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LARGE GROUP ISSUES

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- o Maintenance of effort provisions
- o Benefit demands of employers
- o Unbundling of services
- o New funding techniques
- o Multiple options versus adverse selection

MR. THOMAS L. MILLER: I'm a member of the American Academy of Actuaries and Senior Vice President of Internal Affairs for Blue Cross and Blue Shield of Kansas. Mr. Howard Atkinson, Jr., is an Associate of the Society of Actuaries and also a member of the American Academy of Actuaries. He is a consulting actuary for the Wyatt Company in Washington, D.C. Mr. William T. Billard is a member of the American Academy of Actuaries and is Vice President and Actuary for the Delta Dental Plan of Michigan in Lansing, Michigan. Our subject matter includes the Maintenance-of-Effort (MOE) provision which falls under the Medicare catastrophic provision. We will talk about benefit demands of the employer including point of service, the preferred provider organization (PPO) process and products, and unbundling of services. That will be followed by multiple options versus adverse selection and large group funding techniques.

MR. HOWARD ATKINSON, JR.: The Medicare Catastrophic Act of 1988 was signed into law on July 1. This Act significantly changed the scope of Medicare benefits paid both under Part A and Part B. Most of Part A in hospital benefits have become effective in 1989. The Part B benefits will become effective in 1990. And in addition, new benefits for out-patient prescription drugs will begin being phased in 1990 through 1993. In the case of hospital insurance I'm sure you are aware that the in-patient acute care hospital days are now unlimited after a $560 deductible. They have eliminated this whole spell-of-illness concept, which for many claimants means that they no longer have to pay more than one annual deductible per year.

Skilled nursing facility benefits also increased the number of days from 100 per spell of illness to 150 days per year. In addition, there is no longer a prior hospitalization required. Coinsurance for skilled nursing days is $25.50 per day for day 1 through 8. Now this compares with the 1988 skilled nursing coinsurance amounts of $67.50 per day and it was applicable for days 21 through 100. Hospice benefits have also been implemented and the 210-day lifetime limit has been eliminated. In 1990 under Part A there will be an improvement in the home health benefits.

Under supplementary medical insurance Part B, Medicare will pay for 100% of Medicare-approved amounts in excess of a $1,300 out-of-pocket limit on expenses. Now that includes a $75 deductible, as well as a 3-pint blood deductible, in addition to the 20% coinsurance. In 1990 they will also pay for I.V. drug therapy and immunosuppressive drugs. As I said, in 1991 the phase-in of the out-patient drug benefit will begin, which is 50% after a $600 deductible. Financing for these benefits is to be done totally by the enrollees; 37% of the financing will be paid by all Part B enrollees and the other 63% will be covered by an income-related supplemental premium. In 1989 the premium will be $4 per month in addition to the $27.90, and the income-related supplemental premium will have a 15% income surcharge, which translates into $22.50 per $150 of annual tax liability, which has a ceiling of $800.

Now let's move along to the maintenance of effort and its implication for large groups. First of all, maintenance of effort as you know requires employers to be responsible for determining as of July 1, 1988 whether they offer to their employees or former employees who are covered by Medicare any duplicate Part B benefits and, if so, the actuarial value of such benefits as of July 1. If the actuarial value of duplicate benefits was $30.50, which is 50% of $61, the employer is

required to offer additional benefits or refunds or a combination of both equal in actuarial value to the 1989 value of the duplicate benefits provided as of July 1.

Now according to the law actuarial value is the value of the benefits to the employees, not the cost to the employer, so in other words, it doesn't include retention items. What is the rationale for maintenance of effort? Well, maintenance of effort is intended to equalize the costs/benefits impact of those Medicare beneficiaries not covered by employer-sponsored plans presumably who will personally benefit by the enhanced Medicare benefits, compared to those covered by employer-sponsored plans who would only see the responsibility of benefit payment transferred from their employer to Medicare. Now for a large employer or for any employer in general under maintenance of effort there are key questions that should be addressed. These questions are enumerated as follows: To which beneficiaries does the maintenance of effort obligation apply? To some employers this is not an easy task to determine. How much is the gross obligation? Has any of it been met? And if so, what is their net obligation? Then after that you must determine how to allocate your obligation among the employees and retirees. How can this obligation be met and what about applicability of the retirees enrolled in a health maintenance organization (HMO)? Those are some of the basic questions that maintenance of effort draws out. To whom does it apply? Well, the Act says that it's for all private employers, all public employers except the federal government and except for any employers who participate in a multiemployer plan. The Act itself says that the beneficiaries are former retirees and employees. Now the definition in the Act is pretty strict; however, the *Federal Register* has come out with a broader definition so at this point you're sort of at your own discretion in terms of what definition you want to believe.

