | | | | | |
| preventive | X | X | | | X | X | | | | X | X | | X |
| long-term care | X | X[18] | | X[19] | X | X | | | | | | | |
| Limits | | | | | | | | | | | | | |
| quantitative limits on services | | X | | | X[17] | | | | | X | | | |
| dollar limits | | | | | | | | | | | | | |
| marginal services excluded | X | | | | | | | | | | | | |
| medically necessary & reasonable | X | X | X | | X | | | | | | X | | |
| high front-end deduct. and copays | X | X | | | X[20] | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | AHA | Pepper | Kennedy | AMA | Stark | NGA | USCC | BRT | HLC | NAM | ACP | AFL-CIO | NLC |
| **IMPROVED AFFORDABILITY** | | | | | | | | | | | | | |
| Federally-Administered Controls on Prices or Total Expenditures | | | | | X | | | | | | | X | |
| State-Administered Controls on Provider Prices or Total Expenditures | | | | | | X | | | | | | | |
| Optional Use Of Public Program Rates By Private Insurers | | | | | | | | | | | | | X |
| Incentives Operating Among Purchasers, Providers, And Consumers With Negotiated Payment | X | | | | | | | | X | X | | | |
| Required Management Of Care | X | X | | | | | | | | X | | | |
| all care | X | | | | | | | | | | | | |
| only selected services (e.g., long-term care) or selected populations | | X | | | X | | | | | X | | | |
| Promotes Management of Care | | X | | | | | | X | X | | | | |
| Disclosure Of Provider Cost And Quality Data | X | X | | | | | | X | X | X | | X | X |
| Guidelines On Technology And Special Services | X | X | | | | X | | X | | | | X | |
| Use Of Medical Practice Parameters | X | X | | X | | X | X | X | | | | X | X |
| Tort Reform | X | X | | X | | X | X | X | X | X | X | X | X |
| Anti-trust and Other Legal Reforms to Promote Cost Containment | X | | | | | | | | | X | | | |
| Promotion Of Living Wills And Advance Directives | X | | | | | | | | | | | | |

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## Endnotes

1. Some of the proposals are at the "principles" stage and may change significantly. Please refer to the attached summaries for the source and status of the information reflected in this chart.
2. Rep. Stark's proposal calls for public program coverage of all Americans for basic coverage, but it also mandates that employers supplement basic coverage with private coverage if they currently provide more than MediPlan's benefit package. Consequently, this "maintenance of effort" provision takes on some of the character of a pluralistic system. MediPlan LTC is completely public.
3. ACP's position paper presents a national universal financing plan as its long-term goal, but concedes that the immediacy of current access problems may make it necessary to suppport incremental expansions in insurance coverage through Medicaid expansions and, perhaps, an employer mandate. The recommendations presented in their paper are limited to the long-term goal.
4. While BRT's principles call for universal access, the program elements reflected in the principles would not provide for universal access.
5. The USCC adopted a long-term goal of universal access through a pluralistic system, but its proposal is limited to an expanded Medicaid program and a series of provisions designed to improve access to affordable private insurance.
6. Also includes tax-exempt rebates to employees selecting insurance plans with premiums less than those of employer's other plans.
7. Community rating would be required only for the system of regional insurers who would provide insurance to small businesses.
8. Does not propose any alterations of the Medicare program.
9. Catastrophic protection provided only for low-income enrollees.
10. Premiums would be service specific only for expanded benefits to current Medicare beneficiaries whose premium and cost-sharing levels for current services would be grandfathered under the new public program.
11. Presented as one of several options.
12. NGA splits this responsibility between federal and state governments: the federal government would establish guidelines for minimum benefits, while state governments would be responsible for establishing a process to develop, determine, and define the specific benefit package.
13. Enriched package under public plan.
14. BRT would eliminate any federal or state mandated benefit laws.
15. Exemption from state mandated benefit laws would appear to apply only to small employers.
16. Provides exemption from state mandated benefit laws only for basic catastrophic plans.
17. Quantitative limits for hospital care benefits and cost-sharing are eliminated for low-income individuals, thereby providing for some catastrophic coverage for the poor.
18. Means-tested.
19. Asset protection plan.
20. High front-end deductibles and copayments would apply only to long-term care coverage.

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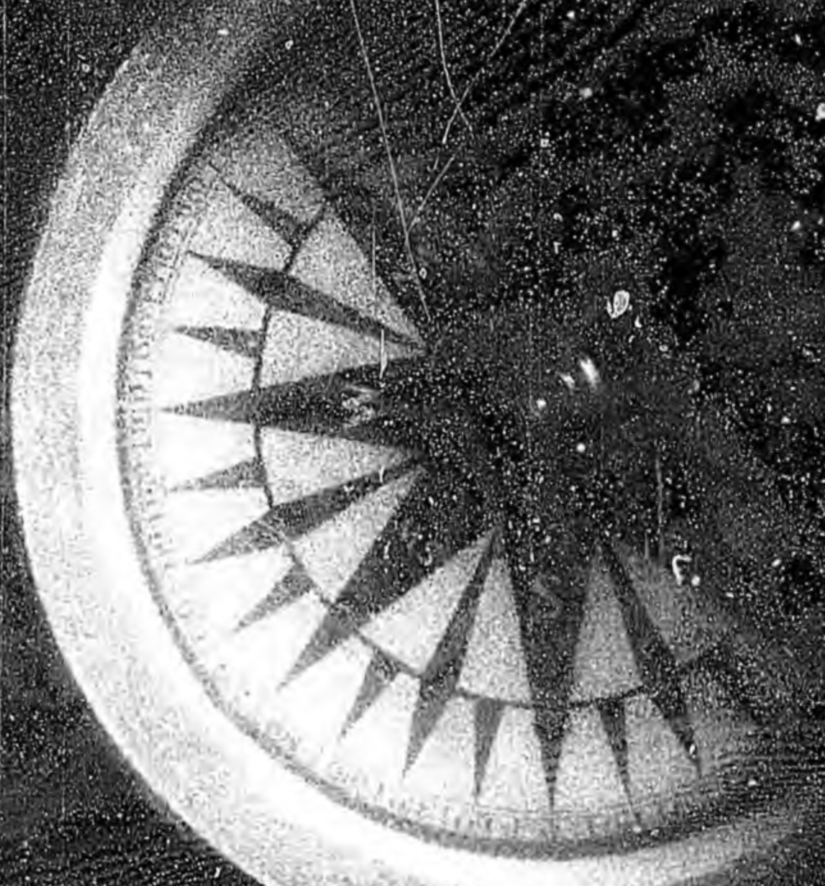


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The Official Publication of The National Association of Life Underwriters

Special Issue

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## FOCUS ON CLIENTS



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# EDITOR'S NOTES

# Is There Still Hope For Free Enterprise?

Whispers are starting in the corridors of Congress. Grumbles are growing louder in corporate suites. There is a sense of inevitability at some insurance companies.

It seems that politicians, doctors, consumers and even insurance executives are wearying of the fight to keep health-care costs down. After great sighs, they are beginning to murmur, "maybe a national government-run plan wouldn't be so bad."

It almost certainly would.

While the concept of government as Universal Nanny loses its intellectual force around the world, here in the home of capitalism there is a growing desire to cut private enterprise out of the health-care system as if that would somehow solve our health-care delivery problems.

It almost certainly would not.

True, health-care costs are difficult to restrain. Also true, the current system needs substantial change to cover the uninsured and guarantee cost-effective health care for all. But it's a long leap from that to a giant government bureaucracy doling out health care like food stamps.

Without the influence of market forces, health-care costs will rise even faster. Without competition among providers and between insurers, and without pressure from corporations to keep employee benefit costs down, the price spiral will get worse.

In Canada, Great Britain and other countries with socialized medical systems, government health care has lead inevitably to government rationing of health care and, after a brief pause, a renewed price spiral. History shows us that modified capitalism—a market economy to distribute goods combined with a safety net for those who cannot compete—is the fairest, most cost-effective and productive way to distribute goods and services. Insurance is the critical element in a free enterprise medical system, and the stresses and strains on the insurance business have been immense. Of course, in many ways the insurance industry is simply the bearer of bad tidings, being blamed for a message no one wants to hear. We bring the message of over-utilization, cost shifting, waste and misapplication of resources.

Nonetheless, there is a real question whether or not the system will survive. Can those concerned, including our industry, creatively modify what doesn't work and keep what does? Can we as a nation manage to keep choice possible? Does the most technically advanced medical system in the world have any hope at all?

Those are the questions we thought deserved a special 13th issue of *Life Association News*. And after thousands of hours of research and hundreds of interviews, we can say with confidence that some tremendously intelligent and energetic people across the country, especially in the insurance industry, are working very hard to preserve the best parts of our system.

There is still hope, they told us, but time is running out for an industry solution, for a free-enterprise solution.

Ian Mackenzie

VIEW POINT

# High-Tech Ambulance Chasing

Back in the depression days of the 1930s, entertainment was delivered mostly by radio comedians who could articulate visual pictures in their routines. One such comic used to tell the story of a lady who slipped on a banana peel and before she hit the ground three lawyers were there asking to handle her lawsuit. This story, and others, popularized the term "ambulance chaser" as applied to lawyers specializing in personal injury lawsuits.

Today, such lawyers no longer wait for the accident to happen before pursuing their client. They now advertise aggressively to precondition the public to the notion that if anything out of the ordinary occurs, a lawsuit is the only solution.

Insurance companies, doctors and others offering professional services in this way are characterized as something just short of the devil himself. In contrast, the lawyer is portrayed as a modern-day St. George slaying the dragons of incompetence and oppression.

Ambulance chasing was not regarded as an honorable occupation during the depression—but rather a survival technique. In my view, the use of the electronic media and other high-tech communications has not changed that perception, despite the pious proclamations in their ads. Most lawyers I know are embarrassed by these activities and decry the damage being done to the image of an otherwise honorable profession. They privately admit, however, that it is not likely that the rest of the legal profession will be able to control this practice.

Unfortunately, the image of the legal profession is not the major problem created by this activity. Because we have thus become the most litigious society in the world, the price of almost all goods and services produced in our country carries a surcharge to cover the cost of this extravagance.

Nowhere is this more evident than in the cost of delivering health care. Admittedly there are many contributing factors to the high cost of health care, but litigation is probably the least essential.

One can understand the need for extra professional hands during surgery as well as standby machines and personnel in case of problems. But I don't think we need a standby lawyer eager to make a case.

By Jack E. Bobo, CLU, FLMI, NALU Executive Vice President

I cannot say with certainty how much the proliferation or threat of litigation increases the price of health care, although I have seen numbers that are frightening. It has been estimated that the overall cost of health care adds $700 to the cost of producing a car in the United States as compared to $300 in Germany and $200 in Japan. Malpractice litigation is virtually unknown in either Japan or Germany—so draw your own conclusion.

If excessive litigation cannot be curbed, what is the answer? In my report to the National Council last September, I suggested that the time had come to design around the problem. We do need to care for and indemnify casualties of the health-care delivery system—but the tort system is outmoded and too expensive.

**There are many contributing factors to the high cost of health care, but litigation is probably the least essential.**

Others have reached similar conclusions. In 1988, Sarah Christianson, ASA, Ph.D., an actuary with the Principal Financial Group, wrote an essay as part of her actuarial studies that outlined a plan much along the lines of my September report.

Her proposal would establish a system giving patients free medical and rehabilitative care for anything related to error or negligence. In exchange, a patient's right to sue would be limited to four narrowly defined situations. Frivolous suits would be subject to a penalty of all trial costs. She further proposed that funding be a flat percentage (probably less than 5 percent) of all medical fees. The benefits and cost savings of the plan are too numerous to mention here.

My hope is that a full text of her proposal will be printed in a subsequent issue of *LAN* along with any additional insight she may have. I believe the concept is viable, but much thought and preparation must precede any effort at implementation. I would be very interested in hearing from anyone else who has pondered this question. Any proposal for health insurance reform that omits the tort question is, in my view, grossly inadequate. ■

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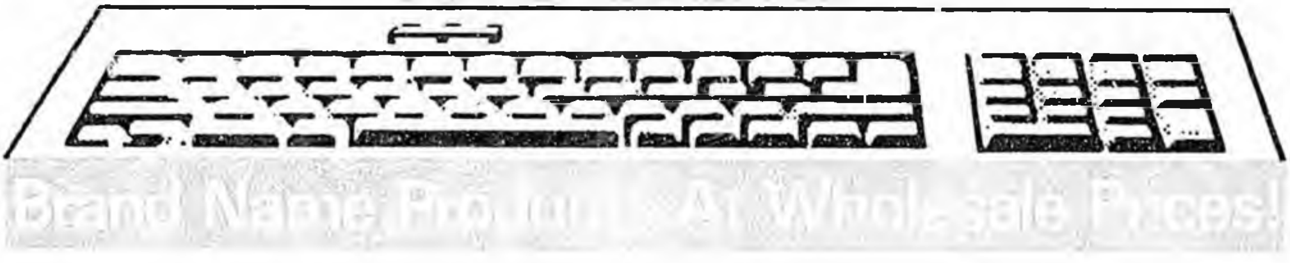

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# The Baby Is Healthy

Just one year ago, the National Association of Life Underwriters (NALU) initiated the development of our health conference, the Association of Health Insurance Agents (AHIA). A lot has taken place in 12 months and we now have a strong and growing youngster.

During initial organization, discussion focused on what should be done, who would be affected and how to begin. By now you are seeing activities that respond to these questions. AHIA is off and running.

Still, some members continue to ask, "Why should I become involved in AHIA?"

Most of the members of our state and local associations sell or buy health insurance. Every member pays taxes that directly or indirectly support health insurance programs and policies at both national and state levels. In addition, every member has a personal opportunity and responsibility to vote for the people who pass the laws that affect and control so much of our health care, health delivery and health financing.

Health care and health insurance directly impact all of us. Those members who are heavily involved in health insurance work are familiar with the complexity of the problems, the elusiveness of solutions and the moving targets of legislation and regulation. Never in our industry has there been a more complex arena than health and never has there been greater need for better understanding of these subjects. Because health hits home to all of us, there is no one who isn't affected.

Most of us also recognize that no single person, organization or group has a monopoly on solutions to our health concerns. If it did, the problems we face would not exist. NALU has a direct responsibility to its membership to maintain high visibility and activity. Addressing the needs and concerns of 140,000 life and health underwriters gives us a strong presence where it is needed—in Congress, in state legislatures and in other industry organizations. Through our state and local associations, our positive, visible involvement gives legislators, companies, agents, consumers and other organizations an added dimension as they view the problem and search for realistic solutions. It is not a matter of which group; it is a need for all groups to work together.

By John N. Neighbors, CLU, LUTCF, NALU President

To date, hundreds of you have stepped forward to join and work for AHIA. You are creating a strong organization that will capitalize and focus on what NALU has been doing for many years. Similar to the birth of the General Agents and Managers Conference (GAMC) and the Association for Advanced Life Underwriting (AALU), we have brought together under the AHIA banner a team of leaders and specialists who provide the expertise, direction and motivation necessary to bring health insurance activities to the forefront.

Those who join AHIA will benefit directly from the programs and services of the health conference and all of NALU will gain, making the entire life and health insurance industry stronger as a result. The bottom line is better health care and more effective financing of health-care delivery for all Americans.

**The bottom line is better health care and more effective financing of health-care delivery for all Americans.**

There are always reasons, and people to dig up reasons, for not doing something. I've heard most of them relating to the health conference. They've ranged from excessive dues to potentially harmful impact on other industry groups. I'm glad these members spoke out, because along with the negatives came some very valuable ideas and suggestions about the conference. There is no monopoly on brains within NALU. The best ideas and the best input have always come from individual local members, both new and old, from locals large and small. With your input, we've created a better conference. From your criticism, we maintained sensitivity to all points of view. Keep those cards and letters coming, because putting a label on the door, creating another group, is not the objective, just the beginning.

If the health insurance industry is to be a major player in the solution of the nation's health care problems, and if agents are to be involved, all of us must come together. We must talk together and we must work together. ■

# The Health-Care Crisis: Time Is Running Out For An Industry Solution

By Chuck Jones, *LAN* Associate Editor

Ask anyone. Health care in America is in trouble.

Ask doctors and hospitals; they'll tell you they're losing money. Ask the public; they'll tell you they can't afford to buy insurance, and the coverage they can afford has such high out-of-pocket expenses and strict underwriting exclusions that they aren't getting the care they need. Ask the insurance companies; they'll tell you outrageous medical inflation is driving premiums up and that critics are making them the scapegoats.

Whatever the cause, more than 30 million Americans have no health insurance and no secure access to health care. While the exact number of uninsured has often been the subject of heated debate, no one disputes that it is in the millions—and the U.S. Census Bureau counted 31.5 million uninsured during the last census.

Particularly worrying is that many of the uninsured are not poor or out of work. According to government studies, about two-thirds of the 31.5 million are "working poor"—people who are employed but whose employer does not offer a health-care plan and who can't afford to buy one on their own. Only the remaining third are unemployed or destitute.

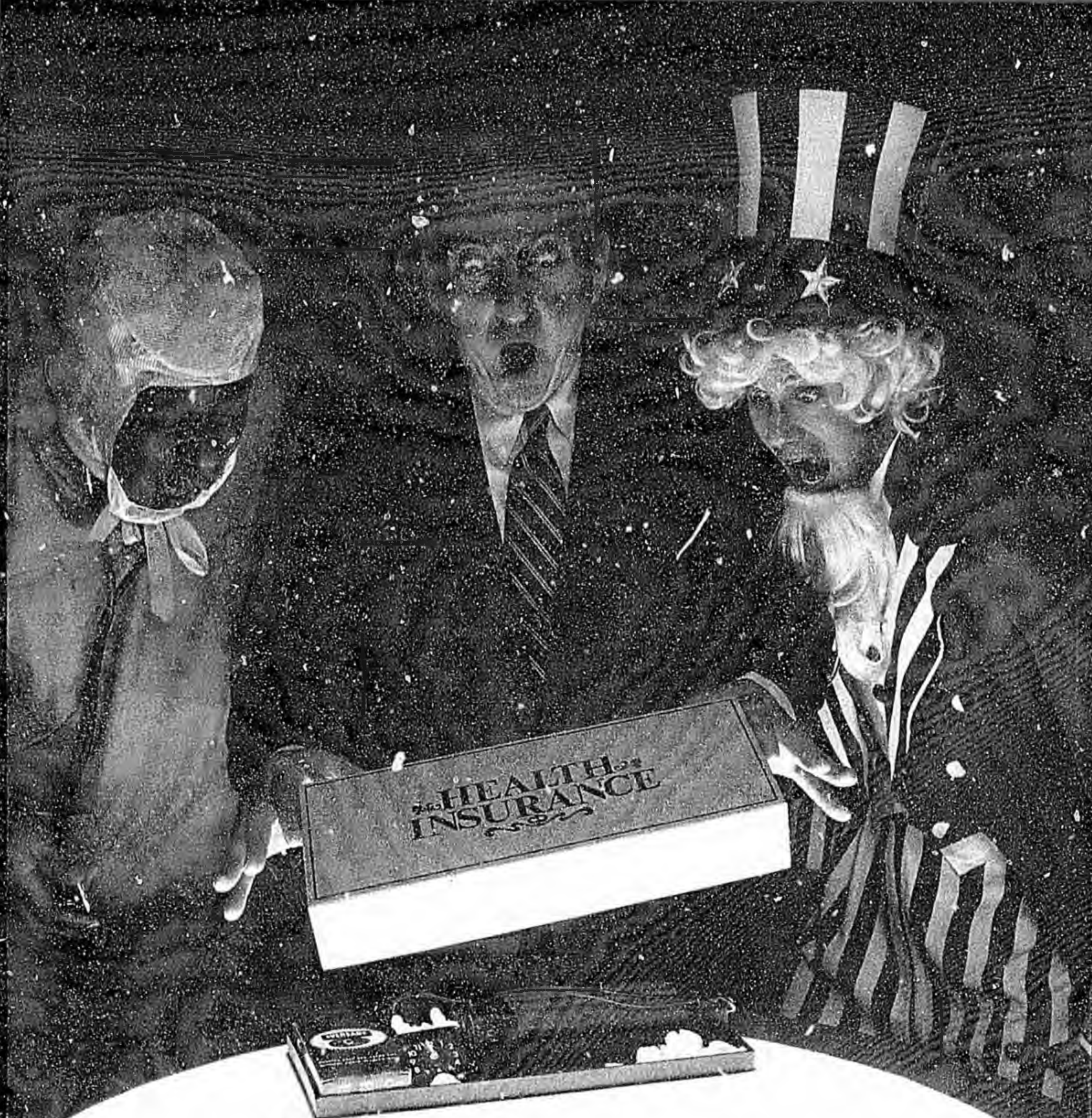
Although the United States spends more on health care, in absolute terms and as a percentage of gross national product, than any other country, many believe we are not getting our money's worth. Theodore Jay Gordon, chairman of the Futures Group, a respected research and trend analysis organization, believes that America is not getting good value even for those people who have access to health care.

