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IMPACT OF INFLATION IN GROUP INSURANCE

Moderator: PAUL R. FLEISCHACKER.
Panelists: DAVID W. PRAY, DAVID W. KRUEGER, WALTER C. WOODWARD

1. Dynamic pricing alternatives

2. Trend towards "Administrative Services Only" (ASO) and "Minimum Premium Plan" (MPP) and other financing arrangements

3. Changes in reserve techniques

4. How to assure adequate surplus levels?

5. Should plan design be changed?

6. Separating economic from insurance risk

MR. PAUL R. FLEISCHACKER: The cost of employee benefits has been growing at an annual rate of about 14 percent compared to a growth rate of 6.9 percent in the Gross National Product. The total employee benefits package, including vacations, holidays, and Social Security costs, now amounts to approximately 35 percent of payroll. Health costs alone have increased from just under 40 percent of total welfare and pension benefits in 1950 to almost 52 percent in 1975. For employers, this has meant an annual premium increase of 10 to 20 percent just to maintain the current levels of benefits.

As a result, employers have been actively seeking ways to reduce,or at least control, benefit costs. One of the ways is the adoption of alternative funding methods - that is, alternative to the traditional insured plans. According to the 1978-79 Source Book of Health Insurance Data published by the Health Insurance Institute, the number of Administrative Services Only contracts and Minimum Premium Plan contracts underwritten by insurance carriers has been growing steadily. For 1977, it was estimated that some 14 percent of the total insurance company group coverage was represented by Administrative Services Only contracts and Minimum Premium Plans. Such arrangements represented approximately 12 percent of the total insurance company group coverage in 1976 and less than 5 percent prior to 1975. According to our benefit consultants, 1978 and 1979 should show a significant increase in self-insured coverages. One of our panelists will speak in more detail on alternative funding arrangements.

How has inflation affected the underwriters of group insurance coverages? How have they responded to the consumers'demand for controlling these costs?

Our first speaker on this subject will be David Pray. Dave is the Vice President and Actuary at Employers Life Insurance of Wausau. He will address the topics of: 1) Dynamic pricing alternatives; 2) Changes in reserve techniques; and 3) Surplus - where have all the dollars gone?

MR. DAVID W. PRAY: Dynamic Pricing. Group Health is a fast line of business. The bottom line can shift rapidly and erratically. We are all aware

of the effects that social legislation, inflation, costly new medical treatment, and the malpractice crisis have had in producing these undesirable effects. Perhaps we ought to add to the well-known list the things we ourselves have done which have added to our woes:

1) We have increased maximums payable for all claims, subjecting ourselves to large shock losses for a single occurrence.

2) We write more and more business with floating limits: semi-private room and board, full hospital miscellaneous, usual, customary and reasonable on physician's charges. Claims increase every time a hospital or clinic bumps its prices. We still try and guarantee our rates for a year at a time.

3) We have expanded coverages and encouraged full employer-paid benefits. Deductibles and co-payments have been neglected in the process. We understand that this increases the supply of benefits without a direct cost to the patient. We seem surprised that this produces an unprecedented demand for medical services.

I suppose anyone could add to this list, but why beat a dead horse? I just wanted to make sure that we all understand that we, too, have contributed to our own mess. The question remains: what are we going to do about it?

The topic posed here has a catchy name: Dynamic Pricing. What does it mean? Will it catch on? Will it save us from insolvency?

Well, I have given it a lot of thought and here is what I think it means. Dynamic Pricing means you can change your rates on existing contracts any time you want. On one level it makes sense. Doctors and hospitals can change their prices any time they want, legislators can mandate new benefits any time they want. We as insurers do not carry big reserves we can dip into to tide things over until we can slowly and deliberately adjust to new conditions. Therefore, if we are going to protect ourselves against loss, we have to be able to raise monthly premiums at will in response to rapidly deteriorating conditions. We have to set these contractually. We cannot let insurance departments tie us up with red tape and delay proving we need rate increases.