A stricter definition says that employees who turn 65 and are covered by Medicare as of July 1 are eligible for maintenance of effort, and the broader definition says that any employees who are covered as of July 1 who may retire during 1989 or 1990 are eligible for MOE. For example, let's say you have an employee who turns 65 in November 1988 and subsequently retires in January 1989. Under the strict definition, that employee is not eligible for maintenance of effort. However, under the broad definition, since he was an active employee as of July 1, 1988 and retired during the maintenance-of-effort period, then that employee or retiree is eligible for maintenance of effort. Now it's likely that this evolving regulation will require employers to use the more broad definition. For an employer how is this obligation determined and what is it based on? Well, the law says that it can be based on the national actuarial value as published by the Secretary of Health Human Services (HHS). I'm sure you all know that was quoted as $65 in 1989 for Part A benefits, and at this point they haven't published anything official, but the estimate is $94 for 1990 under Part B.

Second, it also says that an employer can opt to calculate the obligation under any reasonable actuarial method that looks at the experience of the employer. So for large employers or employers that have a large number of employees they should consider using the second approach, because in all likelihood it will save them money. The reason it will is because the $65 that the Health Care Financing Administration (HCFA) calculated presumably was based on the overall Medicare population whose morbidity average age is higher than the average employer retiree population. HCFA also assumed in its actuarial value that plans cover all these benefits and that they cover them at 100%. So it behooves large employers to begin, if they haven't already, to fine-tune their ability to compile and gain access to the necessary demographic and claims data in order to begin calculation.

What I would like to do is go through a case study that we did of a maintenance-of-effort job for a public employer that had a significant number of employees and retirees to be covered under maintenance of effort. How did we go about calculating their gross maintenance-of-effort requirement as well as their net obligation? As I eluded, the law will allow you to use the actual claims experience of the employer if available and if large enough to compute the actuarial value of the duplicate benefits to see if you have to comply with maintenance of effort. In this case we actually use the 1987 incurred claims data for this group that has run out through late 1988 so practically all the claims are in. Let's review a portion of the 1989 benefits related to in-patient hospital which gets at the elimination of spell-of-illness concept. We use the 1987 incurred claims experience and project it forward to 1988. Based on those covered as of July 1 we compute the value of duplicate benefits. What we in fact did was repay claims assuming that the Medicare coordination was under the new benefits. What you can see from this example is, by doing so, given the provisions of the Medicare Catastrophic Coverage Act, the employer plan would have

paid only 10.5% of the total claims instead of the 12.7% under old Medicare. That's a 2.2% potential savings to the employer, which translates to $39.93 per participant.

Moving on to the skilled nursing and following the same procedure, under the new provisions the coordination is such that 26.9% of claims are shifted from the plan to Medicare for another $8.05. Taken as a whole, total Part A duplicate benefits are calculated in 1988 at $47.98, which is obviously greater than $30.50. This employer must comply with maintenance-of-effort provisions in 1989. Let's move quickly through what I have done. I have taken that same procedure and projected the benefits to 1989, which shows that the value of duplicate benefits in 1989 is $50.99. Now the projections for this from 1987 through 1989 were not done using employer experience but were done using trend factors published in the *Federal Register*. You have the option there in terms of tracking the experience for the employer for those benefits assuming it's large enough to be creditable or using the values as calculated by the HCFA. So, you have three options really; you can either refund the money to the retirees, or you can improve the plan by giving them additional benefits equal in value to the value of the duplicate benefits, or a combination of both.

Now in the case of Part A benefits you calculate the value of the duplicate benefits for 1989 and the total for 1990. If you plan to give duplicate benefits, then you have a shorter period of time, if you wait until 1989 in which to spread those benefits. So it might be well if you add more benefits at the beginning of the year so that you can spread the cost out over the year. Now on a per capita basis this is just showing the value of the $50.99 and how it is broken out between hospital and skilled nursing: $42.40 for hospital and $8.59 for skilled nursing. A total of $50.99 per participant shows that the value of the duplicate benefits is $1.6 million. I might point out that when determining the maintenance-of-effort obligation one can take into consideration any employee premiums or contributions rather than what was paid. So for this particular employer, spouses were required to contribute 40% of the premium. The premium was equal to $50 so that on a pro-rated basis the $20 employee contribution represented 40%. So the employer can take credit for 60% of the duplicate benefits for $30.59. Actually, the net or the gross maintenance-of-effort obligation for this employer is $1,535,000, having reduced the spouse or the duplicate benefits down to $30.59. So once you have calculated what your gross obligation is, how do you meet that and what is the remaining obligation after having done that?