The United States spends twice as much on health care as Japan, according to Gordon, yet infant mortality is twice as high. Similar comparisons can be made with most other industrialized nations.

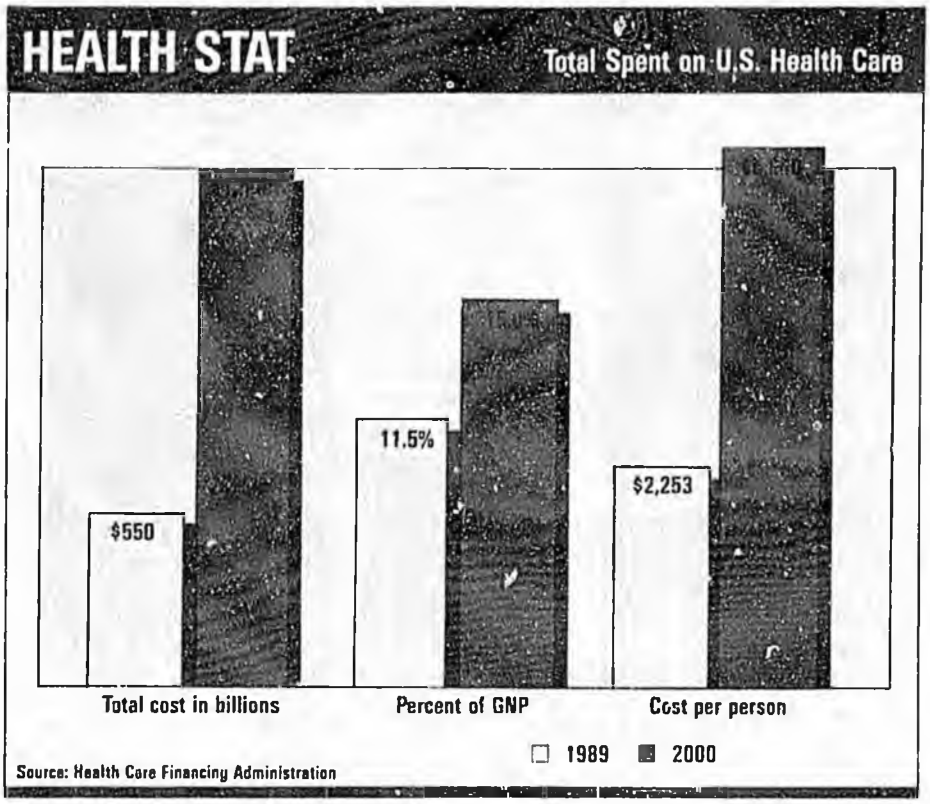
While the United States is the acknowledged leader in medical research and sophisticated medical technology, it is failing to deliver the fruits of its medical labor to the people who need it. The American system, Gordon says, simply allows too many to fall through the cracks.

The federal government and the insurance industry are beginning to take notice. The two most frequently proposed plans in Congress for cov-

PHOTO DAN GLASS




**With over 30 million people without health-care coverage in the United States, a revolution of sorts is taking place. Just how are these people going to get health care — and who will pay for it?** ■




ering the uninsured are a national health-care program, similar in structure to Canada's, or a requirement that employers provide health-care coverage to employees and their dependents. While these proposals are meant to broaden the public's access to health care, there are unanswered questions about both.

### THE CANADIAN SYSTEM: FOR AND AGAINST

The Canadian system is itself beginning to experience many of the same cost-control problems as the American system, but with rationing added to the mix. However, federal legislators increasingly believe that any solution to our health-care woes must be national in scope and will likely have to come out of Washington.

The government's argument for creating a Canadian-style system is that not enough people are adequately covered. They can't afford medical coverage and insurance companies aren't eager to sell it to them anyway. In response to public outcry and to special-interest sob stories, Congress is looking cautiously to enact some sort of national health-care legislation.

The Pepper Commission, a bipartisan congressional group that conducted a two-year study on comprehensive health care, recommended that the United States adopt a national health-care program. In addition, many legislators, including Rep. Fred Grandy (R-Iowa), Rep. Dan Rostenkowski (D-Ill.) and Rep. Fortney Stark (D-Calif.) introduced universal access to health-care bills in the House during the last Congress.

None of them went anywhere, but Sen. John D. Rockefeller IV (D-W. Va.) will introduce another universal-access bill, based on Pepper Commission recommendations, in Congress this year. Although chances of passage seem slim, it is likely to get widespread coverage from the press and much public support.

If Congress does enact a national health-care system, the general public will take its lumps as the program eventually leads to health-care rationing. It seems almost inevitable. Other countries with national plans ration their health care.

While Rockefeller and others feel that a national health program similar to those in England and Canada would work in this country, Robert Murray MacMillan, M.D., executive director, Health Insurance Division of the Ontario Ministry of Health, disagrees.

According to MacMillan, a number of things would happen under a national plan: Waiting lists for surgery, restriction or refusal of elective treatment and surgery, and the government could simply cut off the care when their money runs out. It's happened in Canada, he says.

A Canadian-like health-care system probably would have initial public support because "Americans can't conceive of not getting health care if they can't afford it," MacMillan says. But such support would not last long because taxpayers would revolt at having to pay more taxes to fund the program while getting less coverage and having services rationed. "Canadians are far more tolerant of taxes," he says. "We have to be."

What's a government to do? If it doesn't ration, money will be sucked out of worthy existing social programs and the U.S. federal deficit will grow faster than it currently does, MacMillan says.

Think of how popular rationing will be with the American public. The federal government will be deciding who gets care and who doesn't; the elderly most probably will be shut off from expensive health care in favor of treating younger patients, and those with chronic and terminal diseases may be passed over for treatment because "wasting" money on them "would not be worth it." The government, in effect, would be deciding who would live and who would die.

Consider the following scenario:

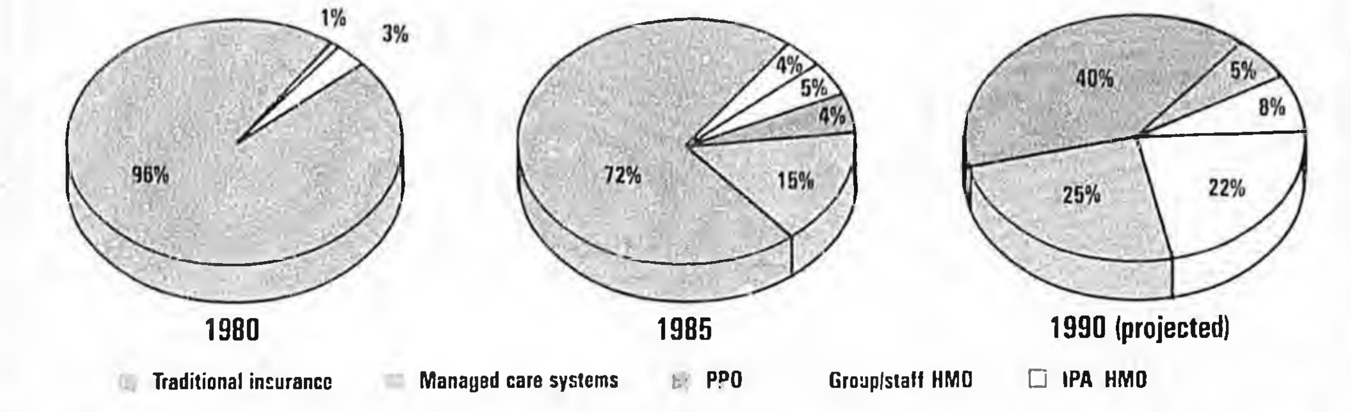
You're 61 years old with diabetes and your kidneys give out. Dialysis would prolong your life by maybe eight to 10 years, but dialysis costs $600 per session, and you need to go three times a week. Add to that the cost of therapy, transportation and medication and you're looking at well over $100,000 a year.

Over 10 years, the government will have spent more than $1 million on you: You, who are approaching retirement and will no longer be productive to society. You, who will only get progressively worse and will almost certainly need hospitalization several times over 10 years. You, who already have diabetes and will die relatively soon anyway.

So why not do it now? asks the gov-

# HEALTH STAT

Enrollment in Private Health Insurance By Plan Types




Source: December 1989 *Business & Health*

ernment, who, after all, is controlling the money and care. Die now, avoid the suffering and (incidentally) save your fellow taxpayers the expense. By the way, do you know how many children—who have bright futures and long lives ahead of them—we can treat for the $1 million we would spend on you?

Pretty cold, isn't it? Your 10 years of life has just been converted into a $1 million savings to the government. It could happen.

### MANDATED EMPLOYER COVERAGE: FOR AND AGAINST

The other popular notion on Capitol Hill—forcing employers to provide coverage to their full-time employees and their dependents—has received mixed reviews.

The Pepper Commission has recommended that the United States force employers to provide the coverage, but the business community is quick to point out that requiring employer-provided health care could cause massive small-business failures and make big business less competitive internationally.

"I don't know if it's going to put [small business] out of business, but it's certainly not going to help them," says J. Beryl Clifford, CLU, RHU, secretary of the Association of Health Insurance Agents (AHIA), a conference of the National Association of Life Underwriters (NALU). "If they can't afford to provide benefits now, how are they going to provide them if the government says they have to?"

When a company is forced to buy insurance, the agent's role is diminished, Clifford says. "They're going to say 'I have to buy this. I don't have to wait for an agent to come and sell it to me, so why do I need an agent?' "

Optimists say this approach may, on the other hand, create business for health insurance agents. If an employer must buy coverage, the thinking goes, then he'll seek out an agent. Pessimists say small businesses would wind up hiring only part-time workers and those who have no dependents.

Further, because an employer mandate would involve minimum federal standards, some industry observers believe that companies now offering excellent group health plans will be tempted to switch to cheaper plans that offer only the minimum.

Consider the following scenarios:

■ The Mom & Pop Shop employs 10 full-time people. Suddenly, they're forced by law to pay for a group health policy to cover all 10 and their dependents (and small-group rates are pretty expensive). They can't afford to do that because they measure their profit in pennies.

Regretfully, they reduce the number of hours they give each employee, change their status from full time to part time, and hire 10 more part-time workers to take up the slack. Not only is this a shock to the employees, many of whom will quit to find work elsewhere, but mom and pop now have a reorganizational nightmare to contend with and their business could quite possibly go under.

■ Super Shop, a small, but very profitable convenience store in a good location, employs 12 people. The owner can afford a high-quality small-group health plan for his employees—low deductible, low copayments and a lot of benefits.

Along comes the federal minimum standard for employee health coverage, and it's almost 50 percent cheaper than the current plan. The benefits are almost nothing compared to what the shop currently offers, but he switches to the less expensive plan anyway because it's cheaper. Why not? He's a businessman and he wants to maximize his profit. But that leaves his employees paying more money for less coverage.

### ALTERNATIVES

Fortunately, the federal government isn't the only one that thinks it has answers. The insurance industry and other business sectors have ideas on how to better solve the problem of access to health care.

While many of these solutions are interesting, some would not be too effective: "IRAs for health insurance," proposes Theodore Gordon. He suggests the government allow Americans to set up private, tax-free bank accounts to pay for catastrophic health care later in life. Unfortunately, this idea would only work for the upper and middle classes—those with

money to save. It won't work for those with low incomes—the very people who need health-care assistance most.

But it is very much in the interest of the health insurance industry to find alternatives to these radical proposals. Containing and managing cost is the only equitable solution from the insurance industry's point of view. Companies, for example, are looking into case-management and cost-containment programs to bring the astronomical costs of health care down and to keep them in check.

One insurance company organization that leads in this area is the Health Insurance Association of America. Its cost-containment and case-management programs are the model that several companies follow to try to keep costs—and hence premiums—down. (For more on what companies and agents are doing in the area of cost containment, see the article on page 28.)

Although some doctors and hospitals are making an effort to reduce the cost of health care, there is little they can do without losing money, according to Dr. James S. Todd, executive vice president of the American Medical Association. "One cannot really expect health-care costs to diminish under any system as long as the population continues to age. The older a person is, the more health care he utilizes."

Todd says that the only way providers can cut costs is to make harder decisions on who gets treatment and who doesn't. "We're going to have to make sure that we only give care that has a reasonable probability of being successful," he says.

While there are no specific bills currently in Congress that would prohibit the federal government from adopting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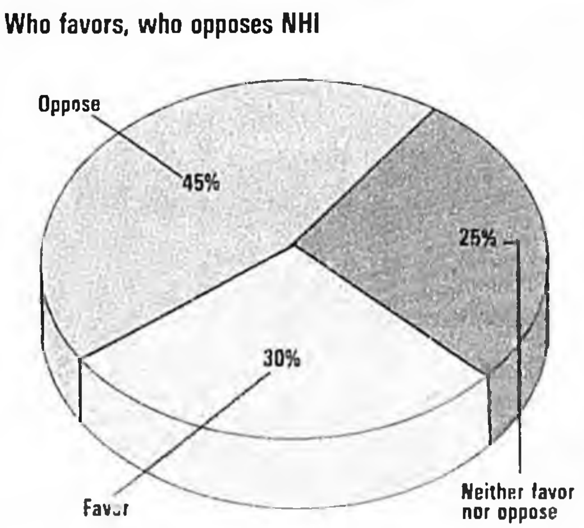
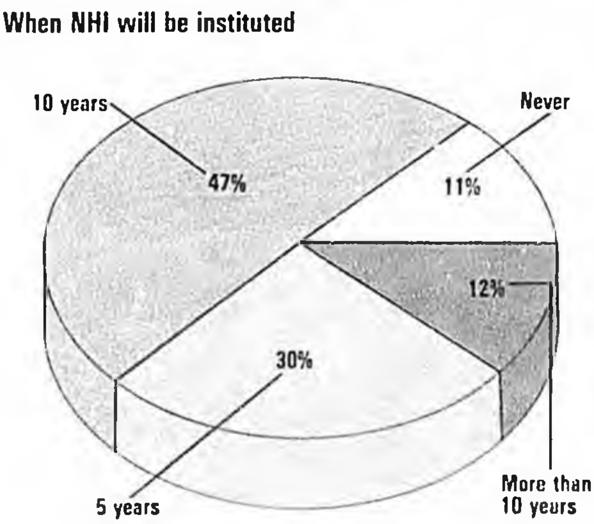
## HEALTH STAT

**What Executives Think About National Health Insurance**




Source: April 1990 *Business & Health*

> **"If they go to a plan like the Canadians have done, there'll be no place for an agent in the scheme of things. It would, in effect, put the health insurance business out of business."**
>
> —*Beryl Clifford*

a national health-care program, a private-sector solution is still possible, according to David E. Hebert, Counsel, NALU Government Affairs. There are several bills in Congress that would allow more liberal tax credits to those employers who provide coverage for their employees and to those who are self-insured, Hebert says.

The effect on the health insurance industry of a government-sponsored health program that gives everyone access to health care is obvious: Health insurance sales will plummet and those agents who make their living selling it may find themselves out of work.

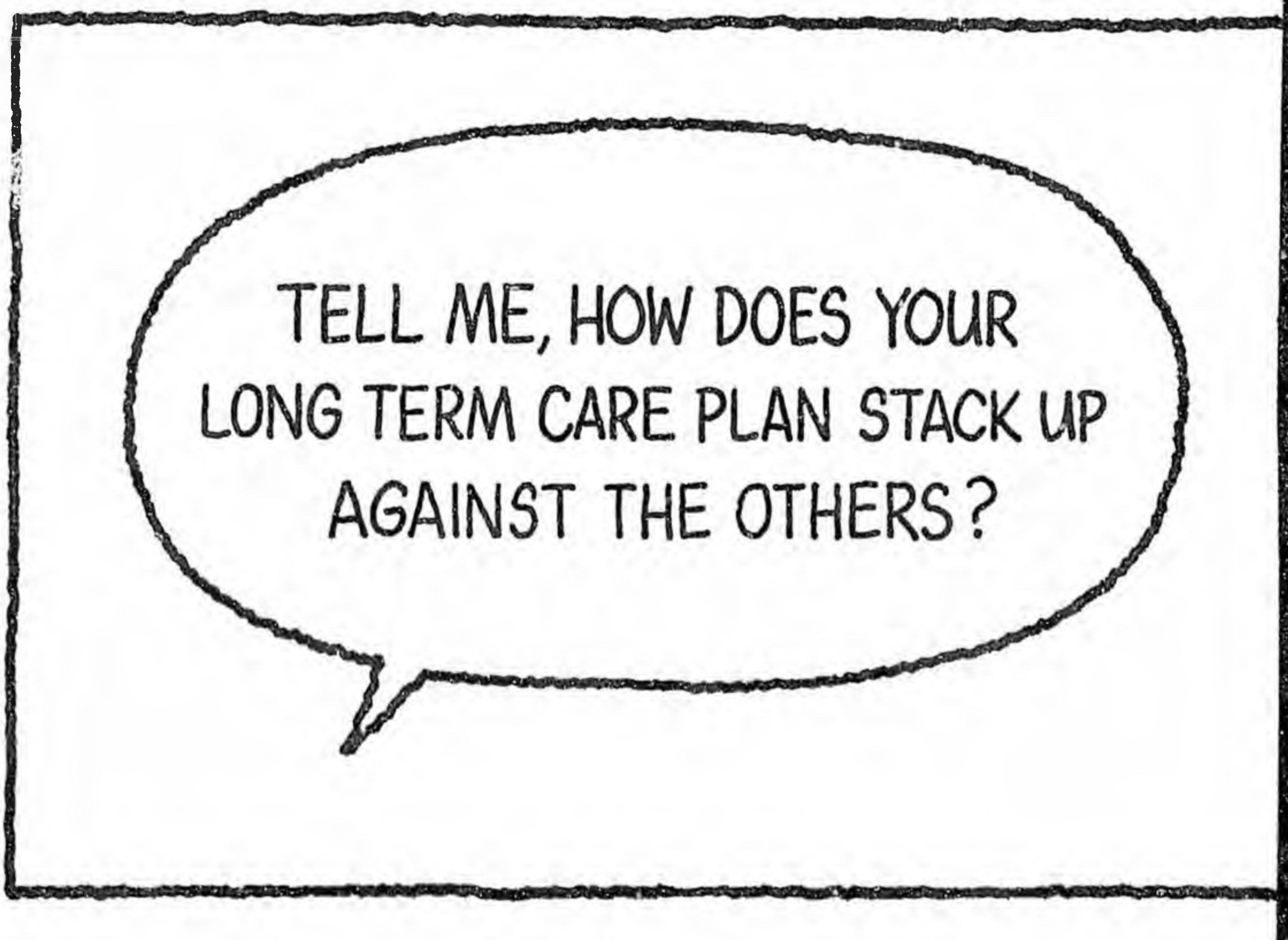
"If they go to a plan like the Canadians have done, there'll be no place for an agent in the scheme of things," Beryl Clifford says. "It would, in effect, put the health insurance business out of business."