It seems straight-forward enough. We have an erratic, unstable claim situation. Our job is to match revenues with outgo. Therefore, we develop an erratic, unstable pricing system to offset the losses and all is well.

There is a small hole in this. No rating scheme will work unless the contingency insured against is under control. Stated another way: you can not provide insurance unless the contingency is "insurable". Well, consider the conditions necessary for "insurability".

1) On balance, the insured and the beneficiary would rather not have the contingency occur.

2) The insured will, on the basis of self-interest, try to keep the contingency from occurring, or, at least, try to arrange his affairs so that the effects are minimized if it does.

3) If the contingency occurs, the insured will have a stake in the loss. He will, therefore, try to minimize the cost of repairing the damage.

When these basic rules are violated, claims will occur that would not have occurred in the absence of insurance; the insured will seek "red carpet" treatment for his losses. He will get "his money's worth" out of the insurance. As the costs rise and insurance premiums go up, intelligent selection will force potential insureds to decide whether it is a better deal to forego insurance or whether they can beat the system by turning in more claims than they pay in premiums. From our point of view, this is "anti-selection". It is a phenomenon occurring in every case where premiums are high and rising. Where anti-selection exists, and the buyer has the choice to insure or not insure, the insurer will lose no matter what pricing system he avails himself of.

Dynamic Pricing may ease our situation temporarily. But, unless we get back to the fundamental problem of controlling the contingency, Dynamic Pricing or any other kind of pricing will fail.

If you are interested anyway, here is a list of things you can do to make your pricing more "dynamic": (None of them will work, of course.)

1) Attach an interim rating endorsement to each policy, enabling you to get more frequent rate increases. Incremental price increases cause less case turnover than annual quantum leaps.
2) Add a section to your rate manual showing lists of cost factors to be applied to the manual rates for the various future effective dates of coverage.
3) Eliminate refund plans for all but your largest customers. Offer retroactive rating schemes in lieu of big rate increases. Put terminal retro endorsements on all policies which allow you to collect premiums after the buyer switches carriers. Call these "Cash Flow" plans if you like. Letter of credit for the reserves are also popular.
4) To cut the cost of reprinting your rates every three months, add ten or 20 points to your age/sex factors periodically. Put out rates by rating territory and move all areas up a table or so periodically.

New Reserve Techniques. There are not any. And, all the old ones require careful measurement of claim parameters and lags. In practice, these things are subject to what the physicists call "the Heisenberg Effect": By the time you measure it, it's changed too much to be useful.

I prefer simplicity. A simple reserve system that works is to be preferred over a carefully constructed, logically consistent one that does not.

I am like you. I have to get these things out monthly. I do not have time to ponder the imponderables. Speed is to be preferred to accuracy.

I apply a factor to the last 12 months' paid claims on active business for these sublines: dental, statutory accident and sickness (A&S), comprehensive major medical, super-imposed major medical, and basic group. I apply a run-off set of factors to cancelled business. For health maintenance organization (HMO) business, I have another set of factors. For long-term disability (LTD), I use a modified 1964 Commissioners Disability Table (CDT) on open claims.

I make several tests to see if my factors need changing:

1) I check the tabular to actual claim costs for the LTD business, sort of a "page 6" test. I occasionally raise the reserves when they are out of line.

2) I reconstruct the "reserves needed" for all terminating business to see if the reserves held were sufficient.

3) I check the "accident year" run-offs on calendar year-ends in an effort to prove that annual statement reserves were sufficient.

I try to provide in the reserves a 5% to 10% cushion over actual results. Occasionally, I have been successful.

One other thing: successful measurement requires excellent claim coding. The kids who handle our claims did not graduate from the top 10% of their class and the turnover is incredible. Things are probably the same where you live. If you have a reserve technique that is consistent with this situation, let me know and I will use it immediately.

Surplus - Or, Where Have All the Dollars Gone? "How much do you need?" is the way this question is stated. It is more fruitful to restate it as "how can you hold on to what you have?"