Well in the case of this employer as I mentioned before, the Medicare Part B premium for additional benefits of $4 per month can be included or used as an additional benefit so they can take credit for that. They can enhance other benefits if they choose to comply with the maintenance of effort. One thing that this employer selected to do as well was to eliminate from their plan the three-day hospital stay prior to admission to a skilled nursing facility, so they are able to gain benefit from that as well.

Moving on to the next example, this particular employer has now met the substantial portion of its maintenance-of-effort obligation by taking credit for the $4 per month Part B premium, $48 a year annually, and the skilled nursing credit for elimination of a prior hospital stay. Now it's impossible to calculate from the employer's experience the value of the elimination of the skilled nursing, the 3-day hospital stay, because obviously those are claims that you never see. What we were able to do was look at the analysis of data that was done by the Congressional Budget Office. Their calculations for packages of that indicated that skilled nursing credit is valued at approximately $1.25 per participant. So you can use this approach or any other reasonable approach showing the net obligation for this employer. The question is how can this obligation be allocated? Are you required to do so in any particular way? The answer is no, you can do so on any reasonable basis. You might select to do it on a retiree basis.

In that case, all retirees, whether they have a spouse or not, would receive the same benefit. You could do it on a per participant basis, in which case retirees with eligible spouses would be reimbursed more than retirees without eligible spouses. The law also goes on to say you can use any other method that is equitable or that is not inconsistent with the law. For this particular employer they would have the option then of using the scenarios on a per retiree basis and give everybody $10.96. Or they can give that to all retirees only. Or they can look at it on a per participant basis and give each participant $8.34.

This would mean twice that amount per retiree and spouse; or they may choose to use a different method which in effect allocates the benefits where the obligation came from. That would in effect give more to the spouses since the plan was not duplicating as many benefits for the

spouses as they were for the retirees. As I said before, this final obligation can be done either in terms of cash or enhanced benefits. Obviously cash is easier to do. However, their potential federal income tax implications involving refunds like that would be subject to possible withholding and most definitely subject to taxation at federal income tax time.

In terms of implementing new benefits, after the maintenance-of-effort period it may be very difficult for an employer to rescind those benefits, so one must be careful in that respect. What about an employer that also has some retirees and enrollees in an HMO? How are they affected and what are their requirements? There are two ways HMOs can operate. They can operate under a risk contract with HCFA and under that kind of scenario the law says that the employer has basically the same obligation to look at maintenance of effort and duplicate benefits. It says that the employer expected to negotiate for either additional benefits or refunds with the HMO. In the case of HMOs that have a cost contract, the HMOs obligated themselves to adjust their premiums and/or benefits to comply with maintenance of effort.

Last but not least, in terms of the outlook for the future for maintenance of effort, since the 101st Congress has come into session there have been numerous bills already presented that have looked at either repealing or changing the Medicare Catastrophic Act. Given some of the tax implications of this bill and revenue concerns, it's a possibility that maintenance of effort will be extended beyond 1990 and that primarily is due to a lot of lobbying going on by senators presently.

MR. JAMES P. CONWAY: Do the enhanced benefits have to be within the context of the health plan or can it be any form of benefit you offer to the retirees?

MR. ATKINSON: The law is not very specific in that regard. The interpretation of it that I have seen is that it does have to be in terms of health medical benefits. However, I would not think it wise to try to do otherwise. There are some employers who may have gone on to say what they are going to do is implement not necessarily benefits in a traditional sense, but look at maybe some retiree medical education things that will help them hold down claims cost and so forth. They will want to put a price tag on that as maybe that will also satisfy some of the maintenance-of-effort requirement. But I would be very leery of using nonmedical benefits to satisfy this provision.

MR. JOHN C. SHANK: I just wanted to make a couple of comments related to the policyholder in doing this. The new accounting rules that are coming down the road are going to make us identify his retiree cost. Because of the improved benefits this is only going to increase the liability that the employer has to recognize on his accounting statements.

MR. ROBERT RONDA: What does the Act provide in terms of monitoring? What does the employer have to keep on hand to demonstrate that they have complied? Which department is going to be checking up and so on?

MR. ATKINSON: Well, the Act is not specific at all relating to compliance or any government reporting. I suspect that it's to be on some kind of an honor system. I would suspect that if the employees felt they were not being treated fairly they would cause an outcry. But there is nothing in the Act at all that looks at compliance or reporting.

MR. MILLER: Now we are going to switch gears a little bit and Mr. William Billard is going to speak on benefit demands of the employer, including the point of service, PPO process and products, and unbundling of services.