Agents are crucial to getting health care to the public, Clifford says, because they educate consumers about what a good health plan should include and they guide them to the best coverage for their money. Without agents, the consumer would be spending his hard-earned money on plans he doesn't understand and which may not be right for him.

Another problem with a federal health-care program, according to Clifford, is that it takes regulatory authority out of the hands of the states and concentrates it at the federal level—a move that is sure to be opposed by businesses and many local governments.

"We have a better chance of solving the health insurance problem properly if several states work on it instead of just one body—the federal government," Clifford says. "One of the reasons for keeping regulation with the states is that you have 50 small laboratories to try out solutions." Also, a state government usually knows the individual needs of its citizens better than the federal government does. Being closer means being in a better position to track whether programs are working.

Whatever form a restructured health-care system takes, agents and



companies will need to adjust their roles to fit, says Clifford.

If they want to keep legislators at bay, insurers will have to either relax their underwriting practices to include more people or form risk pools for uninsurables that would spread the risk among many companies.

Agents, however, will play a new role in addition to that of salesman, Clifford says. They will become educators and planners, because no matter what the government provides, there will always be something better for the client who can afford it.

> **"We have a better chance of solving the health insurance problem properly if several states work on it instead of just one body — the federal government."**
>
> *—Beryl Clifford*

### SO WHAT'S GOING TO HAPPEN?

With the government, industry and consumers all concerned about health care in America, what is likely to happen?

At worst, we end up with the federal government dictating who gets what care and in what quantity. Under this system, rationing is very likely, taxes will rise and the federal deficit will be passed on not only to our grandchildren but to our great-grandchildren.

At best, from an insurance industry point of view, things will stay pretty much the way they are. Companies will probably still look into ways to control costs, but agents will sell, the companies will underwrite, and the poor and uninsurable will be taken care of by the government through Medicare-like programs.

Most likely, however, according to industry and government thinkers, there will be a combination public/private system. The government will take care of the indigent and uninsurable and private insurers will step up efforts to sell affordable health coverage to individuals and groups.

America's health-care problem isn't quite the time bomb many people think it is. Just a little level-headed thinking on everyone's part should defuse the potentially explosive situation and keep everyone alive and healthy. ■

*I/R Code: 100.00 Accident & Health Insurance; 4350.03 Federal Legislation*

**Jack Hadley**

*Co-director, Center for Health Policy Studies, Georgetown University*

# National Health Care Unlikely In The Next Century

## Health Talk

**"Cost-containment programs that limit payment to providers can make coverage more affordable and should receive a high priority regardless of what happens with the fate of national health insurance."**

*—Jack Hadley*

**Jack Hadley, co-director of the Center for Health Policy Studies, Georgetown University, discusses some of the ways in which our current health-care system can be broadened to insure more people, and what it will mean to the insurance industry.**

**LAN** *What kind of health-care system do you think will be in place at the turn of the century?*

**Hadley:** I think it will still be a pluralistic system. I doubt that it will be a single national health system as in other countries. But I think it's going to be a system with more constraints and limitations, particularly in the area of provider payments.

**LAN** *What would you recommend in order to get medical coverage to the estimated 31.5 million people who are uninsured?*

**Hadley:** Not all people are insured for the same reasons, so there are multiple things that need to be done short of having a mandated national system. I think the government can do a lot to expand access to government-subsidized insurance.

The idea would be to take something like the Medicaid or Medicare programs and make them a subscriber-available insurance program for people who cannot afford to buy private insurance. Depending on one's income level, people could buy into an expanded government insurance program with the cost of their premium decided according to their income.

Another thing that would probably help, particularly for people who are medically uninsurable, are private insurance risk pools. They could allocate people randomly or in some fair

**I think it's a consequence of the fragmentation of the insurance system in the sense that no insurance company has the clout in the marketplace to impose any kind of meaningful constraints on provider payment.**

—Jack Hadley

way among different insurance companies so that people who want to buy insurance for pre-existing conditions [can buy it].

**LAN** *Would it be best to do this state by state?*

**Hadley:** That's certainly a logical way to do it—as long as all states have the same kind of pools so that there wouldn't be any disadvantages to people living in one area or another. Whether it's metropolitan areas or states or a collection of states is not a major issue, but given that regulation of private health insurance often occurs at the state level, the states seem to be the most logical organizational unit for doing that.

**LAN** *Would forcing employers to provide health insurance for their employees be a valid way to get more people insured?*

**Hadley:** It's one way. I don't know that it's necessarily the best way. It's a second-best solution because legislators are not willing to consider raising income taxes or making cuts in other programs to finance subsidies for health insurance. Mandating employers to do it is a way of imposing a tax without explicitly raising taxes.

I don't think it's the best way, but I think it is a way to extend insurance to a lot of people who currently do not have it. There would, however, clearly be some employment defects in the short run. Small employers, if hit with the additional cost [of paying for insurance], would have to cut back on employees or they would go out of business.

But I also think that over some period of time, wage rates in firms that are mandated to buy insurance will go up. And while there will be losses in some sectors of the economy, there will probably be job gains in the health sector. So the net effect over time will be minimal. But in the short run, there will be some sort of job loss.

**LAN** *How would a national health-care program affect the health insurance industry?*

**Hadley:** If it required community ratings, it would take insurance companies out of individual risk rating. Even so, there certainly would be a lot of activity for private insurance companies in terms of competing for subscribers at the community level, in claims processing, in benefits administration and in offering benefits that extend beyond the minimum mandated package.

**LAN** *Will the health insurance industry have to change the way it does business?*

**Hadley:** My guess is yes. I think the majority of what health insurance companies are offering has changed quite a bit already in the last 10 years with a lot more emphasis on managed-care programs and utilization-review programs.

If the government sets the way in determining rates of payment for providers and if private insurance companies buy into the government-established rates, one of the things I see happening then is that programs and products that emphasize special discounts for subscribers really won't have any market.

**LAN** *Do you think a Canadian-style health insurance system would work in the United States?*

**Hadley:** I think the odds of it happening are very small, but if it did happen, I suppose it's workable. Most of the rest of the world have national health programs so I don't see any reason why it wouldn't work here.

**LAN** *Would a national health-care program lead to waiting periods and rationing as it does in Canada?*

**Hadley:** With some things it inevitably would. But on the other hand, you have to ask "waiting periods and rationing relative to what?" Considering the 15 percent of Americans who don't have health insurance, I don't think it would be worse by any means.

**LAN** *What would you say is wrong with our current health system?*

**Hadley:** The cost of care is a big problem. I think it's a consequence of the fragmentation of the insurance system in the sense that no insurance company has the clout in the market place to impose any kind of meaningful constraints on provider payment. Either legislative action by the government or collective action by insurance companies would bring it about.

**LAN** *Would medical malpractice tort reform or cost-containment programs help bring down the cost of coverage?*

**Hadley:** First of all, I don't think medical malpractice is a major cause of high costs. It's a problem for some physicians and some specialists, but in terms of overall impact of health-care costs, it's minimal.

Among cost-containment programs, my feelings are that the ones that would have the biggest impact are programs that limit provider reimbursement. For example, if the Medicare Perspective Payment System for hospitals were adopted by private insurance, it would have a major impact.

Also, Medicare is about to implement a fee schedule for physician services. If private insurers adopted that fee schedule instead of paying physicians what they charge, it

would have a major impact on costs.

Cost-containment programs that limit payment to providers can make coverage more affordable and should receive a high priority regardless of what happens with the fate of national health insurance.

**LAN** *Is cost containment something that is being widely used now?*

**Hadley:** I think there are a lot of activities that are called cost containment, but most of them either reduce benefits to subscribers or increase coinsurance rates and deductibles. That shifts some of the costs back on the consumer.

Another type is managed care/utilization review/HMO-type programs, and they have a substantial effect on cost.

**LAN** *What would you recommend to bring down the cost of health insurance?*

**Hadley:** The most promising approach is greater regulation of payment rates. I think a lot of the problems this country has experienced over the years are due to the lack of limits on what providers are reimbursed. This includes physicians, hospitals, labs, pharmaceuticals—the whole array of medical products.

**LAN** *Do you think the government will throw out our current system and go to a totally government-administered program?*

**Hadley:** I think throwing out the current system is very unlikely, but the likelihood of insurance reform is certainly possible and has a greater probability of happening.

The reforms most likely to be considered are community rating methods rather than individual risk rating, pools for high risk individuals, and possibly some kind of collective action on the part of private insurance companies that would enable companies to negotiate rates or to adopt government rates. ■

*I/R Code: 100.00 Accident & Health Insurance*

John McCain (R-Ariz.) is AHIA-sponsored. Invited as key speaker is Louis Sullivan, secretary of the Department of Health and Human Services.

Three Underwriter Updates, which are educational seminars, are scheduled for release in June. The seminars include: Errors and Omissions—Defensive Practices in Health Insurance; Alternative Funding Sources of Health Insurance; METs/MEWAs.

A discount for *Spencer's Research Reports on Employee Benefits* and *Spencer's Compliance Guide*, which are manuals put out for agents by Charles D. Spencer & Associates, Inc., is available to all AHIA members. The discount was promised at the NALU convention last September.

### MEMBERSHIP PACKAGES

AHIA has two classes of membership; active and associate. Active members are those who currently sell health insurance or are in field management. Associate members include those who are not eligible for active membership but are affiliated in some capacity with health insurance; individuals who are in tangential professions that have a vested interest in health insurance issues are also eligible.

From the beginning, AHIA advocates also promised greater grass-roots involvement; part of the conference's purpose is to facilitate an enhanced NALU grass-roots political system by expanding the Life Underwriter Political Involvement Committee (LUPIC) to include more members knowledgeable about health issues.

Each AHIA committee member chose local associations in each state to focus their efforts on. Each vice chairman will now contact key people in the associations and encourage them to become involved by joining AHIA and coordinating health programs at their meetings.

"So far, AHIA is growing rapidly and is being accepted in the industry. Membership has already surpassed the five-month projections," says E. Dawn Lindsey, FLMI, executive director of AHIA. "We're excited about the progress we've made and all indicators point to a healthy future for the conference." ■

*I/R Code: 1000.09 The National Association of Life Underwriters*

and local health and employee benefits chairmen and state and federal law and legislative chairmen, will have an expanded capacity using AHIA as a new resource. AHIA intends to create a membership that is deeply involved in the health market, thus bringing continuity and identity to NALU's health-related policymaking process.

At the national level, AHIA has its own board of directors, including a president, an acting immediate past president, a president-elect, a secretary/treasurer and seven directors. AHIA has four committees—membership, communications/member services, legislation and meetings.

**What is the association's focus?**

AHIA primarily focuses on four areas crucial to the well-being of agents:

- Improving the legislative environment of the health insurance and employee benefits markets;
- Enhancing the communications process between local and state association members and national headquarters;
- Expanding health related educational opportunities for agents; and
- Informing consumers about health insurance and employee benefits. ■

• One-time qualification
• Eligibility (new employees)
• High-risk systems
• Taxation
• ERISA exemption of state mandates
• Minimum standard benefit plans

In addition to the task forces, the committee decided that C. Gibbs Smith Jr., CLU, Nashville, Tenn., will serve as liaison with the NALU law department on federal issues. Task forces will be formed as they become necessary.

Finally, the legislative committee agreed that it will develop public policy position statements. They will deal strictly with health issues.

### COMMUNICATIONS/MEMBER SERVICES IN ACTION

The Health Legislative Report is now an official AHIA publication. Only AHIA members, local and state health and employee benefits chairman, state presidents and state and federal law and legislation chairmen will receive them.

AHIA has also created a newsletter, *Health Matters*. It is now bound into *LAN* for three issues (see page 53 for premiere newletter); after three months, it will be sent monthly to AHIA members only.

One of the biggest events planned for this year is the Columbia Institute Seminars: The Arizona Forum on Health Care—A Focus on Our Needs and Goals; and the 1991 Colorado Conference on Health Care—Meeting the Needs of the 21st Century. The Arizona conference, chaired by Sen.

## All You Ever Wanted To Know About AHIA

**Why has NALU created an association dedicated to health and employee benefits agents?**

America today is debating the future of the private health insurance industry. Therefore, it is vital that agents who participate in the health market be part of that discussion. Though NALU has been active in health insurance issues in the past, its board of trustees felt that the association should strengthen its current health-related structure so as to more effectively respond to the pace of today's historic dialogue.

NALU's mission statement pledges the association to "improving the business environment for those engaged in . . . underwriting." And over the past 100 years, it has done just that. By creating AHIA, with its specific focus on "health underwriting," NALU is fulfilling its intended mission and enhancing the positions of field underwriters nationwide.

By virtue of its name, AHIA gives its members immediate recognition as health insurance and employee benefits professionals. By combining that recognition with an expanded structure and NALU's resources, AHIA will enable agents to become better informed and more involved in today's industry reform movement.

**What's the mission of AHIA?**

The mission of the Association of Health Insurance Agents is to provide leadership in sustaining and improving the business environment for those engaged in health underwriting, enhance the professional skills of those providing health products and foster greater financial independence for the public.

**What experience does NALU bring to the health insurance agent?**

NALU has been involved in health issues as long as agents have been providing health products. A formal committee has been in place since 1952; the word "health" was incorporated into the NALU bylaws in 1965, and just last year the association spent over $2 million on health insurance and employee benefits issues. NALU has been the only agent voice in many congressional committee debates, including such key issues as the Internal Revenue Code Section 89 reform, small group underwriting and pricing, the Pepper Commission and, most recently, medigap reform. In other words, it has experience in health issues. By creating AHIA, NALU is acknowledging that it must do more if agents are to participate in today's health care debate.

**Does NALU have any other conferences?**

NALU already has two specialized conferences within its ranks—the General Agents and Managers Conference (GAMC) and the Association for Advanced Life Underwriting (AALU)—both of which have proven the benefits of the conference structure.

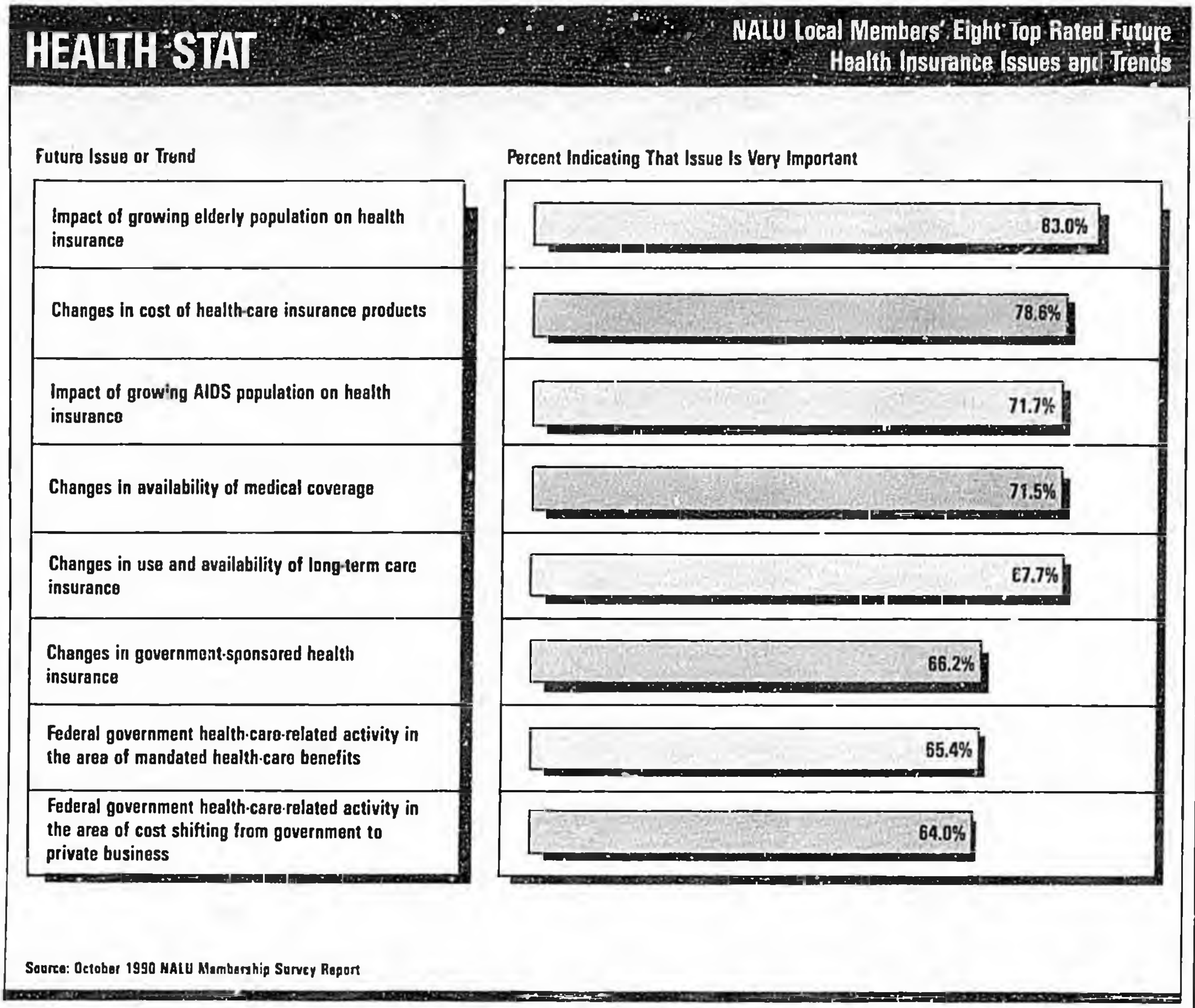
Since their inception in the 1950s and 1960s, AALU and GAMC have become respected organizations within the insurance community.

AALU began with a working committee of five, and now boasts a membership of 1,500, plus a waiting list. Its lobbying clout on advanced life insurance products is unmatched and its annual convention is described as one of the most informative in the industry.

GAMC, which like AHIA was a committee before becoming a conference, is now an indispensable tool to general agents and managers nationwide.

**How is the association structured at the national, state and local levels?**

AHIA is a national organization with direct membership. Though no local or state associations will be created, the health structure that currently exists in local life underwriters associations will be enhanced through AHIA. All state




- Mandated coverage
- State and federal regulation
- Consumer education

Other areas of concern include: Mandated benefits, legislative education, retiree health care, cost containment, tort reform, regulated agent compensation, the Employee Retirement Income and Security Act (ERISA) pre-emption, AIDS, continuity of coverage, managed care, Canadian-style health care, federal minimum standards, multiple employer trusts and multiple employer welfare arrangements (METs/MEWAs), medical individual retirement accounts, flexible spending accounts, Medicaid expansion, medigap, indigent pools, accelerated death benefits, initiative legislation, §125, state licensing and continuing education.

Next on the agenda, three task forces were created. The first, Access to Health Care, is a task force whose objective is to create a questionnaire that can be used by key state association officers to review bills proposing to create state health plans or risk pools. The chairman of this committee is Carl W. Hill, CLU, board liaison to the legislative committee.

The second task force, Long-term Care, will address and respond to issues raised by David E. Hebert, counsel, NALU government affairs, regarding Congress and its treatment of long-term care. Co-chairmen of this committee are Richard F. Breen, JD, CLU, ChFC, of Plymouth Meeting, Pa., and Donald R. Bryson, CLU, of Sarasota, Fla. The following issues will be analyzed:

- Agent's commissions
- Agent abuses (stacking, replacement)
- Packaging versus endorsement
- Taxation of long-term care product benefits
- Disclosure of commissions
- Minimum policy standards

Small Group Plans, the third task force, will analyze the following issues as they pertain to groups with a maximum of 25 employees.