Common sense, not risk theory, is what is needed here. If you have arranged your affairs so that you are always profitable, your surplus will increase and never really be needed. If you have been sleeping at the switch, as it were, your surplus will decline and always be needed.

So, the first step you must take in settling on the level of surplus is to ask yourself how well you have protected the bottom line.

A wise old accountant once told me to be sure to remember that the bottom line is always the last one on the page. It is the result of the interaction of all the other lines that precede it. It is protected by controlling all the other elements that make it up.

In your analysis, start at the top where it says "premium". Ask yourself some simple questions. Is my pricing system such that premiums can be quickly raised to offset increases in outgo? Is my collection system working? Are we getting the customers to pay on time? Are they reporting their enrollments properly? Ask other questions. Find out. Make changes if you can. Protect your premium.

Move down the list: commissions, taxes, expenses, claims, reserves, dividends. Ask more questions. All kinds of things. Do we have good standards for reasonable and customary claims? Have we ever audited a large hospital claim? Are we paying Workers' Compensation claims by mistake? Are we recovering enough through coordination of benefits (COB)? Do we need a dividend plan? Are our reserves strong enough? On and on. Take action.

When you are satisfied that you have done all you can, you can now get to the heart of the question that was originally set out: How much surplus do I need? by asking yourself this:

> Now that I have this line of business under good control and on as sound a footing as I can get it, what surplus needs do I have?

The answer is: you need surplus to cover all the chance contingencies that you cannot predict or control. And, since no one knows how much that is, your job is finished.

My conclusion is facetious, but my point is clear. Your first duty is to keep your line of business in shape. Only then can true risk analysis be undertaken.

There are several sensible approaches to the risk problem. First, consider your company as a whole. Decide how much you can stand to lose before you interrupt growth or expansion plans, create problems for the stockholders, and so on. Provide a few worst case scenarios for your company to get an idea of how bad things might get. Study the history of your own company, other companies like yours, and the industry as a whole. Make a list of things people have done to reduce the effects of hard times or to recover from catastrophe. Do you have other lines of business which can provide cross-support if accident and health (A&H) goes sour? Are they big enough to really help you through a crisis? What sort of reinsurance are you carrying? Check your loss carry forward and carry back under the federal taxes.

Remember: Uncle Sam owns 46% of your profits. Make sure he owns 46% of your losses as well.

On the way through this analysis, judge for yourself what successful operations have had that differentiated them from less successful ones. Use this knowledge to improve your company as best you can.

As a last measure, apply whatever mathematical techniques you want to your situation. You may, at this stage, be ready to properly interpret the answers you get.

MR. FLEISCHACKER: Our next speaker is David Krueger. Dave is a Consulting Actuary with Milliman and Robertson, Inc. in Milwaukee. He will speak on the topics: 1) Trends towards other financing arrangements including economic risks of such arrangements, 2) Changes in reserve techniques, and 3) Should plan design be changed?

MR. DAVID W. KRUEGER: The trends toward ASO, MPP, self-insurance, etc. by larger employers have been well-documented in recent years, and certainly have impacted on most insurance companies with group accounts over 200 employees. Employers wish to maximize their investment dollars, and are seeking out the various alternatives to keep cash in house, to reduce the advance payment of insurance premiums, and to earn a more favorable return on this cash.

The current high inflation and high interest rates spotlight even more the trend to ASO-MPP, Delayed Premium and Retro-agreements, and it may be worth considering some of the reasons for this shift in recent years. Then we shall be better able to anticipate how both employers and carriers may react in the current environment.

In the next few years, I think insurance carriers will have to decide, if they haven't already, whether they are going to remain in the risk business for medical expense insurance. Do insurers want to accept the medical care risk and write insured contracts, or do they want to transfer the risk back to the employers, and then just pay claims and provide stop loss coverage? Stop loss coverage is probably a bigger risk, when comparing the potential loss to the premium dollar income.