MR. WILLIAM T. BILLARD: I am going to talk a little about concepts from a dental perspective and I'll let you do the translating. I think they can be translated to a general health line. I would like to start off with a brief commercial -- I just want to give you some idea of what my company is because we are a little different from most of the insurance companies represented here.

First of all, we're a nonprofit service corporation. We're founded by enabling acts of state legislatures much like the Blue Cross and Blue Shield plans. Sometimes I refer to us as the Blue Cross and Blue Shield of dental insurance, which generally makes the Blues plans and Delta's plans mad at me -- but in essence that's what we do. There's a Delta plan or at least a Delta presence in almost every state and in some cases they are tied in with the Blue plans. We underwrite and administer group dental programs. The Michigan plan does $300 million in

premiums. That doesn't sound like much until you consider that it's only in Michigan and it's only dental. About half of that business is with General Motors (GM), Chrysler and the State of Michigan. Some of the other major groups we have enrolled include most of the large school districts, universities, cities, counties, hospitals, and banks. We also share administration with the California and Rhode Island plans in a program which covers dental benefits for the dependents of all the U.S. Military Personnel. The Michigan market is dominated obviously by the auto companies and the United Auto Workers (UAW) and they are our major customers and have a major impact on the market of any body who does business in Michigan. Because of the limitations in my background I'm going to take a slightly less global approach to benefit demands of employers. I would like to talk about how the process works in the auto market and then show you a product or two products, really, that were developed through this process.

The product enhancement process as I know it is usually initiated in the auto market: G.M., Chrysler and the State of Michigan, which are all organized by the UAW. The State of Michigan only recently enrolled and benefit levels in that market are selected through the collective bargaining process. Everybody who does business with those people is subject to negotiations. The United Auto Workers has a separate department, the social security department, whose main job is to research and search for new benefits, evaluate them, and decide what's the best kind of benefits for their members. So most of our benefit demands that we hear come out of this kind of process.

Now there are two ways that this gets to us. One is through informal dialogue with both management and the UAW. Our marketing reps make service calls and chat with these folks on a regular basis and they will tell us what's going on. We try to keep our finger on the pulse that way. We also have a General Motors representative and a UAW representative on our Board of Directors and so we hear a lot of what's going on in both places through our board meetings and discussions. There is also a formal process which begins about a year prior to each negotiation; these are usually done every three years. The UAW social security department will contact us and request our ideas for the changes in the dental program. They'll also contact other carriers and they'll have other sources of their own where they will try to get ideas. They evaluate these ideas. They'll ask for costing, if that's appropriate, and then during the whole process management and the UAW will both keep in contact with us. They'll make various requests during negotiations; sometimes it gets kind of hectic, sometimes you'll get a 2:00 a.m. phone call because when the negotiations are hot they often go far into the night. So that part gets to be kind of fun.

Two years ago we decided to develop the Dental PPO product in response to the informal process at General Motors. We turned out to be a little ahead of the market with this offering. GM decided not decided to offer a dental PPO, at least to their Michigan employees. I believe they have one in Indiana and we had the product available. We offered it as an option to Ford in an effort to take over the Ford business from a competitor.

At this point I would like to give you a brief description of what we call our standard PPO program. Our standard PPO program is an open panel approach; in other words you can't go to a nonpanel dentist. It's a point-of-entry or point-of-service program. It can be used in conjunction with an open enrollment dual choice program. A traditional program, the PPO can stand alone where the employees just have a point-of-service choice and reduced benefits when they go to a non-PPO provider.

Let's look at the payment schedules first. We developed payment schedules that are about 20% or 25% below the mean dental fees for each procedure and we took these schedules to the dentists to try to get them to sign up. We have two schedules for general practitioners that are area-based and one separate schedule for specialists. All specialists are combined in one schedule. We also took some liberties with trying to gerrymander things first; for instance, we think that dentists charge too much for bitewing x-rays. We made these allowances a little lower than the 20-25% range, and there were other profiles, for instance, teeth cleaning, that we made a little bit higher than that range. When the dentists sign up in Michigan there is a Prudent Purchase Arrangement Law (which is really a PPO law but they didn't want to call it that) so all dentists have to be eligible if they want to qualify under this law. All dentists must be eligible for a PPO.

So we just sent our payment schedules and some materials around to all 5,000 dentists in the state. We figured we needed to have about 400 or 500 sign up to have a viable program. We were hoping to get about 1,000; we ended up getting about 800. We were pretty much in the middle of the

range and so we considered that successful enough to have a viable program. Payment to non-PPO dentists is on a schedule that's discounted 20% from the panel schedule. In other words, the dentists have to accept the PPO schedule to be a member of the PPO, but if a patient is in a PPO and goes to a nonpanel dentist, he gets paid on the basis of a schedule that's 20% lower than that. So in effect if the patient goes to a dentist whose fees are at the mean fee level and the dentist is not a panel provider, then in effect he's getting fees that are discounted 30%, 35% or 40% -- somewhere in that range.