- Size of group
- Guaranteed renewability (National Association of Insurance Commissioners)
- Medical underwriting
- Affordability
- Pre-existing conditions
- Plans (METs, association, discretionary, Taft/Hartley, Health Maintenance Organizations, Blue Cross/Blue Shield, etc.)
- Disclosure of rating practices
- Mandating of coverage
- Continuity of coverage
- Mandating benefits

# New NALU Health Conference Off To Strong Start

By Rivka Tadjer-Winkler, *LAN* Managing Editor

## Focus On AHIA

Just five months after its inauguration, the Association of Health Insurance Agents (AHIA) is 3,000 members strong and working to fulfill its campaign promises.

AHIA is the National Association of Life Underwriters' (NALU) newest conference, devoted entirely to health insurance matters. When the NALU National Council voted AHIA in at NALU's convention last September, proponents of the conference promised that benefits of membership would cover legislative issues, public relations/communications and member services.

NALU created the conference, according to Karl E. Hansen, CLU, ChFC, LUTCF, president of AHIA, to intensify its efforts to have the insurance industry's voice heard and reckoned with on health issues that affect not only the insurance industry, but the nation at large.

At NALU headquarters Dec. 3, 1990, AHIA's committees met with the AHIA board of directors to create action plans for each membership benefit area.

### A LEGISLATIVE ACTION PLAN

The legislative committee first ranked current legislative issues. The top 10 matters that AHIA will devote its resources to are:

- Small group underwriting and pricing
- Access to health care
- Long-term care
- The agent's role
- Taxation
- Uninsured pools
- The Consolidated Omnibus Budget Reconciliation Act (COBRA)

AHIA
Association of Health Insurance Agents

**Already 3,000 members strong, AHIA is quickly taking action to become recognized as a leading health association in the industry.**

## HEALTH STAT

**Extent of Executives' Concern About Health-care Issues**

| Issue | Very concerned |
|---|---|
| Rising health insurance premium costs | 92% |
| Mandated benefits | 65% |
| Paying for catastrophic illnesses such as AIDS | 64% |
| Dependent coverage costs | 60% |
| Workers' compensation costs | 58% |
| Communicating benefits and costs to employees | 54% |
| Quality of medical care services | 53% |
| Drugs in the work place | 49% |
| Quality of care provided | 47% |
| Retiree health benefits costs | 46% |
| Alcoholism in the work place | 45% |
| Mental health costs | 43% |
| Inability to determine value of health-care services purchased | 42% |
| Prescription drug costs | 31% |
| Disability and rehabilitation issues | 30% |
| FASB retiree liability compliance | 25% |

Source: April 1990 *Business & Health*

. . . I mean if private enterprise can't conduct itself in a fair and competitive manner for the benefit of all, then it seems like we have to ask the government to step in. And I'm sure you insurance guys would hate that."

You're right, I replied. I would hate that. But not because it would hurt my business. Rather, I have serious doubts that socialized medicine would serve us with the same high quality medicine we have come to take for granted.

Sure, it would offer the greatest access to the millions of uninsured but at a cost, according to reliable sources, of over $300 billion a year in new taxes.

And, if the facts learned from countries with socialized medicine can be trusted, we in this country will learn what the rationing of health service really means. I don't think this country will tolerate standing in line waiting for treatment, nor will it tolerate medical shortcuts to save money.

It won't hurt my business, because I'll sell extended health insurance benefits like they do in Canada, England . . . you know, countries with government-controlled medicine.

I'll be selling it to those people who can afford it and who want the best care when they need it. No waits.

"So what's the solution?" he finally asked.

Well, first, all of us must understand the whole complex problem and realize that there is no one solution or "quick-fix."

Second, all of us connected to health-care services have to find a level playing field. And that means we all have got to give a little.

Insurance companies have to give a little on premiums.

Hospitals need to share their resources with other lesser equipped hospitals and be willing to give up a little bonus and live with a little less profit. We don't need 28 hospitals in the Chicago area capable of performing open heart surgery.

Doctors need to learn how to operate with a little less income. Developers of high-tech medicine need to exercise greater cost control and give up a little on stock dividends. Lawyers need to get out of the way of tort reforms that would cap medical-liability awards and give a little on fees.

Third, the federal government needs to balance the budget so it can fund Medicare and Medicaid adequately. Expansion of these would allow many of the uninsured to be covered for basic services now denied.

Fourth, everybody involved in health care has got to get its administrative act together. Our collective inefficiency is costing us millions of dollars in waste. Millions that would go a long way in reducing the cost of health care along with opening up greater access for the uninsured.

Finally, all states should create "risk pools" for those denied health insurance due to pre-existing conditions. Such a pool should be funded by "special taxes" paid by insurance companies, employers and by users of cigarettes and alcohol.

"Why not put in a few bucks from state lotteries and other legalized gambling?" he interrupted.

Good idea, I said. Consumers need to become smarter health-care shoppers and think twice about lifestyle choices. Preventative medicine is cheaper than corrective medicine.

"That all sounds pretty naive to me. No matter how much sense it makes. By the way . . . "

Yes?

"Have a nice day on your boat."

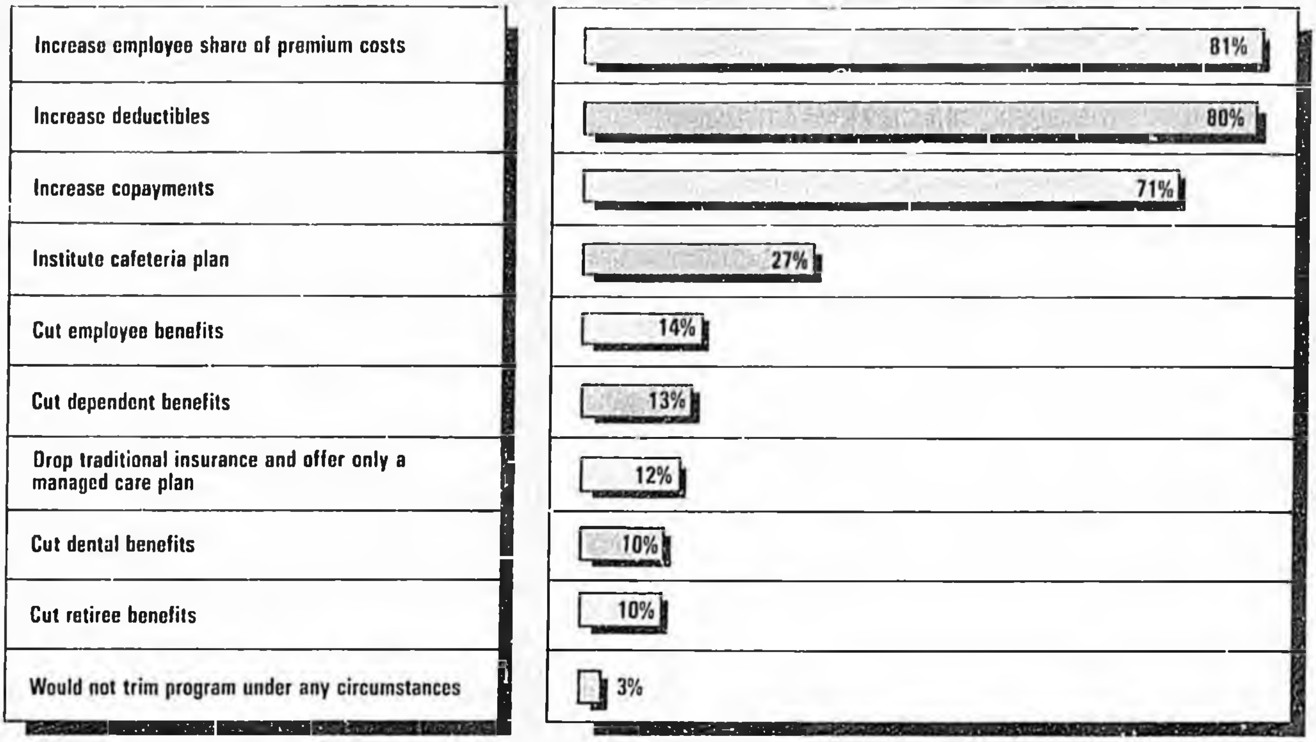
Click! ■

*Conrad Meier is president of Meier Insurance Services, Inc., a firm specializing in health care and pension plans for small employer groups in southeastern Wisconsin and northeastern Illinois. His address: 4343 Grand Ave., Gurnee, Ill. 60031.*

*I/R Code: 100.00 Accident and Health Insurance*

## HEALTH STAT

**Ways Executives Will Cut Health Programs to Lower Costs**




Source: April 1990 *Business & Health*

around for the best price on prescription drugs?

"Never. They all charge the same, don't they?"

Absolutely not, I said, one octave up. Reliable studies have shown that doctor's fees, hospital charges and prescription costs are not all created equal. They can vary substantially for exactly the same service.

Figuring I made a good point there, I added: I bet you spent more time shopping for your new car than you did for health-care services.

"Hey, Conrad. Who's got time to shop around for the best prices in health care? When I get sick I want the best care available, right away and whatever it costs. Besides, I don't pay the bill, the insurance company does."

Exactly my point, I countered. If the cost of claims came down as a result of everyone using the most cost effective services, your premium would reflect the savings. Problem is, most consumers don't shop.

There seems to be an unwritten law that says you're forbidden to ask how much it will cost to restore your health.

Before he could recover from that, I asked when the last time was he complained to his congressman about those expensive state-mandated benefits?

"Never. What's that got to do with anything?"

Because there are over 750 mandates to which insurance companies must comply. Every one is another layer of cost added to health care. Some mandates are reasonable I grant you, but you must admit forcing health insurance to cover the cost of a hairpiece leaves room for questions.

I was on a roll, so I asked if he understood how cost-shifting by doctors and hospitals forced his insurance premium up.

"No, I don't, but I bet you'll tell me."

Right. In the years 1980 to 1988, federal funding for Medicare and Medicaid has been consistently reduced. The budget proposal for 1991 requests a further reduction of $60 million. Look, it comes down to this: If the actual cost of health care used by patients on Medicare and Medicaid isn't more fairly reimbursed to the doctor or hospital, the cost will continue to be shifted to private-paying patients and will eventually be reflected in a higher premium for you.

I'll say this too: The health insurance industry is not altogether blameless in this scenario. Administrative and marketing costs consume about 20 cents of every premium dollar. I suspect at least half of that is used to uncover fraudulent charges and billing errors.

And, I think many insurance companies have lost sight of their purpose in life.

"Well, it sounds to me like I'm trapped in the middle of finger pointing by you insurance people, doctors, hospitals, lawyers, whoever . . . ."

Taking a breath, he continued with: "I've never been in favor of socialized medicine, but it looks like a national health plan is the only answer

# Explaining The Health Insurance Crisis In Three Octaves

By Conrad Meier

## Focus On Clients

**A crackling colloquy that will leave you perfectly tuned to soothe even the most savage client.**

I expected his phone call. Actually, it was one of many that day.

Two octaves higher than usual, my client said: "I just got my new health insurance premium and I hope you're enjoying your new boat."

I took a deep breath and tried to explain that health insurance premiums are *reactive* to the costs being charged by doctors and hospitals and are a direct result of state mandates and cost shifting. Your premiums have nothing to do with me layering on another level of profit, I told him. In fact, the insurance company that just raised your cost 11 percent, lowered my commission 5 percent.

"So what the hell is going on?" he asked, still two octaves up.

I said I could respond if he'd let me ask a few questions first.

"OK," now down one octave.

Did you ask your doctor how much he was going to charge you?

"No. Nobody asks that."

Did you ask the hospital how much they charge?

"No. Nobody asks that, either."

When's the last time you checked a hospital or doctor bill for accuracy?

"I never check the bills. Besides being confusing, they say they are accurate 99 percent of the time."

That's interesting. Insurance claims experts report consumers don't realize that one out of two hospital bills have charges for services never rendered and that some charges are inflated due to cost-shifting. A few doctors alter their billing to include tests never done. Many charge for unneeded exams to shield from malpractice suits.

When's the last time you shopped

PHOTO DAN GLASS

February 1991

# Revolutionary News

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> **There are a lot of things we can do in the public and private sector to make sure information is available and to make sure there are good incentives — better incentives — to have more cost-conscious behavior.**
>
> *—Gail Wilensky, Health Care Financing Administration*

vided. That's something we in the federal government can help and it's something the private sector can certainly help in terms of making sure they're more cost-conscious.

Employers can offer better incentives to their employees by paying a fixed amount, not a percentage of whatever plan an employee chooses, if there's a clear incentive to go to a more cost-conscious plan. Employers can make sure information is available about which providers are providing better services, and they can provide some incentives to go there.

There's an activity that Cleveland is starting up that has physicians and private insurance groups working together to get a better sense about what works and what doesn't work in medical care and making sure information is disseminated to the people who need to know.

There are a lot of things we can do in the public and private sector to make sure information is available and to make sure there are good incentives—better incentives—to have more cost-conscious behavior. We need to make sure we get better behavior on the part of physicians, hospitals and the insurance industry.

It would help a whole lot if we could have the participation of the American population, too. There's an awful lot of behavior we spend money on that can be changed [such as] smoking and alcoholism.

**LAN** *So this should be a concerted effort among the medical profession, the insurance industry and the public?*

**Wilensky:** It's going to be real hard to have it happen unless we get all the different sectors moving together. You can have some impact if you only go after the provider community. You can have some impact if you go after the insurance community. But you're going to do a whole lot better if you have all these different sectors working together.

Whatever we end up with, it will be very much an American way of solving a problem. It will be pluralistic. I don't believe it's going to be a unitary government-financed, government-operated program. I don't think we like those. I don't think we trust them. We would be very unhappy with that.

I think we will retain our public/private mix of financing and a lot of diversity about how we go about doing business because we've set up a whole lot better incentives to make the providers of health care and the consumers of health care more cost-conscious about what they're consuming. ■

*I/R Code: 100.00 Accident & Health Insurance; 4350.03 Federal Legislation*

**Gail Wilensky**
***Administrator, Health Care Financing Administration***

## Health Talk

activities. One is an ever-growing frustration about the inability to contain health-care costs in the sense that we really have to be more active and more serious in trying to contain health-care costs.

I also see some serious discussion about how to try to improve and expand access to private insurance for the working population and about public insurance. I see some discussion about long-term care and its implications.

These discussions are going on all over the place. They're going on in the administration, in businesses, in the National Association of Manufacturers, the Business Round Table, the American Medical Association, the American Hospital Association [and at] Social Security. I think there is a consensus that we need to make some changes but there is no consensus about how to go about making these changes.

I also think there is wide agreement that unless and until we can do something to reduce the rate of spending, we are not going to go after the access problem. We're just not going to do it. I don't think there a sense that we have to solve the cost-containment problem before we go after access. But I believe there really is a wide spread agreement that we're not going to seriously expand or change access until we have some credible reason to believe we can control health-care costs.

**LAN** *How can costs be contained?*

**Wilensky:** The Health Care Financing Administration is coming forward with our own package of specific proposals we would like to see enacted.

We need to instill better incentives in terms of how health care is pro-

**"Reform needs to occur and sometime in the next couple of years is reasonable. The insurance industry may well have some phase-in period because it's somewhat hard to have change occur all at once."**

*—Gail Wilensky*

# Insurance Reform, Not Socialized Medicine, Is The Answer To Insuring Americans

**Gail Wilensky, administrator, Health Care Financing Administration, discusses how the federal government might tinker with the U.S. health-care system—and how it might affect the insurance industry.**

LAN *What is the probable future of the health-care industry?*

**Wilensky:** I believe we will continue to have a mixed public/private system of health insurance. There will continue to be the private health insurance industry.

It seems to me that there's a growing consensus [that] there needs to be some reforms in the insurance industry, particularly as it relates to small business. There is not quite yet consensus about what those reforms should be and how they should be achieved, but there is a growing recognition of the need for some changes.

That's healthy, and it is especially healthy that the insurance industry itself has been involved with some of those reform proposals. I think that makes it much clearer that change is likely to occur when the [insurance] industry participates in the discussion.

LAN *When do you think this will happen?*

**Wilensky:** Sooner rather than later. I think probably in the next couple of years is a reasonable time line.

There's a lot of interest and there's been a lot of discussion going on within the industry and outside the industry. The Pepper Commission [and] a number of other groups have made recommendations that deal with some of the same issues.

It is an issue that there's widespread agreement. Reform needs to occur and sometime in the next couple of years is reasonable. The insurance industry may well have some phase-in period because it's somewhat hard to have change occur all at once. But there is much less need for a long phase-in for insurance market reforms than there is for changing how health care is financed and provided.

LAN *Do you think the United States will see a national health-care system soon?*

**Wilensky:** I don't think it's a possibility right now. At this point, we really haven't come to a consensus as to what we want to do. I think [universal access] will be regarded as one of the options of how to expand public and private insurance to the under-65. Some of the long-term proposals are less likely [to come about] than even the under-65 proposals.

What I see now are three different

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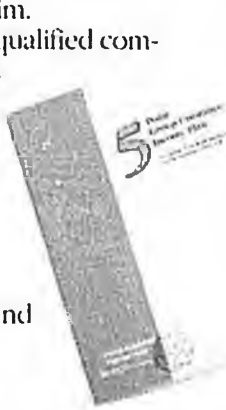

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**Two cost-cutting measures that may not be a wave of the future, at least not as big a wave as initially anticipated, are self-insurance and wellness programs.**

nity to argue his position in person. In many cases, a different course of action can be negotiated. If there is no agreement, the attending physician has the right to appeal to another physician in the same kind of practice as his.

According to Janice Spillane, president of CoMed in Columbus, Ohio, these procedures have been able to save between 5 and 10 percent of hospital-related costs for its parent company.

Spillane says that the hundreds of managed care providers like hers have expanded their scope beyond the review of hospitalization expenses. Today, these companies evaluate the appropriateness of the facilities people are being admitted to, and recommend alternative treatment plans if necessary.

"I think managed care is definitely the wave of the future," says Spillane. "By the mid-1990s, virtually all health care will be delivered under some kind of managed care umbrella, whether it's an HMO, a PPO, a hospital precertification system or review of outpatient procedures."

Two cost-cutting measures that may not be a wave of the future, at least not as big a wave as initially anticipated, are self-insurance and wellness programs.

Writing in *Business & Health*, Maria R. Traska quotes several sources who say that the trend toward self-insurance, especially among large employers, is leveling off. One of those sources, Leonard Wood of Blue Cross/Blue Shield, Chicago, says that "self-funded employers had higher costs the same as the insurance companies did. But many of the employers hadn't had a 'down phase' until then. Employers are a whole lot more realistic now."

Wellness programs, regarded as a panacea in the mid-1980s, have not proved as effective at cutting health-care costs as proponents first thought. Such programs tend to cover a lot of ground, and therefore require a lot of overhead. They offer programs in anything from weight control and nutrition classes to fully-equipped exercise facilities, from smoking clinics to drug and alcohol abuse counseling.

Though companies that have instituted wellness programs have reported a measurably healthier workforce and lower absenteeism, the cost often offsets any savings in health-care expenses.

Peter Conrad, a sociologist at Brandeis University, says that companies should avoid thinking like accountants when it comes to their wellness programs.

"Health promotion may be an effective use of the benefit dollar," says Conrad, "not in terms of cost containment or improvement in health but in terms of productivity."

Finally, consumers and employees themselves are being asked to assume an ever larger share of the financial burden of health care. It's a request employees aren't always eager to comply with.

"It's not going to be easy to sell the idea of employees picking up more of the health-care tab themselves because of the traditional employer-employee relationship," says Carl Hill. He points to two of his Blue Cross/Blue Shield clients, Chrysler and General Motors, as cases in point.

"Their utilization is atrocious," says Hill. "One reason is the nature of the business—assembly lines tend to breed health problems with drugs and alcohol. Another is that they have Cadillac benefits, largely because they're union-negotiated and have been hard to come by over the years. Which means they'll be even harder to give up."