Part of the solution, if there indeed can be a definitive solution, perhaps can be found by looking at the past -- how did the industry (Blue Cross plans and commercial carriers alike) get into this situation of losing fully insured business. One idea that has been advanced is that the carriers have done a poor job of communicating the risk of medical care to the employer. The carriers have not made the purchasers aware of the risk factors. Have the companies been able to demonstrate to the employers -- 1) the type of fluctuations which can occur in medical costs from year to year, 2) what can cause these fluctuations, and 3) the stability of a budgetable premium? In short, the insurance company should attempt to quantify the risk and communicate it to the employer!

The brokers, consultants, and third party administrators have come in and stated to the employer that a lot of money can be saved by chopping out the "fat" from the premium. The brokers are saying "there is no risk, claims are claims;" and then they focus in on the retention - the 10% or 15% of premium, and attempt to bring it down to 5% or 10%. The employer has little ammunition to fire back, and by the time the insurance carrier responds to the employer, it may be too late to save the case from going self-insured.

It may well be that the best course of action for the employer is to adopt an alternative financing mechanism, rather than remain under an insured contract. But we believe that both the employer's consultant and the carrier should point out to him the risk involved with non-insured contracts. Again, quantifying the risks - showing what are the risks and the corresponding levels of probability. For example:

--What protection is given by the stop loss contract?
--Are conversion plans to employees available?
--What are the chances that claims will exceed 125%, or 115% or 105% of expected claims?
--How are expected claims calculated?

From the employer's point of view, it is good business practice for him to assume the maximum risk with which he is comfortable in his employee benefits as well as other coverages, i.e., product liability.

What can be done by carriers to respond to the market's demand for cash flow advantages?

--Demonstrate risks to the employer
- large individual claims, how they can fluctuate and how high they can be
- effect of missing the expected level of claims
- secular trends which haven't been considered, economic conditions, new procedures, HMOs

--Train agents to be able to discuss the alternatives.(To do this, actuaries may have to become more involved in marketing.)

--Overall strategic planning - Do carriers want to be in the large case market on an insured basis, or even on an alternative funding arrangement? Traditionally, profit margins have been thin.

Most companies have had adequate claim reserves during the past two or three years. This has happened probably because the trend factors built into the initial premiums and renewal rates have been adequate - the actual experience trend has been less than this prospective, anticipated trend. Now in 1980 when the medical care trend levels may be at 20%+, group actuaries probably believe that their reserve methods will be able to respond to inflation in medical claims.

If reserve techniques are based on claim levels, the claim completion factors may not be reflecting sufficient trend adjustments. If the reserve technique is based on premium exposure, then the methodology will probably reflect current trend, as long as the pricing is building in current trend levels.

I would like to back up to the point I made about reserves not reflecting sufficient trend if based directly on claims. One of our techniques which we use to monitor trends in claim payment patterns for reserve purposes is as follows: We calculate claim lag factors based on the most recent 12 months of data, the most recent six months, and the most recent three months. The 12-month set of completion factors are the more reliable because more data is used. However, the 12-month factors would not carry the full effect of the current inflation, because of the influence of older claim data and the claim reserve would be understated. The 3-month and 6-month factors would pick up more of the current trend by having lower completion factors; however, there is less stability in such reserve estimates, by having swings up and down from quarter to quarter.

The conclusion is that in an inflationary environment, the group actuary needs to upgrade his calculation methods and take account of specific technical considerations. As consultants, we want to make sure that all aspects of our clients' risks and liability have been recognized, in addition to claim reserves. Such items might be coordination of benefits, financing arrangements, reinsurance and claim expense reserves. Also, any special effects due to cancelled business, economic cycles, and any external factors should be considered.

What can the employer and the insurance carrier do in plan design to reduce the effects of inflation?

The first thing that comes to mind in plan design is deductibles and coinsurance. Unit premiums can perhaps be continued at the same levels or at modest increases with the introduction of additional copayments borne by the

employees. Another alternative is the Low Option/High Option packages, where the employer continues to pick up the full cost of the Low Option Plan, which has copayments or benefit limitations. The employee pays the additional premium if he or she wishes the High Option benefit package, which generally has little or no copayments. Such a "minimum" plan or "Low Option" concept could eventually be legislated as part of a national health insurance (NHI) program.