I want to talk about utilization review briefly. We run every PPO provider's utilization statistics from the previous year through a schedule utilization review statistical test and determine whether we want to keep them. Incidentally, we don't use just this PPO business because we obviously don't have enough experience yet. So we use total fee-for-service experience. Most people think that if you're going to have a PPO you really have to have a good utilization review program. I believe that but I believe that you need a good utilization review program even if you don't have a PPO. So this is a statistically based system; it has significant testing built in. We have an in-house review mechanism to dismiss abusers from the PPO. We get the dentists and the actuaries together and argue about whether we should throw somebody out if we see utilization abuses. It then goes to a staff committee that has a final review. We have a clause in our contract with the dentists which allows us to dismiss them unilaterally without costs. Just 30 days notice and they are gone. We don't have to go through this for our traditional program; we have participating dentists, but we have a very elaborate procedure we have to follow to dismiss them.

This is really clear-cut in the PPO program. The dental policies and the contract limitations in the PPO are the same as for our traditional program. We decided we needed tight policies and contract limits and we use the same ones for the PPO as in our other usual customary and reasonable (UCR) programs. So this is the program that we prefer to propose to Ford and the UAW. While the UAW social security department took a look at this program and said that it is a good program, they asked what happens if a patient selects a PPO in our open enrollment and then goes to a non-PPO dentist. We said, he would to pay some out-of-pocket expenses and they can be fairly significant. Of course, the UAW didn't like that and they said well if the patient goes to a non-PPO dentist he gets traditional benefits, but if he goes to a PPO dentist he gets improved or enhanced benefits. That sounded like an offer we couldn't refuse so we developed the program like that and we call it the enhanced PPO. The enhanced PPO is point-of-service only; there is no point in having an open enrollment period because you are going to get the same benefits. It just depends on which dentist you go to whether you get the enhanced benefits. Non-PPO dentists as we said are paid at the same benefit levels as the traditional program. In other words, at Ford this was a takeover program. They already had benefits in place and we were going to take it over and have the people get the same benefits if they went to a nonpanel dentist. Then if they went to a panel dentist they got enhanced benefits. So theoretically anyway, the enhancement in benefit levels would encourage the employees to go to the panel dentists. The advantages of this approach are: (1) no open enrollment is necessary, (2) of course nobody loses benefits, everybody has the same benefits, the worst you can get are the same benefits you already had, and (3) the enhancements can be chosen so that some savings are generated. The rates are 20%-25% lower so you have that amount to play with in terms of the people who go to the enhanced PPO. So you can enhance the benefits by 10% and decrease the rates by 10% for all the people who go to the PPO. And of course, the more people you get to go to the PPO the more you can reduce the rates. So that had some appeal to management. There are some disadvantages to this program too as you might imagine. The main one may not offer enough incentive for the patients to switch dentists. It depends a lot on the benefit level of the traditional program.

Now we happen to have a high level traditional program in effect at all the auto companies and so it's difficult to enhance benefits in such a way to make the employees change dentists. I'm not going into a lot of detail about that, but, for instance, all preventive and diagnostic procedures are covered 100%. I think that's where you can really get people to change dentists; if you have oral exams, cleaning and so forth covered at 100%. Even a couple dollars out-of-pocket versus no dollars out-of-pocket might cause them to change. But it's already covered under the current program at Ford so we couldn't enhance benefits in that way to make the people switch. And the problem is if you can't get people to switch, the dentists are going to say, "wait a minute, I signed up for this PPO, all I had is the same patients that I had before and lower benefits, and they may drop out of the PPO." They have to be able to see that the lower fees equate to more patients or there is nothing in it for them. Another problem is that it's expensive to administer and underwrite this program. In essence, we have to do a separate product development for each group

because each group has different traditional benefits and each group has different cost alternatives. To make this little savings and enhancement thing work out, you almost have to do an individual evaluation of each group and you have to predict migration patterns. For risks you have to predict migration patterns of how many people are going to go to the PPO. It's not very cost-effective to administer at this point. Another disadvantage is that by giving patients more choice you increase utilization overall. I truly see this in triple option programs in medical. So I think that you have to build some of that back into the price too. You give people a choice and they are going to a find choice that's more comfortable for them and they are going to use the benefits more than if they are forced into a choice that they didn't make themselves. So I think that's a problem and you have to rate for that. The other disadvantage is that it takes the lower-fee dentists out of the traditional program provider pool. In other words, we think that the dentists that sign up for the PPO in the first place are traditionally lower-fee dentists. Their regular fees are closer to the scheduled fees so the lower-than-average fee dentists in the standard PPO program, if you have a dual choice situation, are still in the traditional pool because if the patients who don't choose the PPO still go to those dentists we're still getting those dentist's regular fees in the traditional program. In the enhanced program the dentists are automatically paid on all of their fees in the PPO and so in effect you have taken the lower-fee dentists out of the pool which increases the average fees of the dentists who are still in the traditional program pool. So that's basically what enhanced PPO is all about.