Employers of all sizes are opening their books to their employees, letting them know exactly how much they're paying for group insurance and other benefits. It's an eye-opening experience for many employees.

"Come the first of the year, employees in our own firm are going to have to start contributing to the cost of their health-care benefits," says Sally Nelson. "It will be the first time in the firm's 25 years in business they've ever been asked to do that."

Getting employees to go along willingly, or at least persuading them not to balk, is going to take a great deal of education and persuasion. This is something Richard Jones thinks agents are ideally positioned to do, even if it means stepping outside the traditional bounds of the agent's role.

"We've got show the employer different methods of cutting costs, even if it means acting as negotiators between employers and health-care providers," says Jones. "We have to be creative, act as the catalyst that gets things going, come up with solutions, initiate some action. That's why the Association of Health Insurance Agents (AHIA) is so important in putting out information that will help agents assume that role."

It's clear that great changes are needed and that managed care, in one form or another, is going to be a permanent fixture of the national health-care landscape. Though the bloom may be off the HMO rose, variations on the same theme are attempting to revive it, providing the flexibility of indemnity plans without the limitations of traditional HMOs. And the PPO alternative continues to grow in popularity.

The bottom line, however, may rest with consumers themselves. If the days of employers picking up the entire tab for health-care benefits are not yet completely over, they are most assuredly numbered.

"If we want private enterprise to continue providing health care," says Richard Jones, "we can't just sit back and let the government take control." ■

*I/R Code: 100.00 Accident & Health Insurance*

who shouldn't. Eighteen percent wanted consumers to make the decisions, and only 3 percent trusted elected officials with that power.

Nevertheless, the Oregon state legislature has embarked on the first stages of a Medicaid rationing plan that would emphasize primary care of children and pregnant women instead of costly, high-tech treatments.

"From Oregon's point of view, it was simply the recognition that we've got a limited amount of money we can allocate," says David Nelson, legislative representative for the Oregon Life Underwriters Association in Salem, Ore. "We had to determine what are the most important services to provide. The result was an antiselection against high tech services."

It's too early to tell the results of Oregon's experiment, however, since it hasn't even had a chance to get off the ground yet. The federal government must grant an exception for Oregon to implement its Medicaid rationing program, according to Nelson, and it has not yet done so.

### UP TO PAUR

Another form of managed health care that came on the market four or five years ago is something New York Life calls Prior Authorization Utilization Review (PAUR), and everybody else calls *pre-certification* or *pre-authorization*. New York Life uses a subsidiary, CoMed Management, Inc., to monitor hospital expenses before claims are paid.

The idea is that a panel of trained staff nurses screen claims using preestablished criteria based on the severity of the patient's illness and the services they require. Cases that don't meet the guidelines are referred to physician consultants who make the final determination.

If there's a difference of opinion between the panel and the practitioner, the practitioner is given an opportu-

## The Case of the Rolling Russians: Health Care Fraud Makes a Bad Situation Even Worse

In the minds of the public, the bad guys of the health care crisis are usually those greedy, heartless health insurance companies. Clearly, the public hasn't had the opportunity of meeting the brothers Smushkevich, and others like them.

Russian emigres, David and Michael Smushkevich had a sweet deal going in their adopted home of sunny Southern California. They operated a fleet of vans, packed with medical testing equipment, which they called "rolling labs." Their scam was to pull into the parking lots of health clubs, shopping malls, churches and nursing homes and offer free physical exams for anyone who wanted them.

Then the brothers billed three large national health insurers for over $100 million of unnecessary or unexecuted diagnostic and medical tests, with bills ranging between $10,000 and $18,000 per patient.

When the three insurers finally caught on, they brought suit, and won—to the tune of $18 million in damages. Metropolitan Life was awarded $7.7 million; Aetna Life & Casualty won $7 million; and Employers Health Insurance received $3.3 million.

Unfortunately, none of the companies is likely to see a single dime. Shortly after the suit was filed in 1986, the brothers Smushkevich rolled themselves and all their assets out of the country. One brother is reported to be in Mexico while the other is back home in Russia, presumably exploring the felonious possibilities of perestroika.

The three insurance companies involved in the case are all members of a relatively new organization, the National Health Care Anti-Fraud Association (NHCAA), formed in 1985 to deal with a problem that is not new at all, and more widespread than many people realize.

"Health care fraud touches all of us both directly and indirectly," says NHCAA board member James L. Garcia, of Aetna. "Estimated to be $50 billion a year and rising, health care fraud is a significant factor in the increase of health care costs."

R. James Guzzi, chairman of NHCAA, estimates that between 5 percent and 25 percent of the $600 billion the nation spent on health care last year reflects outright fraud or abuse that flouts the letter of the law. The prime culprits, an estimated 75 percent of the time, are health care providers, while consumers themselves make up the difference.

The stated mission of the NHCAA is to improve the prevention, detection and civil and criminal prosecution of health care fraud. Toward that end, the antifraud organization acts a network for sharing information on insurance fraud schemes among its member companies, conducts regular seminars on fraud detection and prosecution, and helps identify and track trends in health care fraud cases.

"NHCAA is enhancing its abilities to share information on specific health care fraud offenders," says NHCAA Executive Director Richard H. Ekfelt. "As our data base increases we will become increasingly effective, through joint investigations, at stopping fraudulent practices and prosecuting health care fraud offenders."

—*S.F. Sullivan*

pick a primary care physician from a list of doctors that CIGNA has contracted with after thoroughly evaluating their credentials and visiting their offices. The primary care physician acts as the member's health-care manager. He decides whether he can provide the necessary care himself, or he can refer a patient to a pre-authorized specialist within the network.

The open-ended HMO, however, allows members the option of going outside the network on their own. If they do, CIGNA's plan stops working like an HMO and begins working like a typical indemnity plan, with a 30/70 co-payment and a deductible.

"There are financial incentives to keep you in the network," says Amy DeMarco, spokesperson for CIGNA. "But you've got the flexibility to go to Sloan Kettering in New York if you feel you really have to, and still get some benefit."

One of CIGNA's earliest POS clients was Allied-Signal, Inc., an advanced technology company that instituted a POS plan it called the "Health Care Connection" in 1987. Allied-Signal was spending $355 million a year on health care and looking at projections of more than $600 million for 1990.

"Our corporate costs have been 23 percent lower for employees enrolled in the "Health Care Connection" than if these employees had remained in the fee-for-service indemnity plan," Edward L. Hennessy Jr., Allied-Signal's chairman and CEO, told the National Association of Manufacturers in March last year. "The savings to our company amount to about $750 per employee annually."

At 37,000 employees, that translates to a savings of around $28 million.

POS's haven't been around for very long, but more and more big companies are starting to market them and "they're taking off like wildfire," according to Health Insurance Association of America (HIAA) spokesman Donald White. "I call it employee-friendly managed care."

"The results [of managed care] have not been up to everyone's hopes," says Neil Waldron. "HMOs and PPOs have done a good job at reducing prices and shifting the setting of care from an in-patient to an out-patient basis . . . [but the] incremental impact has not been that great.'

### TRIAGE

If all else fails, some suggest that the next step in cost containment might be triage. Also known as rationing, triage was originally a battlefield practice, a procedure for stretching overtaxed resources by treating only the most severely wounded first.

Translated into civilian life, this means deciding which patients, medical conditions and forms of treatment will be covered by health insurance and which won't.

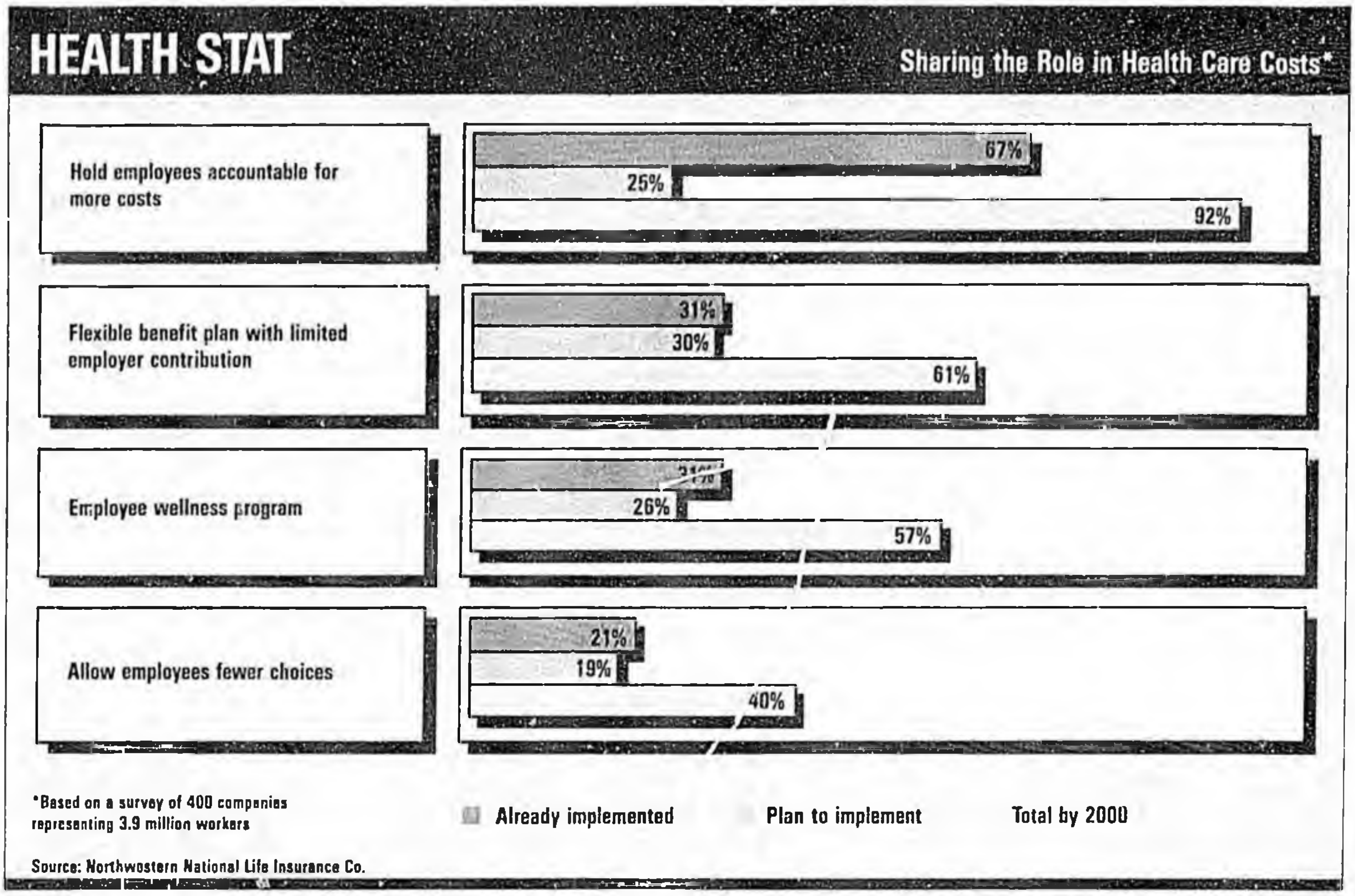
In a recent survey on health-care rationing, Northwestern National Life in Minneapolis defined rationing as denying health care services on the basis of predetermined criteria such as age of the patient or cost.

This would mean that, under a rationing system, an elderly patient who required expensive treatment might be denied coverage in favor of a younger person or an infant.

According to Northwestern National's survey, 85 percent of Americans believe that some form of rationing would work better at containing costs than the current health insurance system. Twenty-six percent believed that children should be given priority for health care services over the elderly.

"I don't know how Americans would really react if it came down to rationing," says Michael Conley, senior vice president of group insurance for Northwestern National. "I've got an 80-year-old father who had a quadruple bypass. I might be in favor of rationing as an abstract concept, but if you ask me to ration him out of the care he needs, I might have a different answer. And I'm not alone. Rationing opens up a whole lot of very difficult ethical and moral questions."

And who should be answering those questions? According to the survey, 50 percent of the respondents preferred a panel of medical professionals to determine who should get care and




sicians per patient and overall utilization. They also promote preventive health care.

With a PPO, groups of hospitals and providers contract with physicians, employers, insurers and other groups to provide services to plan members. The providers negotiate a discounted fee in return for patient volume.

Elliot K. Wicks, Ph.D., associate director of Policy Development and Research at the Health Insurance Association of America (HIAA), thinks more research needs to be done to find out how effective managed care plans are.

"It will be a couple of years before we can know how much savings we can expect," says Wicks.

Although the quality of care with PPOs hasn't really been criticized, HMOs are a mixed bag, according to Neil Waldron, vice president of product development for Massachusetts Mutual. Some do well and some don't.

"There is nothing inherent that says HMOs or PPOs will not provide good quality care," Waldron maintains, "but the question of care permeates the whole health-care system, not just HMOs."

HMOs are the original managed care arrangement and are used by over 14 percent of the U.S. population. They provide an agreed-upon amount of health-care services to enrollees, usually with no deductibles or with minimal copayments. HMOs can either employ health-care providers directly or contract with medical groups.

Despite their wide usage (enrollment in HMOs alone has increased tenfold in the past two decades, according to Dr. Arthur M. Southam, of CareAmerica Health Plans), the cost-cutting effectiveness of HMOs has come under heavy attack.

Some argue that HMOs are nothing more than assembly line operations, where doctors diagnose rows of faceless patients who sometimes pass too swiftly down the conveyer belt. Many employers claim they are not controlling health-care costs effectively.

Only one-third of U.S. employers feel that HMOs control health-care costs, and 60 percent feel PPOs control costs, according to A. Foster Higgins & Co., a national benefits consultant. Another survey, conducted by Confederation Life, found that HMOs are losing ground to utilization review and PPOs, which are gaining in popularity.

Employers also said that from 1988 to 1989, HMO premiums went up 16.5 percent, from $1,991 to $2,319 per employee.

Furthermore, according to American International Healthcare in Rockville, Md., the HMO industry has lost over $2 billion between 1986 to 1989, while the number of HMOs decreased from 607 to 575 between January 1989 and January 1990.

At the same time, HMO premiums increased 16.7 percent in 1989 (according to CareAmerica Health Plans) and are expected to increase another 12 percent by next year.

Some industry leaders say the cost increase of HMOs is at a higher rate than the overall rate increase of the health-care system.

A new wrinkle in the HMO fabric that could change the whole tapestry is something called an open-ended HMO or a point-of-service program (POS).

Under a POS, such as the one pioneered by CIGNA, members get to cently, a Washington, D.C., consumer magazine rated over 300 dentists in the metropolitan area, right there alongside the microwaves, stereos and toaster ovens.

By conducting opinion polls among patients, the magazine rated the dentists on competence, chair-side manner, condition and quality of equipment, efficiency and, of course, price. The magazine plans to accord the same treatment to hospitals in a future issue.

Traditionally, however, the impetus for keeping health-care costs in check has come from the middlemen; the companies and institutions that, in one way or another, cover the cost of health insurance. Uncharacteristically, one of the earliest players to realize costs were getting out of hand and to take preventive action was the United States government.

In 1982, faced with rising costs and deficits, Congress directed Medicare to develop a structured payment system for reimbursing hospitals. The purpose of that system, known as diagnosis-related groups (DRGs), was to keep costs down by standardizing payments for specific treatments.

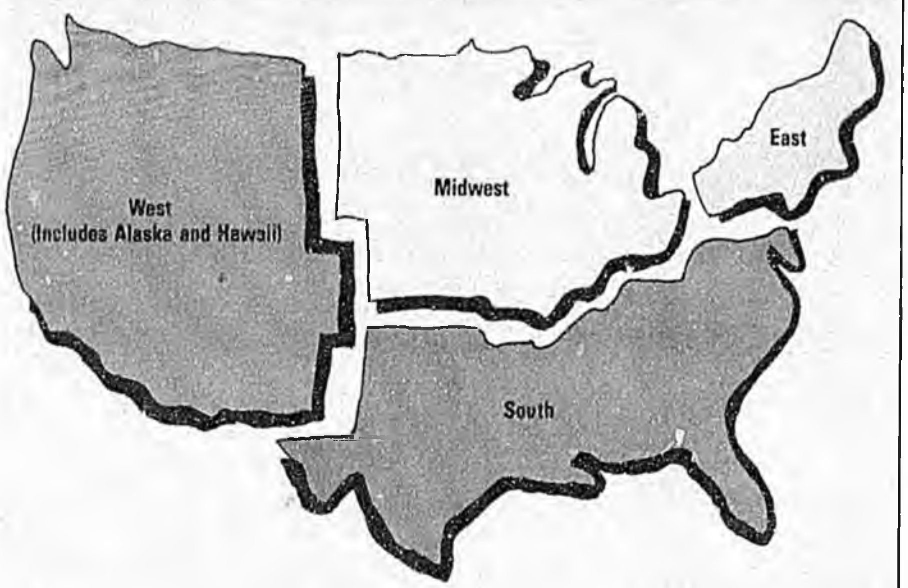
But that's not exactly how it worked. Since hospitals couldn't charge the government what they wanted to, they made up the difference by charging private insurance carriers more. While the use of DRGs succeeded in keeping Medicare's costs down, they merely shifted the cost from the government to the private sector.

Cost shifting is only expected to get worse. Last year, Congress reduced Medicare reimbursements by $34 billion over five years and introduced a new system of reimbursements to private physicians called resource-based relative value scale (RBRVS).

Based on a Harvard University Medical School study, RBRVS assigns a certain value reflecting the resources required for a procedure, compared with a specific baseline. Again, whatever Medicare saves through these procedures is sure to be passed along by the hospitals to private payers.

## HEALTH STAT

**Supplemental Benefits of Managed Care: Where in America Do You Find Them?**




### Regional Variations of Managed Care

Percentage

| | | | | |
|---|---|---|---|---|
| HMO | 74 | 58 | 44 | 69 |
| PPO | 57 | 31 | 35 | 16 |
| Managed mental health care | 25 | 35 | 26 | 30 |
| Case Management | 47 | 37 | 38 | 34 |

### Regional Variations of Supplemental Benefits

Percentage

| | | | | |
|---|---|---|---|---|
| Separate prescription drug program | 31 | 37 | 27 | 43 |
| Vision plan | 49 | 29 | 27 | 34 |
| Dental plan | 94 | 79 | 77 | 79 |
| Long-term care plan | 25 | 18 | 19 | 23 |

Source: April 1990 *Business & Health*

### MANAGED CARE

Probably the most common cost containment practice today is known as managed care; this is usually in the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

PPOs provide their members with health-care services by selected providers and help reduce health-care costs by limiting in-patient care, unnecessary surgery, the number of phy-

## Focus On Cost Containment

"The Rand Corporation estimates that 25 to 33 percent of all health-care services are not medically necessary," said O'Brien at a meeting of the National Association of Independent Insurers. "This translates into at least $150 billion."

In any other marketplace, competition would be a strong incentive to keep costs down. But Americans don't seem to be comfortable with the idea of shopping for a doctor or a hospital.

"We Americans, when we need health care, want nothing but the very best and history has proven that price is secondary," says Carl W. Hill, CLU, Blue Cross/Blue Shield of Delaware in Wilmington. "We're hard business people when it comes to just about every other buying decision except health care."

Not long ago, the health-care industry started making moves that looked a lot like competition, according to Sally I. Nelson, of Nelson, Desmond and Payne Insurance in Falmouth, Maine. Doctors started competing with hospitals by opening up their own walk-in clinics, doing their own lab tests and investing in high tech equipment.

But appearances are deceiving.

"They're already taking business away from hospitals," says Nelson. "But they aren't charging any less. Many statistics say that costs are actually higher because of it, at least in our state. So it's really more cost shifting than competition."

There is also the prevalent perception that the more expensive a doctor is, the better he is. When it comes to health care, you get what you pay for.