Another possibility for the employer is to not increase his contribution on the dependent coverage. With more working spouses, the employee may elect to drop the dependent coverage if the employee contribution becomes too high and the spouse can get primary coverage. Other plan design changes might include the following:

1) Deductibles could be related to income or indexed in some way.
2) Cafeteria plans which offer the employee a choice of benefit options.

I do not visualize plan design changes as described above being implemented with much frequency in the near future. Medium and large employers, as well as unions are not going to take away first-dollar benefits. Employers are making some requests to carriers for alternative benefit designs, but by and large they do not alter their present plan.

The small group market and multiple employer trusts offer areas in which plan design could be effective in reducing the impact of inflation on health care costs. The Low Option/High Option package may be a viable product to offer through the trust mechanism in spite of the selection problems that can be created by the option approach. Or perhaps the mandated-type NHI plan, with good catastrophic coverage, and front end coinsurance, can be made available to the small group market.

The items concerning plan design are essentially cost sharing devices with the employer and the employee, with the employee being asked to pick up some of the direct cost so he gets a feel for the medical care charges. In this way, perhaps the employee will begin to be discretionary in his use of medical care coverage.

Many of us believe that the providers hold the key to inflation and cost containment. Changes in the way health care is delivered, that is, how providers provide the care, might be considered an offshoot of plan design. How are the premium dollars distributed to the providers? This topic is a very big one and is dealt with elsewhere in this meeting, but let me highlight some of the dynamic things that are happening in "plan design" from the delivery point of view.

1) County Medical Foundations are agreeing to fee schedules and risk pools through HMOs, so that they can retain their patients.

2) Hospitals are banding together to sponsor HMOs, to save their patients from going to Kaiser-type HMO plans, which operate their own hospitals.

3) Primary Care networks are being formed in several parts of the country (an employee's primary care physician is given a capitation amount and is responsible for the medical care of that employee, including hospitalization and specialists' referrals).

4) Employers are forming Health Care Coalitions, to determine how their health care dollars are being spent, and to attempt to influence the amount and quality of care.

5) Data reports to physicians - It is educational to doctors to see how many operations (tonsillectomies, etc.) the other doctors in the area are performing. Also, physicians see the hospital bills and how much each treatment or test costs.

MR. FLEISCHACKER: *Our final speaker is Walter Woodward. Walt is the actuary* for Blue Cross of Western Pennsylvania. His topics are: 1) Changes in reserve techniques; 2) Should plan design be changed?; and 3) Separating the economic from the insurance risk.

MR. WALTER C. WOODWARD: Changes in reserve techniques cannot be isolated from inflation itself when pricing/reserving service benefit hospital, usual and customary physician and either comprehensive or "wraparound" major medical. On fully insured plans, there is total interdependence among inflationary trends, product pricing, and methods used to determine incurred but not reported (IBNR) claim reserves. Each affects the other. Pricing for fully insured programs is the portion of our job that is normally the most visible to your sales force, although inflationary trends, or expectations thereof, necessarily affect pricing. The determination of IBNR values, for purposes of dividend calculation or retrospective premium adjustment, is also directly affected by known or estimated increases in the unit value of services, as well as by the change in the mix of and volume of services consumed by insureds. If a stable group had 50-60 days of outstanding claims worth $2,000 of hospital ($300/day) and physician services ($200/day) per day one year ago, then adequate provision must be made for the 12-16 percent increase in cost that has occurred since then. This is especially true on group termination when you have no provision for retrospective premium determination as is the most common practice at my company.

Let me digress for a moment, just to say that if I cite examples of how my company does certain things, it is not because I believe it is the only right way or necessarily the best way. It is the way my company has evolved, and one of my biggest challenges is to sustain our growth record while maintaining financial viability. I work for basically a one product company - health insurance.