As far as results, we're still waiting for a decision at Ford -- this has been going on for a year and a half or so -- they have some loyalty to their current carrier and they are trying to develop a similar kind of program. So I don't know what's going to happen there. But we have put these things out on the market. We sold our first program on July 1, 1988. We have now sold the enhanced PPO program to the State of Michigan. It went into effect for UAW-represented employees on October 1, 1988 and to all other employees on April 1, 1989. We've also sold it to eight other groups. A total of about 70,000 employees are covered under the enhanced program. The standard program has been sold to 28 groups and covers a total of about 3500 employees. In effect those numbers are a little distorted because in many cases the standard program sold them a dual choice. So we've only got the people who actively chose the standard program common in that 3500. Typically 20% sign up for the PPO in an open enrollment situation, whereas the 70,000 covered under the enhanced program includes all the employees and maybe only 20% of those will go to a PPO dentist. All we told them when we signed them up was that people would get a benefit enhancement to go to PPO dentists. But we didn't tell them what it was or how much it was so we had some leeway there fortunately because we had signed the dentists up before we decided to develop the enhanced program. So we were lucky that we had left ourselves some wiggle room. We feel that if we have enough standard programs operating it will keep the dentists involved with the enhanced program. They might want to drop out of the enhanced program but our marketing department has a real necessity to keep the panel of creditable size. So they have a real obligation to sell the standard program whenever they can. They've tried to do that but if you listen to the average group sizes, mostly the big groups want the enhanced PPO. The smaller groups are more willing to go with the standard. We don't really have enough experience to know a lot yet. Early returns look good from an experience standpoint and we think the product is going to be successful. I think that in Michigan anyway this is going to be a real viable product. I think the dental market from state to state varies so much that I won't say that PPOs are going to fly everywhere but I think they are going to work in Michigan. They probably will not work as well in the states where dental capitation has taken hold pretty well -- California, Wisconsin, Minnesota and a few other places. I think the PPO may not do quite as well there.

I would like to shift gears now and speak briefly about unbundling administrative expenses. Third-party administrators have been moving into our area over the last two or three years and typically there are administrative expenses to administer a cost plus program that will be much less than ours. For the overall block of business we were about 11% or so and for a group of 1,000 probably around the 9%-10% range. We'll often get TPAs in who will administer the dental programs for 4% or 5%. Our marketing department, because we are a nonprofit service corporation, thinks that our market is everybody out there and we should have products and programs and the ability to meet everybody's needs. I come from a commercial insurance background so I don't feel quite that way. I think we should carve out the things that we do best and so we beat heads on whether we should try to compete with these TPAs. What we ended up doing is study. We said we do a lot of things that TPAs don't do and the marketing department should go out and sell those things that Delta Dental Plan of Michigan does best. They said, "yes, but can't we do something where we just process claims?" So we tried to separate our functions in terms of core

services and optional services. We decided that no matter what we do we have to cover our overhead; and of course, part of our overhead is tied into the other things that we do that are not core services. But we still have to cover it or else we must lay off a lot of the overhead, and since I'm part of the overhead I didn't think that we should do that. We have to have some sort of distribution arms. We have to service our concept of sales and service. We have to have pricing and reporting, we have to do billing, we have to do our accounting functions, we have to have enrollment, we have to monitor eligibility, we have to price claims and we have to write checks and mail them. And when we measured all these core services we said, "well, maybe we can do this for only about 6%; we might be able to be pretty competitive in that marketplace and if we really had to we could do it at 5%. But let's look at what we get for the other 4%-5% that's in our rates." These are the other things that we do.