"I've had doctors tell me that they charge more than 'usual and customary' because they're worth it," says J. Richard Jones, LUTCF, from Macon, Ga." And they mean it."

Still, there are signs of hope. Re-

**Managed care is supposed to keep the supply-side costs of health care under control. If these measures don't work, the alternative may be even more unpleasant.**

PHOTO CAN GLASS

# Cost Containment: Is It Working?

By Steven Sullivan, *LAN* Features Editor

It doesn't cost anything to get sick in America. But it does cost a pretty penny to get well, and the cost seems to keep rising all the time—more than twice the pace of general inflation. It won't be long, many critics maintain, until only the wealthy can afford to be healthy.

There's no shortage of finger-pointing when it comes to allocating blame. Consumers point to employers for passing more of the cost of health care on to them. Employers point to insurers for raising insurance premiums. And insurers point to providers for charging too much.

They all have a point, but the fact remains that doctors, hospitals and other health-care providers charge a lot for their services. In 1979, the cost of health care per person was $349. By 1989, the cost had climbed to $2,748. By the year 2000, it's estimated that the cost of health care will reach a sobering $5,500 per person.

The growing cost and use of new medical technologies are major reasons, but surveys show that a whopping 25 percent of the rise is due to unnecessary treatments, while one-fifth is due to the amount that health-care costs have risen above the general inflation rate.

Another reason for escalating costs is that Americans just go to the doctor too often. According to Linda O'Brien, marketing director of Intracorp of Berwyn, Pa., Americans spend 31 percent more of their resources on health care than Canadians, 65 percent more than the Japanese and 79 percent more than the English.

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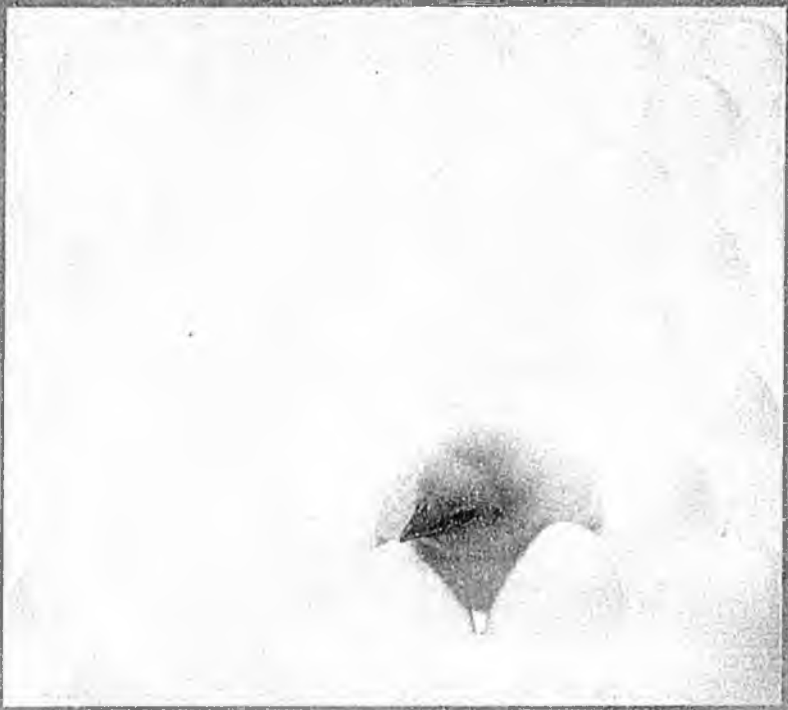

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*Employee Benefit Plan Review, April 1990

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# The AIDS Epidemic: How The Insurance Industry Has Responded

**By Steven Sullivan, *LAN* Features Editor**

Focus On AIDS

When the cost of the acquired immune deficiency syndrome (AIDS) epidemic is reckoned, it is usually reckoned in lives. And the cost is staggering: over 95,000 deaths out of 152,000 reported cases as of October 1990, according to the United States Public Health Service. The Centers for Disease Control in Atlanta puts the number of Americans infected with the AIDS virus at somewhere around 1 million.

But the monetary cost of AIDS is staggering, too, and one segment of the community that seems to be bearing a large part of the burden is the life and health insurance industry. According to a survey conducted by the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA), the nation's life and health insurance industry paid an estimated $1 billion in 1989 AIDS-related claims.

This brings the industry's estimated cumulative total to $2.38 billion since 1986, when actuaries began collecting statistics on claims related to AIDS.

Not surprisingly, like the epidemic itself, these figures point to a rising trend. AIDS-related claims for individual life insurance were 1.7 percent of the industry's total claims paid in 1989, up from 1.1 percent the previous year. Group life claims, calculated at 1.6 percent in 1988, were up to 2.5 percent in 1989. Individual accident and health claims increased from 0.9 percent in 1988 to 1.3 percent the following year, while group accident and health claims rose to 1.4 percent in 1989 from 0.8 percent in 1988. (See tables, pp. 60-61.)

The average size of an ordinary life

**The life and health insurance industry hasn't settled for simply protecting itself against the AIDS drain.**

PHOTO IAN GLASS

**Table 1**
**Estimated AIDS-Related Claims Paid**
**Industry Total for Four Major Lines**
**(Amount of claims shown in millions)**

| Line of Business | 1986 | 1987 | 1988 | 1989 |
|---|---|---|---|---|
| Individual Life | $93.3 | $130.0 | $135.5 | $ 221.7 |
| Group Life | 79.4 | 132.5 | 155.5 | 253.0 |
| Individual A & H | 34.7 | 35.9 | 50.3 | 79.4 |
| Group A & H | 84.8 | 188.0 | 248.6 | 455.0 |
| TOTAL | 292.2 | 487.2 | 589.9 | 1,009.1 |

AIDS-related death claim in 1989 was $28,200, up sharply from 1988's $19,600, but slightly less than the $30,500 average in 1986. The average size of the group life AIDS-related claims was $34,200 in 1989.

"The survey results may significantly understate the number and amount of AIDS-related life and health insurance claims paid by the reporting companies," explains the report. Included among the reasons for this are death certificates that may not contain sufficient information about the cause of death, and health claim information that may not describe a patient's treatment as AIDS-related.

Although the number of reported cases is expected to increase, the impact it will have on the insurance industry is not as great as previously anticipated. One reason for this is that the industry seems to have won its fight to make testing for the HIV antibody part of the underwriting process.

Medical evidence strongly suggests that the presence of the HIV antibody almost guarantees that AIDS will follow. AIDS activists argued, however, that the cause-effect relationship is not necessarily axiomatic. AIDS testing by insurance companies, they maintain, is unfairly discriminatory and they were successful at making it illegal in many jurisdictions across the country.

Recently, however, the District of Columbia and such states as California and Massachusetts have heeded the medical evidence and reversed their testing bans, allowing insurance companies to make HIV testing part of the normal underwriting process.

"Obviously, we expect continued

claims," says Gene Grabowski, a spokesman for ACLI, "although the claims will probably drop off. The vast majority (though not all) of insurance companies are screening with AIDS tests to protect against anti-selection. That means that fewer people with AIDS are going to be in the insured group and we do not expect to see levels like we had last year.

"At this time, the industry has not been damaged by the AIDS claims payouts," adds Grabowski. "We have prepared for it, made the necessary actuarial deductions and set aside enough money for it."

Stanley G. Karson, director of the Center for Corporate Public Involvement, a life and health insurance industry organization, is not quite so sanguine.

"Because of the 10-year incubation period, the number of AIDS cases will be getting much higher in the next several years," says Karson. "The number of infected people is much larger than the number of AIDS cases thus far."

But, he adds, nobody really knows the answer for sure.

### THE RIGHT THING

Does that let the insurance industry off the hook as far as AIDS is concerned? Apparently not. There is another aspect of the financial burden of AIDS the insurance industry has assumed willingly, even aggressively—the support and funding of AIDS education, prevention and research programs.

By the end of 1991, according to figures provided by the Center for Corporate Public Involvement, insurance companies and affiliated trade associations will have contributed an estimated $34 million to education programs, research efforts and community groups serving people with AIDS.

This is not a new phenomenon. The life and health insurance industry took an early leadership role back in 1986 by providing $1.6 million for the first full-scale AIDS public education program. According to Stanley Karson, director of the center, the insurance industry has become the largest AIDS funder in corporate America.

"Clearly, the industry's self-interest was heavily involved," says Karson, "but so what? For 25 years, we have avowed that self-interest is a basic rationale for corporate social responsibility."

In addition to the center, the Industrywide Network for Social, Urban and Rural Efforts (INSURE), a non-profit foundation made up of several HIAA and ACLI companies, has pledged to provide $2 million in matching grants to community-based organizations, $900,000 of which has already been awarded.

Among the recipients, located in ur-

**Table 2**
**AIDS-Related Claims**
**As Percentage of Total Claims**
**Responding Companies**

| Line of Business | 1986 | 1987 | 1988 | 1989 |
|---|---|---|---|---|
| Individual Life | 0.9% | 1.2% | 1.1% | 1.7% |
| Group Life | 0.9% | 1.4% | 1.6% | 2.5% |
| Individual A & H | 0.7% | 0.7% | 0.9% | 1.3% |
| Group A & H | 0.3% | 0.6% | 0.8% | 1.4% |

Source: American Council of Life Insurance/Health Insurance Association of America, 1989 AIDS-Related Claims Survey.



ban and rural areas all across the country, is the Community of Hope Health Services in Washington, D.C.

"The Community of Hope health clinic emphasizes direct care, education and prevention in treating AIDS and those infected with the HIV virus," says Lois Smith, the clinic's director. "In addition, we have a 12-week health advocate training program for people in the community that focuses on a variety of health issues, one of which is AIDS. The grant we received from INSURE has been used to employ one of these health advocates as an outreach person in the low-income community."

In addition to working through industry trade associations, many large life insurance companies sponsor their own AIDS relief programs in their local communities. The John Hancock in Boston, for instance, has sponsored numerous activities to raise money for its local AIDS Action Committee and has made its meeting facilities available to any AIDS-related organizations that want to use them.

John Hancock has also helped fund a 30-minute dramatic film called "Mother, Mother," designed to create compassion and understanding for people with AIDS. The film has had a national distribution and has been the focus of several fundraisers across the country.

"We believe the best way to combat AIDS is through education," says Pamela B. Kruh, spokeswoman for John Hancock. "Most of our support has been for educational programs, sponsorships and fundraisers designed to increase public awareness and understanding of the disease."

"The focal point of our anti-AIDS efforts," says Mark Lucius, a spokesman for Northwestern Mutual in Milwaukee, Wis., "is the education program we've done with the Red Cross here in Milwaukee over the last three years. So far, we've contributed about $130,000."

Northwestern has also given $18,000 to the Milwaukee AIDS Project for library resources and $135,000 over three years to the Milwaukee Blood Center for AIDS research, as well as smaller amounts to numerous other local organizations.

For the past two years, the National Association of Life Underwriters (NALU) itself has been marketing a two-hour AIDS education seminar to member associations across the country. "AIDS Strikes Home: You, Your Company, Your Career" is designed to help agents respond to clients' questions about AIDS, and also to let them know where to get the most accurate information.

In addition, according to Paul Meyer, NALU's director of education and member services, much of the AIDS material has also been incorporated in the recently revised four-hour seminar, "The Dynamics of Group Insurance." Both seminars are available from NALU's order department (202/331-6086).

"Private money has not necessarily been going to AIDS research, at least in our case, because that's where government money has been going," says Karson. "Money for research was not as needed and asked-for by the AIDS community as was money for education, prevention, and direct support for persons with AIDS. That's where our money is going."

By 1992, according to ACLI, the $34 million contributed by the aggregate of all insurer-sponsored programs to the fight against AIDS, is more than they've ever given for any other specific disease.

For Stanley Karson, a man Gene Grabowski describes as the "conscience of the industry," there's more than just self-interest at work here, no matter how enlightened that self-interest might be.

"Another reason for corporate public involvement," says Karson, "one seldom uttered as though it would embarrass or even taint the source, applies so well to the industry's commitment in the fight against AIDS.

"It was the right thing to do." ■

*I/R Code: 4400.03 Life Insurance in Action*

# Living Benefits Riders: Great Hype Or Great Hope?

By Joseph C. Razza Jr., CLU, *LAN* Senior Editor

When Ron D. Barbaro, then president of Prudential's Canadian operations, announced living benefits for terminally ill insureds, headlines blazed the news across Canada and the United States. For the first time in years, press coverage of the insurance industry was extensive and glowing.

Barbaro, who already had a reputation as a creative maverick in the industry, saw living benefits as a practical and humane way for the industry to help destitute and terminally ill patients keep their dignity by providing money for medicine, food and housing. The concept gained such rapid acceptance industry-wide that many believe it was at least partially responsible for Barbaro becoming President and CEO of parent company Prudential of America in the Fall of 1990.

Prudential of America brought the program to American policyholders in January 1990, offering a living benefits option to new and existing insureds as quickly as it could get state approval. By mid-December 1990, 44 states had approved the option and over three million policyholders were covered.

And in November 1990, the company extended the concept to insureds who are permanently confined to a nursing home. The option is currently available to new clients buying policies with face amounts of $50,000, and to clients with in-force policies of $25,000 or more.

James Longo, Prudential's public relations manager, Newark, N.J., said there is no separate charge to the policyowner for this option. However, when the client exercises the option, the company discounts the amount for the six months of interest it loses by paying the living benefit to the insured.

He offered this example: If a terminally ill client owns a $100,000 policy and exercises the option, Prudential will deduct the interest the company would have earned for six months had the policy remained in force. If the current interest rate is 8 percent a year, the company would keep 4 percent of the face amount and the client would get about $96,000.

"The terminally ill insured can collect about 95 percent of the face value of the policy," Longo said. "The remainder is the interest Prudential would have lost. And that is

the only cost involved."

The tax implications of receiving living benefits are unclear at the moment. It is possible that the Internal Revenue Service (IRS) will tax the benefits as ordinary income. The IRS has yet to make a determination on this point.

Many other insurance companies in the United States have followed Prudential's lead and are developing living benefits options, riders and policies (for more detail see our survey of living benefit products on page 68). In some companies, they are called accelerated benefits, and in others convalescent care riders or policies. Because these products are so new, companies do not know how the public or their agents will accept and use them. In some cases, however, new product results have been disappointing.

Robert B. Daney, CLU, ChFC, FLMI, Lincoln National's second vice president of individual products marketing in Ft. Wayne, Ind., said his company offers a convalescent care benefit rider, but the product is not particularly popular with agents and brokers. He estimated that only 10 percent of Lincoln National's policyholders bought the convalescent benefits care rider through the agent/broker distribution system.

On the other hand, a sister company, First Pacific Penn, is writing a lot of this coverage through financial institutions. He estimates this company is putting the rider on about 35 percent of all policies.

In describing these transactions, Daney said that financial institutions

**Focus On Living Benefits**

**Living benefits help clients who are terminally ill to spend their last days with dignity. But despite massive publicity, a great idea hasn't yet translated into great sales for some companies.**

sell the rider primarily as a substitute for certificates of deposit (CD). If a person with a $100,000 CD in one bank decides to move the money to another bank, the first bank refers the lead to its insurance department. In contacting the customer, the agent says, "We're sorry to lose your business in the CD. Perhaps, we have something better than taking it down the street to one of our competitors.

"Could we talk to you about a single premium life insurance policy? This policy will provide comparable crediting rates but also provide additional benefits that a CD at a competing bank couldn't provide, such as death benefit protection and long-term care protection."

Banks do not widely advertise these products because they don't want to have disintermediation between their own CDs and their insurance company. However, once the bank determines that it will lose the CD, then it will pursue the insurance sale and emphasize the accelerated benefits rider.

"We don't think that would be a particularly popular rider," Daney said. "Living benefits are getting a lot of attention in the media. It is something that we want to have. However, I think we will have a similar experience to Prudential and other companies where there is a lot of hype, but not a lot of action."

However, William J. Castle, assistant vice president and associate actuary of Security-Connecticut, Avon, Conn., expects interest in the living benefits option will be high. He predicts that once the IRS clears up the tax questions about these benefits, public interest in these products will be great.

His company will charge a $150 administration fee when the option is used and discount the payout by the amount of interest the company will lose by providing the living benefit to the client. To qualify for Security-Connecticut's option program, a client must have a minimum of $100,000 of insurance with the company.

The living benefit is limited to 25 percent of the face amount, with a maximum of $250,000. Clients may exercise the option for any diagnosed terminal illness, whether or not the policyowner is at home, in a hospital or in a nursing home facility.

Castle said the company used the option rather than either a policy loan or a lien because the policyowner could be severely hurt if the diagnosis was incorrect. He said a lien is similar to a policy loan. The difference is that the amount of money paid to the client as a living benefit may exceed the cash value of the policy. If the diagnosis is wrong and the policyowner survives, the loan interest could equal the death benefit, leaving no money for the beneficiaries when the policyowner dies.

Prudential's Longo said that since January 1990, the company has had about 75 claims, chiefly from clients who were over 50 and suffering with cancer or AIDS.

Fred N. Bush, LUTCF, a Prudential sales manager in North Versailles, Pa., praised the living benefits option, introduced in his area in September 1990.

"We have been contacting all our clients who received the letters to explain the benefit to them. They all want to add the rider," he said. "That leads to the agent reviewing the client's total insurance portfolio. The result is that we are writing a lot of new business. The client reasons that if he needs to use the living needs benefit, he still wants to have some death benefits for the family."