With that caveat aside, let me go on to describe briefly some of the reserving techniques that I am familiar with, with a sprinkling of inflationary implications interspersed.

Probably the oldest, still most widely used, and in my opinion least sophisticated method of determining IBNR reserves is to apply a percentage of earned or paid premiums. The method can work well in the aggregate, thus assuring "product line" level solvency, but will break down badly when reduced to a client-level or "sub-product line" test. The biggest problem with this method is that the interdependency of inflation, pricing and reserving is virtually locked into at the front end. The company which sells a health care package at $K per unit of exposure where K is predicated on X percent inflation and an IBNR of two months of outstanding claims (based on earned premium) can suffer financially when "X" proves to be "X+2" or when major clients track their own IBNR as substantially less than 2 months of earned premium.

Another method for accruing claims liability, which affects reserving and is affected by inflation, is what I call the "pure premium" method of accrual. Because I am sure most of you have first-hand experience with using this technique for forecasting purposes, I will not discuss it in any detail. I will say, however, that it continues to be a very useful tool for me to use in accruing liabilities on my company's financial statement on coverages which have relatively long "run-off tails" which our auditors have been able to certify without any qualifying statements. The key here, of course, is to develop a track record and to maintain alternative methods to cross-check your results.

The next two or three methods of estimating incurred liabilities (which is what "reserving" is all about) are closely related. One frequently used by our customers and our sales personnel alike is the incurred to paid ratio. A ratio over 110 percent or less than 90 percent is a "red flag". As unscientific as this is, to the customer -- all of whom believe they are smarter than the actuary -- it is a signal that you or I "blew it". Do not use this method! It does not recognize group-to-group idiosyncrasies, significant changes in the work force such as lay-offs or varying runoff patterns inherent in different lines of coverage. But do not ignore this test either. Your customers will use it; if you do too, you can at least be prepared to explain the how and why the accrual you have established is correct. Do not be caught off guard.

This same method can be useful in pricing a "Block of Business", such as a non-experience-rated aggregate of small groups, none of which is of sufficient size to be experience rated, but which, collectively, form a credible experience pool. Close monitoring of runoff patterns and changes in unit prices can result in an actuary's ability to keep current with up-to-date trends and to maintain equitable rates for such pools.

A more "refined" method of the preceding two is to use "actual" runoff based on an individual group's claims lag history. I say "refined" in quotation marks because as the size of the rating entity decreases, the less reliable an "actual" becomes in predicting an "actual" value at a future point in time. My company's most widely used rating formula - not to be confused with dividend formula - uses a variation of this approach which both smoothes out "glitches" and has been accepted as actuarially sound by our sales force and our customers.

The last two methods of reserving techniques are - to my knowledge - the latest in the evolution of group insurance and admittedly they are the ones I know least about. Both approaches have gained increasing popularity as inflation has depressed the value of tomorrow's dollar or, said the other way, increased the value of today's dollar in our customer's hands. I am sure that in just those few introductory words you have guessed ASO and Minimum Premium are the two. They would have been, except after sitting through the Alternative Funding Methods session at Banff last year, I have concluded that Minimum Premium means too many things to too many people. To me, it is a cash flow arrangement that can be incorporated into various rating mechanisms. ASO is something else. ASO, to me, means "you see that benefits are provided and I will pay the freight."

Benefits, in this case, can be a broad range of cafeteria services in addition to actual claims. The primary distinction here is the customer assumes liability for claims and retains the funds a carrier would hold for IBNR

under an insured approach. With the value of money approaching 20 percent, many accounts are willing to assume the insurance risk in order to retain more capital.

The last method, I will mention briefly, is the "letter of credit" arrangement between an insurer and an account. The insurer performs all of the functions it would under a traditional, fully-insured program. The only difference is IBNR reserves are not held by the insurer. Instead, a promissory note is held by the carrier guaranteeing full payment for claims runoff following group termination.