Coordination of benefits (COB) is different for every group and for every carrier. For every benefit we pay we recover about 4.9% through COB in our main block of business. Our dental policies are things that we do because of our contracts with the dentist. That dentist has to eat. He can't charge it back to the patient. That's 3.9% of total paid claims. The contract time and age limitations, which are things like only two profiles per year and only two oral exams a year and that sort of thing, are things that if the patient wants to have more of them done he can have them but he has to pay for them. So those are really cost shifting kinds of things and that activity saves 2%. We go out and audit dentist, we do posttreatment reviews and we recover payments from dentists when they do things that we don't think are right or that are outside our contract limitations -- that's about a 10th of a percent. We really think that the 10th of a percent is only the tip of the iceberg. There are a lot of things that they don't do that they would do if they thought that they could get away with them. So you could say that's really worth more than that. We also do predeterminations which really is a cost item and doesn't save anything but it sure helps the patient to know beforehand how much he's going to have to pay before he has any services done. Benefit services people handle phone calls explaining benefits and telling dentists whether the patient is eligible. We think this is a very worthwhile service even though it doesn't save anything in claims cost. So we total these things up and it's 14.4%, and that's more than our administrative costs. So how can you not sell this product? We eventually decided through that analysis not to unbundle, not to charge for these things separately, but to just keep all of our whole program intact. There were other considerations in this that were not monetary but we were able to sell it on a strictly dollars-and-cents basis, which was gratifying.

MR. MILLER: I want to talk about large group issues related to multiple choice versus one set of benefits and talk about some funding techniques. I want you to take the role of an employer. The first issue that comes to mind is, why is my rate going up 35%, or 40%. So we need to take a little time and explain the rising cost of health care. This is broken down in several segments. First is the public; we have an aging population and we believe there is an insatiable appetite for health care. I was in a session where they talked about the gross national product being 12% for health care and it's going to 15% or 20%. The speaker said we could use 100% and there probably would still be a service out there that somebody would like to have. So, if we have people who want more services, this is a big reason for the increase.

The medical community is another reason for the increase in medical care. Excess hospital beds -- we believe that an empty bed attracts a warm body. I don't know about your area but we have an excess number of hospital beds and there is a growing number of medical providers. We no longer talk about M.D.s and D.O.s; we talk about CRNAs, RNs, physician assistants, physical therapists, audiologists, chiropractors, dental hygienists, DME equipment, clinical social workers, medical care facilities, mental health centers, occupational therapists, optometrists, out-patient substance abuse, pharmacies, speech therapists, music therapists and others. There are so many providers today and each one of them wants to make money. Also we believe that shortage of nurses is another reason for health care costs rising because with fewer nurses the salaries are increasing. As medical malpractice premiums go up, costs go up. In addition to that, the doctor will practice defensive medicine, and this results in unnecessary medical care.

New technology in drugs and magnetic resonance imaging (MRI), lithotripsy, and laser surgery are increasing costs as well as transplants, AIDS and catastrophic cases. Cost shifting causes subsidization and with 37 million uninsured that cost is being picked up by the employers that are buying insurance. Also inadequate payment by Medicare and Medicaid and shifting of coverage is another factor. At one time the 65-year-olds were all covered under Medicare; now if you are a working elderly person Medicare becomes secondary coverage. Many of the legislative mandates

such as nervous and mental coverage, coverage of mammographies and so forth are adding to the cost. In addition the group brings on some of the costs through adverse risk selection by using multiple options within a group. So what we need to do is tell the employer we have to go back to basics, and the first thing we do is go back to the definition of insurance. Go through that with them and then talk about the group spread of risk which is spreading the possible amount of loss over the number of persons in a group.

We then talk about adverse selection which is the selection by the insured against the insurer resulting in higher amounts paid out per person covered because the disproportionate share of the higher risk persons of the group are covered. Then to bring this point home to the employer we show a simple illustration. I know you understand this but when talking to large group employers some of them do not. Let's assume that 10 of us are in a group and during a certain period of time we used $1,000 of expense. Then of course when that's divided by 10 that $100 per person. Now let's assume they added an option and three of the people had no expense. So the three without expense decide through flex benefits they are going to take the money instead of the benefits. We now have seven people left to use the $1,000 so the expense goes to $142.85. So this group would have a 42.85% increase without any medical inflation at all. The group needs to know some of those basic points.