Bush said, "As of mid-December, my staff has increased its production of life insurance by at least 50 percent. A lot of that increase is attributable to the living benefits. That's the approach that we use. We cover the living benefit in the interview, and it lets us get into a whole needs presentation with the client." ■

*I/R Code: 5600.07 Policyholder Service*

# *LAN*'s Survey of Living Benefits Insurance Riders

| | Company Name<br>Policy Name or Number | Policies It Can Be Attached To | Age Limit on Purchase | Premium Type | Waiver of Premium | Smoker/ Non-smoker Rates | Events Triggering Early Payout |
|---|---|---|---|---|---|---|---|
| 1. | **Aegon USA/Life Investors**<br>Accelerated Death Benefit Rider | Universal Life | 50 | Level | No | Yes | Heart Attack, Stroke, Life-threatening Cancer, Bypass, Major Organ Transplant |
| 2. | **Bankers Life & Casualty**<br>Accelerated Death Benefit Rider | Fixed & Flexible Premium Universal Life | 75 | No Charge | N/A | N/A | Terminal Illness or Permanent Confinement in a Nursing Home |
| 3. | **Best Meridian Insurance**<br>Accelerated Benefit Rider | Whole Life | 65 | No Charge | N/A | N/A | Heart Disease, Terminal Cancer |
| 4. | **Continental General**<br>L4600F (Uni-Flex) | Universal Life | 75 | Increases | Yes, to Age 60 | Yes | Heart Attack, Cancer, Renal Failure, Coronary Artery Surgery, Stroke, Major Organ Transplant |
| 5. | **Continental Western Life**<br>Long-term Care Rider #01359 | Universal Life | 25-70 | Increases | Yes, During Benefit Period | No | Confinement in an LTC Facility |
| 6. | **Equitable Life of Iowa**<br>Silver Plan | Universal Life | 20-65 | Level | Yes, for Length of Disability | No | Unable to Perform 3 Activities of Daily living (ADLs) as Defined |
| | Gold Plan | Universal Life | 20-65 | Level | Yes | No | Unable to Perform 3 ADLs |
| 7. | **Guarantee Mutual Life**<br>Living Benefit Rider | Universal Life | 75 | Increases | No | Yes | Heart Attack, Stroke, Coronary Artery Surgery, Life-threatening Cancer, Renal Failure, Major Organ Transplant, Paraplegia, Blindness |
| | Long-term Care Rider | Universal Life | 75 | Increases | Yes, During Period of Care | No | Confinement to a Nursing Facility or Need for Home Convalescent Care |
| | Long-term Care Plus | Universal Life | 75 | Increases | Yes, During Period of Care | Yes | Heart Attack, Stroke, Coronary Artery Surgery, Life-threatening Cancer, Renal Failure, Major Organ Transplant, Paraplegia, Blindness and Confinement in a Nursing Facility or Need for Home Convalescent Care |
| 8. | **Gulf Life**<br>Death Benefit Advance Rider | Any Policy | 30-60 | Level | Yes | Yes | 6-month Life Expectancy |
| 9. | **ITT Life**<br>Long-term Care Rider | Universal & Whole Life | 20-75 | Level | Yes, 90 Days Beyond Benefit Period | Yes | Unable to Perform 2 ADLs |
| 10. | **Jackson National**<br>Lifeline Ultimate | See Footnote[3] | 80 | Level | Yes[4] | Yes | Heart Attack, Stroke, Cancer, Renal Failure, Bypass |
| | Lifeline Level Term Rider | Lifeline Ultimate & Interest-sensitive Whole Life | 70 | Increases | Yes[4] | Yes | Heart Attack, Stroke, Cancer, Renal Failure, Bypass |
| 11. | **John Hancock Mutual Life**<br>Living Care Benefit Rider | Whole Life | 20-75 | Level | Yes | No | Confinement in a Nursing Home or Receiving Home Health Care |
| 12. | **Leaders Life**<br>Lifestyle | See Footnote[3] | 70 | Level | Yes[5] | No | Heart Attack, Heart Surgery, Cancer or Stroke |
| | Term to 100 with Accelerated Benefits | See Footnote[3] | 70 for 30% benefit, 55 for 60% | Level | Yes[5] | Yes | Heart Attack, Heart Surgery, Cancer or Stroke |

| Percent of Face Amount Paid | Maximum Payout | When Benefit Is Paid | Covers Medical Care Costs Only | Pre-Existing Conditions | Benefit Can Be Collected | States Where Policy Is Sold |
|---|---|---|---|---|---|---|
| Up to 50% | $100,000 | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK, AZ, AR, CO, DE, ID, IN, IA, KY, LA, MD, MS, MO, MT, NE, NM, ND, OH, OR, RI, SD, TN, WV, WI, WY |
| Up to 100% | None | Upon Diagnosis Over Time | No | None | Whenever Qualified | State Approvals Pending |
| 25% | $25,000 | Upon Diagnosis Over Time | No | None | Once | FL |
| 50% | $50,000 | Upon Diagnosis in a Lump Sum | No | 2 Months After | Once | AL, AK, AZ, AR, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, MD, MS, MO, MT, NE, NV, NM, NC, ND, OH, OK, OR, SD, TN, TX, UT, WA, WV, WI, WY |
| See Footnote[1] | N/A | Upon Confinement | No | 60 Months After | More Than Once | AL, AK, AZ, CO, DE, HI, ID, IL, IA, LA, MS, MO, MT, NE, OH, OK, OR, SD, WI, WY |
| 50% | None | As Expenses are Incurred | Yes | 6 Months Before & 6 Months After | More Than Once | AL, AK, AZ, AR, CO, DE, ID, IN, IA, KY, LA, MD, MO, MT, NE, NV, NM, ND, OH, OK, SD, TN, WA, WV, WY |
| 100% | None | As Expenses Are Incurred | Yes | 6 Months Before & 6 Months After | More Than Once[2] | AL, AK, AZ, CO, DE, ID, IN, IA, KY, LA, MD, MO, MT, NE, NV, NM, ND, OH, OK, SD, TN, WA, WV, WY |
| 25% | $250,000 | Upon Diagnosis in a Lump Sum | No | 2 Months After | Once | AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY |
| 50% | $250,000 | After Elimination Period, Over Time | No | 6 Months Before & 6 Months After | More Than Once | AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY |
| 75% to Age 70, 50% Thereafter | $125,000 ($250,000 for Long-term Care) | Upon Diagnosis in a Lump Sum, or Over Time for LTC | No | 6 Months Before & 6 Months After for LTC; 2 Months After for illness | Once for Illness; More Than Once for LTC | AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY |
| 50% | $100,000 | Upon Diagnosis in a Lump Sum or Over Time | No | 6 Months Before | More Than Once | AL, FL, GA, KY, LA, MS, NC, SC, TN, VA |
| 48% | $7,250 per Month | Monthly | No | 6 Months After | More Than Once | AL, AK, AZ, AR, CA, CO, DE, FL, HI, IL, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PR, RI, TN, TX, VI, VT, VA, WI, WY |
| 25% | None | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, WA, WV, WI, WY |
| 25% | None | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, WV, WI, WY |
| 50% | $5,000 per Month for Nursing Home Care) | After 90 Days | No | 6 Months After | More Than Once | AK, AZ, AR, CO, DE, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, TX, VA, WA, WV, WY |
| 30% | $29,070 | Upon Diagnosis in a Lump Sum | No | 90 Days | Once | OK |
| 30% or 50% | $250,000 | Upon Diagnosis in a Lump Sum | No | 90 Days After | Once | OK |

FOOTNOTES

[1] Pays out that portion of the policy equal to the risk at the end of the elimination period
[2] Until face amount is depleted
[3] Individual policy
[4] For life, if disabled
[5] For one year
[6] $100,000 for coronary bypass
[7] After 90 days
[8] Immediately, if shown on the application
[9] 16-75 for smokers

| | Company Name<br>Policy Name<br>or Number | Policies It Can Be Attached To | Age Limit on Purchase | Premium Type | Waiver of Premium | Smoker/ Non-smoker Rates | Events Triggering Early Payout |
|---|---|---|---|---|---|---|---|
| 13 | **Life of Georgia**<br>Accelerated Benefit Care | Universal Life | 15-65 | Level | Yes | Yes | Cancer, Renal Failure, Severe Injury |
| 14 | **Lincoln National**<br>Convalescent Care Benefit Rider | Universal Life | 18-70 | Increases | Yes | No | Confinement in a Nursing Facility and Unable to Perform 3 ADLs |
| 15 | **Midland National**<br>Accelerated Benefit Rider | Universal Life | 80 | Increases | No | Yes | Heart Attack, Stroke, Coronary Artery Surgery, Major Organ Transplant, Renal Failure, Life-threatening Cancer |
| 16 | **Mutual of Omaha**<br>Living Benefits | Employer-sponsored Group Term | N/A | Level | No | No | Terminal Illness with 9-month Life Expectancy |
| 17 | **Nationwide**<br>Long-term Care Rider | Universal Life | 21-70 | Increases | Yes, for Length of Disability | Yes | Confinement to an LTC Facility |
| 18 | **Old American**<br>Golden 50 | See Footnote[3] | 80 | Level | No | No | Terminal Illness |
| | Benefit Pre-Payment Plan | Whole Life | 80 | Level | No | No | Terminal Illness |
| 19. | **Principal Mutual Life**<br>Benefit Advance | Whole Life | None | No Charge | N/A | N/A | 12-month Life Expectancy |
| 20 | **Provident Life & Accident**<br>Living Benefit Option Rider | Employer-sponsored Group Universal Life | N/A | N/A | No | Yes | Terminal Illness |
| | Accelerated Benefit Life | See Footnote[3] | 20-70 | Level | Yes | Yes | Life-threatening Cancer, Heart Attack, Heart Transplant, Bypass, Stroke |
| 21. | **Saleco**<br>L-9570 | Permanent & Term | None | No Charge | N/A | N/A | 6-month Life Expectancy |
| 22. | **Security-Connecticut**<br>Living Benefits Rider | All Policies | None | No Charge | N/A | N/A | 6-month Life Expectancy |
| 23. | **State Life**<br>VitalCare Plus | Universal Life | 20-75 | Increases | Yes, During Payout and 90 Days After | No | Nursing Home Confinement |
| 24. | **Time Insurance**<br>Long-term Care Rider | Universal Life | 20-75 | Level | Yes | Yes | Confinement to an LTC Facility |
| | Accelerated Death Benefit Rider | Universal Life | 75 | Level | No | Yes | Heart Attack, Stroke, Bypass, Life-threatening Cancer, Confinement in an LTC Facility |
| 25. | **Transamerica Occidental Life**<br>Living Benefit Rider | Universal & Interest-sensitive Whole Life | 75[9] | Level | Yes | Yes | Alzheimer's Disease, Heart Attack, Coronary Artery Disease, Stroke, Life-threatening Cancer, Renal Failure |

| Percent of Face Amount Paid | Maximum Payout | When Benefit is Paid | Covers Medical Care Costs Only | Pre-Existing Conditions | Benefit Can Be Collected | States Where Policy Is Sold |
|---|---|---|---|---|---|---|
| 25% | $250,000[6] | Upon Diagnosis in a Lump Sum or Over Time | No | 90 Days After | Once | AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA |
| 2% per Month | Varies | Upon Diagnosis Over Time[7] | No | 6 Months After[8] | More Than Once | AL, AK, AZ, AR, CA, CO, DE, DC, FL, HI, ID, IL, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, TX, UT, VA, WA, WV, WY |
| 25% | $125,000 | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK AZ, AR, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, VT, WA, WV, WI, WY |
| 25% | $50,000 | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK, AZ, AR, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, SC, SD, TN, UT, VA, WA, WV, WI, WY |
| 50% | $3,000 per Month | 3 Months After Confinement | Yes | 6 Months After | More Than Once | AL, AK, AZ, CA, CO, DE, GA, ID, IL, IN, KY, LA, ME, MD, MS, MO, NE, NV, NH, NC, ND, OH, OK, OR, PA, RI, SD, TN, UT, VA, VI, WV, WY |
| 50% | $25,000 | Upon Diagnosis in a Lump Sum or Over Time | No | N/A | More Than Once | AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, LA, MD, MI, MN, MS, MO, MT, NE, NV, NM, NC, ND, OH, OR, SC, SD, TN, TX, UT, VA, WV, WI, WY |
| 50% | $25,000 | Upon Diagnosis in a Lump Sum or Over Time | No | N/A | More Than Once | AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, LA, MD, MI, MN, MS, MO, MT, NE, NV, NM, NC, ND, OH, OR, SC, SD, TN, TX, UT, VA, WV, WI, WY |
| 75% | $250,000 | Upon Diagnosis in a Lump Sum or Over Time | No | N/A | More Than Once | AL, AK, AZ, AR, CO, DE, FL, GA, HI, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, NC, OK, OR, RI, SD, TN, UT, VA, WV, WI, WY |
| 25% | $25,000 | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AZ, AR, CA, CO, DE, FL, GA, IA, KY, LA, MS, MO, MT, NE, NV, NH, ND, OH, OK, TN, UT, VA, WA, WY |
| 30% | $300,000 | Upon Diagnosis in a Lump Sum | No | None | Once | AL, AK, AZ, AK, CA, CO, DE, DC, FL, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WV, WI, WY |
| 75% | None | Upon Diagnosis in a Lump Sum | No | None | Once | AK, GA, HI, LA, MA, MI, MS |
| 25% | $250,000 | Upon Diagnosis in a Lump Sum | No | None | Once | State Approvals Pending |
| 100% | $1 million | Upon Diagnosis Over Time | No | Covers All | More Than Once | AL, AK, AZ, AR, CA, CO, DE, DC, HI, ID, IN, KY, LA, MD, MI, MS, MO, MT, NE, NV, NH, NM, NY, ND, OH, OR, SD, TN, VT, WV, WI, WY |
| 50% or 100% | $500,000 | After 90 Days, Over Time | Yes | None | More Than Once | AL, AZ, AR, CA, CO, DE, GA, ID, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, OH, OK, RI, SD, TN, TX, WA, WV, WI, WY |
| 10% or 25% | $250,000 | Upon Diagnosis in a Lump Sum | No | 2 Months After | Once | AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, KY, LA, ME, MD, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, RI, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY |
| Up to 25% | $250,000 | Varies | No | None | Once | AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, UT, WA, WV, WI, WY |

**FOOTNOTES**
[1]Pays out that portion of the policy equal to the risk at the end of the elimination period
[2]Until face amount is depleted
[3]Individual policy
[4]For life, if disabled
[5]For one year
[6]$100,000 for coronary bypass
[7]After 90 days
[8]Immediately, if shown on the application
[9]16-75 for smokers

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Quality sells itself. Especially to your potential clients who need mini-group health insurance programs. But they can be hard nuts to crack if they have seen their previous carriers desert them or suddenly double their rates. You can't blame them. But you can impress them with John Alden Life's record of stability and commitment in the mini-group health insurance market.

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When you present a John Alden Life Mini-Group Program to a potential client, you can tell them what they want to hear. Explain that 100% rate increases won't come out of the blue. Even when rate increases are unavoidable, John Alden Life spreads the increase across an entire block of business so no single group has to bear the whole load. You could tell them how we don't indulge in the re-entry underwriting, substandard experience rating by group and substandard pooling tactics others use. You could, but the real bottom line is how John Alden Life can keep health insurance costs under control.

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# Don't Forget The Disability Sale

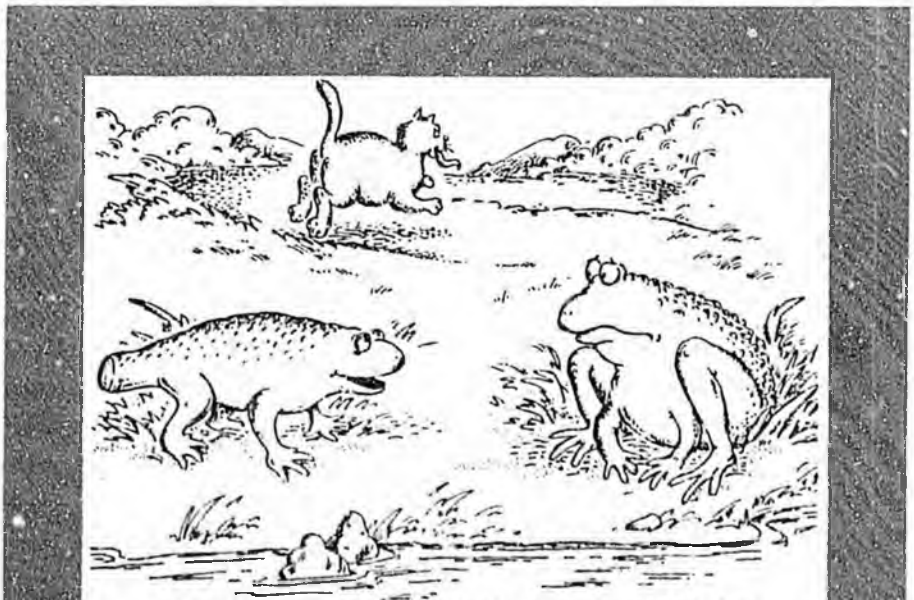
By Steven Sullivan, *LAN* Features Editor

It isn't often that the business press is actually on the side of insurance agents. Yet there it was, printed in the business section of the April 29 *New York Times:* "Many employees . . . assume they have adequate coverage through their employee benefit plans and that they don't need to buy their own policy. But even if your company offers disability plans, buy your own anyway."

Sounds like an invitation, doesn't it? So what are you waiting for?

**Joel Garfield, CM Alliance, Detroit, Mich.,** believes that disability income insurance (DI) is sold, not bought. That means that if most people aren't buying it, there must be a lot of agents out there who aren't selling it. To Garfield, this makes no sense. He points to what he calls "Garfield's Analogy."

"When an individual goes on claim for life insurance," he says, cheek bulging with tongue, "he's usually dead. A person only dies once. And when that person dies, my commissions cease. However, when a person becomes disabled, I can get involved with him. I become a very important man in that family. I am the one bringing the checks when the employer doesn't. And it's usually for a long period of time. While they're collecting, their premiums are waived. But my commissions are still coming. You



*"What do you mean disability? This thing always grows right back."*

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**Focus On Disability**

make more money as an agent by selling disability than by selling life."

Wait a minute. More money with DI? Absolutely, says Garfield.

"The persistency on disability is better than on life. More people are reluctant to drop it and it's not uncommon to see renewals of 15 to 25 percent. You may be dealing with smaller amounts but it's a steady stream of income."

Garfield's sales approach depends on statistics and analogies. He begins by asking prospects about their medical insurance—have their rates been going down or up?

They usually laugh at that one. Up, of course. Garfield explains that part of the reason is usage. More and more people are using their health insurance, which means that more and more people are in hospitals and medical facilities.

If a person is in the hospital, using his medical coverage, then he's not earning a living. And that's why a person needs disability, to make sure that when he can't earn a living, Garfield's company will pay him.

If that doesn't work, Garfield has another approach. He mentions a particular funeral home familiar to most of his clients. How many stories high is it?

One, they answer.

And what about the local hospital? How many stories high is that?

You know, he tells them, they don't make them that high for nothing. Obviously there are more people using the hospital at any given time than there are using the funeral home.

"I still use the same presentation I used 20 years ago," says Garfield. "It's canned but I change it around, adapt it to the situation. You have to have a track to run on in selling disability. There's no question about it—

**Five life underwriters share their ideas about disability income insurance and why it should be a part of every agent's presentation.**

PHOTO DAN GLASS

**"It's just filling in gaps, so to speak. Most people don't have DI coverage. They buy life and health, but you've got to talk to them about the reasons for owning DI. I don't really prospect for it directly."**

*—Bruce (Doc) Holliday, CLU, RHU*

whether it be in securing the appointment, making the presentation, or making the delivery."

And, adds Garfield: "When you ask a question in any sales situation, shut your mouth and wait for an answer."

For **Bruce (Doc) Holliday, CLU, RHU, New York Life, Pensacola, Fla.,** disability is just a normal part of his needs selling presentation. As such, it constitutes about 25 percent of his business.

"The best thing that's worked for me over the years is going through life insurance sales to get to the disability products," says Holliday. "It's just filling in gaps, so to speak. Most people don't have DI coverage. They buy life and health, but you've got to talk to them about the reasons for owning DI. I don't really prospect for it directly."

Most of Holliday's disability work is done as group insurance for small businesses.

"They've got a business to protect as well as their own incomes. I go in and talk about overhead expense insurance, which is a form of DI to protect the business in the event the key person can't come in and operate. The business will lose money but the expenses keep coming in. The fact that the business overhead policy is tax deductible usually catches their attention.

"Disability insurance is a harder sell than life," says Holliday. "People know they're going to die but they don't think they're going to get disabled. You have to bring that out and show them they have a reason to protect something. When I was younger, I didn't buy DI because I thought I was invincible. That's the attitude of most people."

Not everyone agrees. **Don Garms, Mass Mutual, Dallas, Texas,** is an agency staff supervisor specializing in DI. Because he's management, he doesn't sell unless he wants to. When he does, DI is his product of choice.

"It's easy to sell because it's a value that people readily realize," Garms believes. "They don't want to lose their credit rating or their standard of living. They see they've got all their other material assets insured; doesn't it make sense that they would want to insure their ability to earn a living? It almost sounds too simple, doesn't it?"

Garms draws his prospects a simple picture of two parallel horizontal lines. The top line represents their normal income. The bottom line is their normal level of expenses. Once disability strikes, Garms explains, their income either stops immediately or tapers off. The top line takes a 45 degree dive into the bottom line and beyond. The expenses, meanwhile, either increase or stay the same.

"Either way, the two lines cross," says Garms. "Where those two lines cross is where debt begins. If they had been saving 10 percent of their income for the last 10 years, I explain to them, one year of disability could wipe out that 10 years worth of savings. Just like that. It's usually a fact that's hard for them to ignore."

**J. Marlene Hurst, The New England, Albuquerque, N.M.,** sells disability income insurance because she believes in it. Her reason for believing in it has turned out to be her most potent sales tool. But it's one she hopes her fellow sales professionals never have to use.