Both of these last two methods offer very attractive cash-flow advantages to accounts; however, I believe too many accounts see only this aspect of self-insured financing arrangements and totally overlook the financial risk they are assuming. Because of a combination of regulatory, contractual and philosophical considerations, my company does not offer either of these last two financing mechanisms. We have lost some accounts because of this. But as the cost of health care continues to escalate, I see many of the accounts we have lost returning! They were unable to bear the "insurance risk".

The second topic I was asked to address for this session is "Should plan design be changed?" I am going to take the liberty to deviate from that subject slightly and highlight plan design changes that have just been announced as a result of negotiations between the basic steel industry and the United Steelworkers (USW) of America.

Hospital

(1) Expand Inpatient Dental services to provide same benefits in the outpatient department of an accredited hospital.
...although this benefit expands the availability of Dental services payable under the agreement, possible cost savings may result from those procedures currently done on an inpatient basis that can be performed equally well on an outpatient basis where the cost would be significantly less.

(2) Transfer coverage for one routine pap smear per twelve-month period from the basic agreement to the major medical agreement.
...this represents a transfer of liability from a first-dollar basis to one subject to a front-end deductible and a coinsurance.

(3) Implement concurrent Utilization Review Procedure for inpatient admissions.
...the implication here is to eliminate unnecessary admissions.

(4) Revise the Non-duplication provision to exclude benefits payable by another group plan if the other plan (a) does not include a C.O.B. or Non-duplication provision...the other plan automatically becomes the primary plan; (b) includes a C.O.B. or Non-duplication provision but is determined to be the primary plan.

(5) Eliminate the 10-day Maternity Conversion Guarantee provision.
...in other words, there is no coordinating of maternity benefits with this plan's benefits and a conversion agreement with less benefits.

(6) Increase Non-Participating Hospital inpatient allowance to 90% of the hospital's charges.

(7) Add Skilled-Nursing facility benefit in order to get patient to lower cost facilities.

(8) Add Home-Health Care benefit.

(9) Expand kidney dialysis benefit.

(10) Expand outpatient diagnostic benefit to include ultra-sound testing, electromyographies, and pulmonary function testing.

(11) Expand outpatient surgical benefit to include surgical treatment in an approved ambulatory surgical facility (cost transferring).

(12) Expand the inpatient coverage for alcoholism and drug addition.

Physicians

(1) Eliminate the 100% UCR Obstetrical Conversion Guarantee provision. ...same concept as in Hospital.

(2) Add voluntary second surgical opinion benefit.

(3) Add Skilled-Nursing facility benefit.

(4) Add Home-Health Care benefit.

(5) Increase the maximum allowance for both diagnostic X-rays and diagnostic medicals from $300 to $400 per calendar year.

Major Medical

(1) Eliminate all benefits for inpatient admissions in a non-participating hospital.

(2) Increase the front-end deductible from $50/individual, $100 aggregate/family to $75/individual, $150 aggregate/family.

(3) Limit one year continuation of benefits after termination to those not eligibile for the Optional Retiree Major Medical Program.

(4) Expand nursing services benefit to cover LPNs out of hospital - 80% reimbursement for first 240 hours, 50% reimbursement thereafter.

Vision

(1) Add Non-duplication provision.

(2) Increase fee allowances for eye examinations and lens coverage.

Dental

(1) Increase orthodontic lifetime maximum from $500 to $650.

Perhaps it has occurred to some of you to ask, "What has any of this to do with inflation?" The answer, to me, is obvious. Virtually all of the changes in benefits for active employees and their dependents center around either coverage of lower-cost intermediate care types of providers or greater cost sharing between the employer and the employee.

Of far greater significance - inflation-wise - is the concern the USW has exhibited for the health care costs of its retired members. Prior to 1975, the (steel) industry assumed no portion of the cost of health care for its retired workers. Beginning in 1975, the companies began paying for basic hospitalization and medical/surgical coverages for retirees not eligible for Medicare. It was only last year, August 1979, that company-paid coverage was extended to all retirees.