One particular large group that we had enrolled had one traditional carrier and nine HMOs; so in a sense instead of having one group they had 10 groups. I think that point needs to be made first. In this particular group the younger employees selected the HMOs. That's not always true but in this case it was true. In looking at the case mix of the types of claims that were incurred by the HMO versus the traditional, the severity of the cases, where 1 is average, for the HMO was 0.85. So the HMO costs and utilization were lower than the traditional and those selecting the traditional had more severe problems. So what's the potential solution for a group that has multiple options? First of all, they need to stabilize the group by unifying. We go back to the basic definition of insurance again and talk to the employer. What are some of the alternatives? In this particular group a large number of employees had HMOs because of the nine HMOs. So we suggested that everybody go to the HMOs and we would eliminate the traditional. But when we tried that on the employees there was a large outcry because of the lack of freedom of choice. They said, "No, we do not want to go to HMOs." So we said, everyone should go to traditional but the employer was not interested in that because of the lack of restrictive managed care, even though we had some elements of managed care in the traditional coverage. The third option would be to go with a hybrid. That is taking the best elements out of the HMO and the traditional, which resulted in an HMO with a self-referral option. The employer wanted a managed care system and the reason was that a physician could manage the patient's care. The physician knows the patient's medical status and is able to steer the patient to the correct specialist and avoid the cost of duplication of services. Also, the quality of medical care is enhanced. So for this particular group the solution was to go to an HMO with a self-referral option where the option out of the HMO was a deductible with a higher co-pay. Because of this group being spread over a large area, in some areas there was not an HMO with a self-referral option available and in that case they took the traditional coverage but no other options.

In addition to that, the group was interested in wellness care. They charged people who smoke more than those who did not smoke. So the employees had to certify that they were nonsmokers in order to get the regular rate. If they didn't certify they got a $10 surcharge put on their rate. For an 11-month there were 16,723 nonsmoker employees and 4,100 smoker employees. The admissions per 1,000 subscribers was 63% higher for the smokers; the days per 1,000 subscribers were 109% higher for the smokers; the average length of stay was 30% higher; cost per day was 16.6% higher; the out-patient cost per employee was 63% higher; and the professional provider costs per employee were 27% higher. So the total cost per employee on the average is $838 but the nonsmoker is 10% less. The smoker's cost is 36% more than the average. There are areas like this that a lot of large groups are going to be wanting to segregate in some manner.

I want to talk about large group funding techniques. First of all there is a fully insured program which we are familiar with where the group pays a premium in advance and the insurance carrier takes the risk. Second, there is the delayed premium, 30, 60 or 90 days where the employer concludes they would rather pay their dues late and pay an interest penalty. A lot of employers would like to go to self-insurance but they don't feel they have the finances to do that so they go partial self-fund. They may go with a $500 deductible with an 80/20 co-pay and they'll pick up the $500 and the 20% co-insurance on a shared risk basis. Some of them want to go with a cost

plus settlement at the end of the first year. Many groups want to go with an administrative services only (ASO). Some of this is just bandwagon. They see their fellow employer going ASO so they conclude they should go ASO. If they do then they need to put in either an aggregate or individual stop loss.

Finally, I want to talk about split funding. In some groups that are receiving 30%-35% rate increases they do not believe the actuary. They cannot believe that the rate should be that high. Many times, the only way to get them to stay with you is to ask what they think the rate ought to be. And of course they believe it should always be much lower. This group said they thought it ought to be about 85% of what we thought the rate should be. We said "OK, what we'll do then is charge you 85% of the rate. However, you must sign a contract with us that says that 15% will be put in an interest-bearing account and that money belongs to us at year end if we are right and you are wrong. If you're right, then you'll pay us based on the adjustments in our retention that we proposed up front. However, if we're right, then you will owe us not only the additional 15% but the interest earned on that money. We have this in one large group. We built in some incentives related to the managed care concept which says that if we can hit the 85%, we will actually receive a higher retention than if we hit 90% or 95%. They agreed to this to put pressure on our medical review area to hold down the cost of health care. The incentive is based upon the incurred loss ratio at year-end. The lower the loss ratio, the higher the retention we receive. So it's a new way of putting incentive into a program.

FROM THE FLOOR: I have a question on your smoker versus nonsmoker medical cost. Does the plan's sponsor actually make a plan change based on that analysis and did you do any age-adjusted analysis?

MR. MILLER: At this point we have not. We are going to do that but I don't have that information. It probably will not show quite as dramatic a difference once we do that, but we expect the difference to be fairly significant. The group is going to continue with this surcharge. The employee has to certify that he is a nonsmoker to get the rate that is computed and if he does not certify then he gets a surcharge. That surcharge will be adjusted based upon the experience that is being accumulated this year.

MS. JUDITH A. DISCENZA: You mentioned a maintenance-of-effort period but I don't recall what you said about the time limit. Should I assume several years?

MR. ATKINSON: I believe your question was the period in which maintenance-of-effort provisions are in effect. For Part A benefits in 1989 we're in it right now, so by December 31, 1989 employers must have provided the value of any duplicate of benefits in so far as it applies to Part A benefits because Part A benefits were improved in 1989. And in the case of 1990 for Part B benefits there is in my opinion a very good likelihood that this maintenance-of-effort requirement will go beyond 1989 and 1990 because of the potential for revenue raising.