"I broke my ankle five years ago," says Hurst. "It was a very simple fall, one step, not dramatic, not sports, simply walking. It could happen to anybody but I did a real job on it. I broke all the bones, tore the ligaments and tendons, and had extensive nerve damage. It never got any better; it simply got worse. I still have to wear a brace."

It was her own DI policy that paid her bills while she couldn't work. And the brace is eloquent testimony to what a disability can do to someone's life.

Hurst prospects mainly in the professional market—concentrating on doctors and real estate offices. She sells DI not only to the business owners but as an employee benefit as well.

"With professional firms, we try to get the personal in force first, then go back and get the group for everyone," says Hurst. "The most recent one we did like that was a doctor's office. The staff was just ecstatic at getting DI. The doctors saw they could really do their staff—as well as their practice—a big service by providing this as an employee benefit."

Hurst is able to view her own disability with a wry sense of humor. She's offered to rent herself out to other salespeople in her office to help with their disability cases. But the real pain and heartbreak is always there, beneath the surface.

"When I tell my prospects the story of why you need disability insurance, they know it's the absolute truth," says Hurst. "With every policy I deliver, I say that I hope they never have to use it. And that comes from the heart, too."

Another true believer in DI is **Joe Houlihan, Paul Revere, Nassau County, N.Y.** He believes that any life agent who doesn't at least try to cover a client's DI needs is doing a professional disservice. He, too, has arrived at that opinion through personal experience.

"It's difficult for me to listen to people tell me they're never going to be disabled," says Houlihan. "With a mother in a wheelchair for over 20 years due to an accidental blow to her spinal column that precipitated spinal deterioration, I can't hear when people tell me they don't need it."

One prospect once told Houlihan that he'd never been sick a day in his life, so he didn't need disability insurance.

"So?" said Houlihan, "You've never been dead, either, but you have life insurance."

Statistically, Houlihan tells his prospects, the probability is that they're going to become disabled prior to death. In his opinion, the slow, figurative death of continuing to consume without producing is almost worse than a real death.

"It's not just the usual debilitating illnesses like heart attack or MS [multiple sclerosis] that are su[illegible]ing people today," says Houlihan. "They're burning out with stress-related disabilities. They're coming down with depressive neurosis, anxiety attacks, inability to perform and function on a daily basis, and it's construed as disability. DI has become a key element in a person's well-being and financial peace of mind."

Don't accept a prospect's assurance that he's already adequately covered, urges Houlihan. A simple review will often reveal that a person thinks he has far more than he really does. Uncovering that gap can make a skeptical prospect into a grateful client.

And finally, disability insurance can be a great boon to the agent's own bottom line.

"One of the biggest misconceptions is that DI is not lucrative to the agent," asserts Houlihan. "If compensation is keeping you away from it, you're in for a pleasant awakening. Anybody who starts to market this product virtually becomes a true believer in it. It's the most financially rewarding product in the marketplace." ■

*I R Code: 100.06 Accident and Health Insurance: Disability Waiver/Disability Income*

# Payroll Deduction Disability — An Emerging Opportunity

By Allan Checkoway, RHU

**Focus On Disability**

Our ability to respond to change often dictates success. The 1990s offer some new directions in employee benefit planning that can create significant opportunities for those of us who are ready to respond.

With the changing demographics of the work force, where the high divorce rate has created multitudes of one-parent families, we no longer have "average" families with two children per household. Marriage commonly occurs at older ages, frequently with professional couples choosing not to have children. Sixty percent of the households in America are financially dependent upon the incomes of both spouses, and it's expected to increase to 75 percent by the end of this decade.

At the same time, employees, eager to sustain quality life-styles and conscious of rising health care costs, are re-examining their employee benefits programs. As needs have changed, flexible (Flex) employee benefit plans have evolved to allow employees more control over their benefits. The substantial cost of medical insurance, which averages from at least $300 to $500 per family each year, demands regular scrutiny of corporate medical benefits. The use of higher deductibles, coinsurance and sharing costs with employees is commonplace.

And what about disability income? Employers are struggling with benefit programs that cost 30 to 35 percent over and above salary expense. Although the largest share of that expenditure is medical insurance, the total price tag gives employers cause for concern and seriously affects the

**When employers decide not to provide long-term disability benefits for all their employees, the need is still there.**

PHOTO DAN GLASS

**One out of five employees faces the unfortunate reality of a serious, disabling and lingering illness. When the principals in the firm purchase individual disability insurance on themselves, employees are being left to fend for themselves.**

future selection of benefits for employees.

In recent years we have witnessed a moderate growth in the number of companies buying group long-term disability coverage for all employees. Ninety percent of the businesses in this country have less than 20 employees. When the decision is made not to buy group long-term coverage for everyone, the need for adequate disability insurance still exists. One out of five employees faces the unfortunate reality of a serious, disabling and lingering illness. When the principals in the firm purchase individual disability insurance on themselves, employees are being left to fend for themselves.

In focus group studies, when employees are asked how they would survive financially when disabled, too often they indicate "The company will take care of me." Regrettably, their sick leave benefits stop after a few weeks, and they're left with no income and frequently no job to return to, should they recover from their disability.

There is also considerable danger with "pick and choose" plans. If sick leave programs are verbal, or not communicated to everyone eligible for benefits, there's the question of tax deductibility of salary paid while disabled. Discrimination, favoring one employee over another, is clearly an issue as well. An "informal" sick leave program can create an enormous potential liability for the corporation.

What is the corporation's responsibility to a long-term valued employee? How can a company be fair to all its employees in a way that is affordable? These questions lead us to the word **opportunity**. We can offer employers the opportunity to solve the disability problem for all personnel with a multitude of options.

Most employers recognize the risk of disability. They understand that the chance of one employee becoming disabled out of a group of 10 approaches 90 percent. They simply make the decision to help solve the employee's problem and we do the rest.

As part of a company-endorsed program, each employee is given the opportunity to participate in the employer-sponsored plan. The corporation decides up front which approach it plans to take. The cost to the company can be nothing. The firm simply urges employees to consider participating in the payroll deduction plan. It agrees to deduct the premium from each paycheck, to remit to the insurance carrier.

Another option has the company pay some portion of the premium, either a fixed dollar amount or a certain percent of the premium. For example, the company can contribute $200 per participant. With a plan like this, employees will be much more likely to enroll.

Let's look at an example of a $1,000 annual premium. With a 10 percent list billed discount, the total cost will be $900. With the $200 employer's contribution, the employee's cost will be only $700. Therefore, he is receiving a $1,000 value for only $700.

In our role, it's important to understand that the traditional approach is becoming less and less feasible. Benefits used to be employer-paid and consistent for everyone. Modern demographics and the rapidly rising costs of company benefits plans have changed that. Companies are not inclined to buy disability insurance on everyone. Nor do they have to. All they need to do, and should do, is recognize the problem and agree they want to help solve it.

The solution of voluntary payroll deduction programs is a wave of the future. When you propose a workable plan with this as the key element, you can nearly always gain their interest. And you're offering an option for them that spells opportunity for you. ■

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LAN-01

# Group Insurance Planning For Small And Midsized Companies

By Barry Carron, CLU

Medical care inflation has historically exceeded the rate of inflation in other segments of the economy. As a nation, we spend approximately 11 percent of our gross national product on medical care—$189 billion in 1978, $591 billion in 1989. Per capita, we spent $822 in 1978, $2311 in 1989. Research and development costs, the lack of consumer pressure, as well as increased utilization, cost shifting, malpractice claims and increased fraud are fueling this phenomenon.

As a result, both the insurance industry itself and consumers have demanded and begun instituting changes in the health insurance marketplace that address these issues and seek to correct some of these problems.

These changes have occurred in three main areas: Plan design, new funding methods and more flexible benefit options. Not all insurers offer all available options, but with guidance and careful consideration, various combinations can be found among large and reputable companies.

## PLAN DESIGN

The newest product now on the market is a program that combines conventional insurance and health maintenance organizations (HMOs).

By conventional insurance, I mean a plan in which participants have complete choice of doctors and facilities. An HMO, on the other hand, offers participants increased benefits such as wellness care, vision care, etc., while limiting their choice of doctors and facilities.

Under conventional plans, participants must satisfy annual deductibles and coinsurance payments. HMO participants generally do not.

Until recently, the HMO/conventional insurance choice was an either/or proposition, offered only once a year. Today, there are dual option plans in which participants can choose either a conventional plan or an HMO approach at point of service, not just once a year.

Companies such as Prudential, Metropolitan, CIGNA, and New York Life already offer these programs. Others, such as Travelers, U.S. Healthcare and Aetna will be bringing them to market in the near future.

## MANAGED CARE

This trend is important because it brings to the conventional insurance programs the elements of managed care found in HMOs.

## Table 1
**Claim Lag Illustration For Self Insured & Minimum Premium Plans**

Assumed effective date - 1/1/91
Assumed monthly claims - $25,000

| | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Claims Incurred | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K |
| Claims Paid by Ins. Co. | 25K | 25K | 25K | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Claims Paid by Corp. | 0 | 0 | 0 | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K | 25K |

Annual claims 12 × $25,000 = $300,000

Claims Paid by Corp. 1/1/91 - 12/31/91 9 × $25,000 = $225,000

*Claims incurred prior to 1/1/91 are the responsibility of your current insurer. Typical claim lag is three months.

Managed care consists of negotiated doctor fees, reduced hospital and supply costs, wellness programs, individual case management and hospital pre-authorization. The claim savings generated by effective claims management can be substantial. Incorporating cost containment/managed care features into all programs positions the industry not only for the short term, but for longer term savings.

### FUNDING METHODS

Where mid-sized companies formerly had no choice but to pay a premium for a fully insured plan, today there are other options—namely self-insured and minimum premium plans. These options exist primarily in conventional plans (not HMOs) but more and more HMOs and dual option plans will be offering them soon.

In a self-insured plan, a company decides to pay its own claims. It can limit its risk in two ways: First, a specific stop loss agreement insures each individual claim that exceeds a certain dollar amount. This protects the client from the devastating effects of a single large claim.

Second, an aggregate stop loss agreement insures total claims that exceed a certain dollar amount.

In addition to stop loss premiums, the client will typically pay an insurance company or a third-party administrator (TPA) for administrative services (determination of benefits, payment of claims and claims analysis). In a self-insured plan, these administrative services will generally cost less than in conventional plans. Self-insured plans also cost less because the employer is not subject to state premium taxes.

## Focus On Group

**Mid-sized companies formerly had no choice but to pay a premium for a fully insured plan, but today there are other options: self-insured and minimum premium plans.**

"YOUR GROUP INSURANCE SAYS YOU'LL HAVE TO WAIT TILL THREE MORE GET SICK."

Cash flow is improved in two ways:

1. Claims incurred prior to the effective date of the plan were paid by the old carrier. This creates a payment lag where new claims are not paid under the new plan for approximately three months. (See Table 1, p. 87.)
2. In a self-insured plan, claims are paid as they are incurred, not in advance as in a fully insured plan.

Typically, a company with less than 200 employees will not self-insure because it's difficult to protect itself from catastrophic claims. Minimum premium plans, however, offer some of the best features of self-insurance while still providing a ceiling on cost.

In a minimum premium plan, the client pays monthly administrative costs. These charges include claims administration, pooling charges and commissions/consulting fees. Claims, which the client pays as they are incurred, are limited by an insurance company cap. This arrangement allows the client the use of its own reserves and the ability to pay claims as incurred, instead of in advance. The net effect is an increase in cash flow and a reduction in cost. compared to interest earned on these funds.

Another advantage of a minimum premium plan is that premium taxes are reduced. No premium taxes are due on the self-insured portion of the plan. Depending on the state, this could result in a savings of 1 percent to 3 percent.

Minimum premium plans also offer an opportunity for reduced administrative expenses. And if claims are lower than anticipated, the client will see reduced costs immediately.

Basically, a minimum premium plan is truly a fully insured plan with certain funding options not generally available in a conventional plan. These funding options have been designed to create cost savings.

### BENEFIT OPTIONS

Any reduction in benefits should be viewed as cost shifting—transferring the cost from employer to employee.

In order to reduce costs today, companies have the option of asking for direct employee contributions, increased deductibles and coinsurance, or additional benefit restrictions such as an in-hospital deductible. All of these will reduce employer cost.

Asking all employees to contribute to the cost of the plan spreads the cost throughout the company. In-

**Table 2**

**Benefit Options**

| | Change | *Average Cost Reductions |
|---|---|---|
| Deductible | \$100 - \$200 | 5% |
| | \$200 - \$300 | 4% |
| Coinsurance | 80% of \$2,000 to 80% of \$5,000 | 3 to 4% |
| In Hospital | \$100 | 3% |
| Deductible | \$250 | 5% |

*The stated cost reductions are averages arrived at by polling various insurers. These reductions could be higher or lower depending on which insurance carrier and what type of program is used.

creasing deductibles or reducing benefits increases the cost for the plan users. Many companies use a combination of these options to create the necessary impact on costs. (See Table 2.)

Increasing the deductible from \$100-\$200 or \$200-\$300 will result in an average savings of 4 percent-5 percent. Increasing the employee share of covered expenses will also produce a savings.

For example, changing from a plan that pays 80 percent of the first \$2,000 to a plan paying 80 percent of the first \$5,000 will result in average savings of 3 percent to 4 percent. Some insurers are now offering plans that pay 50 percent instead of 80 percent. These plans are often priced 20 percent to 40 percent below the 80 percent plans. Many companies have also begun adding separate in-hospital deductibles (typically \$100-\$250), which can reduce premiums by as much as 3 percent to 5 percent.

Pre-authorization for hospital stays and surgery is a method of making plan participants more responsible for their care. These provisions impose penalties if certain prenotification procedures are not followed. These pre-authorization programs make it possible for administrators to uncover potentially large claims early, enabling them to offer alternative care options where appropriate.

### SECTION 125—PRE-TAX PREMIUM PLAN

Section 125 is a provision of the Internal Revenue Code that allows employees to pay their share of the cost of their group insurance benefits with pretax dollars. Under this provision, employees' paychecks are reduced by the amount they contribute toward the cost of their health-care benefits. That money is removed from the company's salary structure before federal income, Social Security, and in most cases, state income taxes are calculated.

For employees, this results in lower taxable income and higher take-home pay. And because payroll-based taxes are reduced, the company enjoys tax savings.

Assuming employee contributions are required, Section 125 is the way to offer tax relief to the employees while providing some payroll tax relief to the corporation. The administration and set-up of a Section 125 plan is very straight-forward and should be a priority. When it comes to choosing insurers/administrators, those that have shown a commitment to managed care, claims management and cost containment will have the edge.

We are also going to have to face the reality that employees are going to have to be responsible for a larger piece of the benefit pie. If the employees do not share the cost, they will have no incentive to keep costs down.

The current health insurance marketplace offers some important alternatives to conventional insurance plans for medium-sized companies. Careful selection of plans that incorporate some or all of these options is necessary if we are going to control costs in both the short and long term. ■

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*I/R Code: 100.00 Accident & Health Insurance*

# Health Care In The Year 2000: Same Problems, Same Complaints

**Dr. Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management, Baltimore, discusses what he sees as the major concerns affecting America's health-care future and what the insurance industry can do to help shape it.**

**LAN** *There's a flurry of debate surrounding health-care delivery and finance in the United States. What kind of health-care system do you think will be in place at the turn of the century?*

**Anderson:** I think we'll basically have more of the same type of thing. I don't think the American public is willing to confront the difficult choices that need to be made in order to fundamentally reform the states' health-care systems.

**LAN** *So you don't see anything too different from what we have now?*

**Anderson:** By the year 2000, we're going to have the same level of complaints about people not receiving health insurance coverage. I think we're going to have the same concerns about life and health.

**LAN** *Do you see the federal government installing a national health-care program in the near future?*

**Anderson:** I don't think they will put a national health-care system in place. I think that the major issue health insurers are going to have to [confront] in the 1990s [is] providing low-cost health insurance to the small-business men and women.

Second, [insurers will have] to devise a way to provide coverage for those people with chronic illnesses. It can be AIDS, it can be Parkinson's disease, it can be a whole variety of different illnesses, but excluding those people from coverage and not giving them access to any private health insurance is what's going to be the issue for private health insurance in the '90s.

**LAN** *What can the insurance industry do to get the estimated 31.5 million people without health-care coverage insured?*

**Anderson:** We've got two-thirds of those people employed. So only one-third of them are unemployed. The question is "How can we get them covered through their employer?"

Employers, especially small firms, say that the cost of getting any type of private health insurance is so astronomical that they can't afford to do it. So what the government is exploring are alternatives that will force small businesses to purchase it and insurance companies to make it available at a low cost.

**LAN** *How can insurers do this?*

**Anderson:** What we may have to do is enfranchise one insurer in each community or state or some geographic region, give them a franchise to all the small firms and affect some kind of community rate.

**LAN** *Similar to a risk pool?*

**Anderson:** Not a risk-pool type of arrangement but a franchise for that geographic area. In other words, the government will have to, in effect, give [the insurer] a monopoly.

**LAN** *You mentioned that two-thirds of the uninsured are currently working and could probably get insurance through their employer. How would you propose covering the one-third who are not employed?*

**Dr. Gerard Anderson**

***Director, Center for Hospital Finance and Management, Johns Hopkins University***

# Health Talk

**"What we may have to do is enfranchise one insurer in each community or state, give them a franchise to all the small firms and affect some kind of community rate."**

*—Dr. Gerard Anderson*

**Anderson:** That's a government responsibility. The government's clearly got to provide the funding to do that. The mechanism for doing that can be through Medicaid buy-in, basically allowing them Medicaid coverage. Or it can be through the private sector if they are able to make premiums [available] at a low-cost.

**LAN** *If the government were to enact a health-care system based on the Pepper Commission's recommendations, how would that change the industry?*

**Anderson:** It effectively mandates community rating, and that goes against what has happened in insurance for the past 20 or 30 years. It's by legislative fiat, forcing everybody to turn against economic interests, and it will probably mean that insurers will drop out of the market in greater numbers than they are currently.

**LAN** *If a national health-care program is put in place, do you think people will still buy private insurance?*

**Anderson:** I think most people will, in fact, want to spend the extra money. All you have to do is look at medigap coverage to see that is true. Medicare provides the minimum coverage and many people choose coverage beyond that. I think 70 to 80 percent of Medicare beneficiaries choose some kind of medigap coverage.

**LAN** *A lot of people are denied coverage because of preexisting conditions. How do you recommend this be altered?*

**Anderson:** Create this franchise in each community and you have to allow everybody to receive care.

**LAN** *And the healthy people would make up for the people who have major medical problems?*

**Anderson:** Correct.

**LAN** *How should the insurance industry adapt to changes in the health-care system?*

**Anderson:** Private insurance companies are going to have to concern themselves with finding some way to take care of small business and the medically uninsurable. That can be through the franchise I've talked about, or it can be through some other mechanism. But if it doesn't solve those two problems sometime after the turn of the century, the patience of the American public will evaporate. But I don't think it's going to evaporate in the next 10 years.

Maybe by pooling industries [they can] create not one single firm but a whole series of firms which in aggregate would be a large enough firm that they can insure.

**LAN** *Do you think a national health-care system is likely for the United States?*

**Anderson:** It really comes down to how can we cover the uninsured and how can we take care of the medically uninsurable. If [the insurance industry] is able, through the private sector, to cover both problems, I don't think it's likely. If the insurance industry does not take up the challenge, then I think it is increasingly likely.

**LAN** *Do you think the industry will take up the challenge?*

**Anderson:** I think they are trying to develop alternatives. Whether or not collectively they will take up the challenge, I can't predict.

**LAN** *Is health care a big concern with the American public?*

**Anderson:** We have very high expectations from our health-care system, probably unwarrentedly high expectations that they can cure everything and we don't seem to be willing to pay. We're unwilling to pay the price for that level of care. We've got to start a period of education. We can't afford to do everything for every single patient. ■

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