RECORD OF SOCIETY OF ACTUARIES
1993 VOL. 19 NO. 4B

CORE BENEFIT PLANS

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Recorder: JANET M. CARSTENS

- Are core/minimum plans desirable?
- What are implications for state benefit mandates?
- Considerations of family income/health out-of-pocket expenses
- Emphasis on catastrophic versus preventive/primary services

MS. JANET M. CARSTENS: One speaker is going to give us a state's perspective on core benefit plans. The other speaker will give us a perspective from the national level.

In the general session, Walter Rugland stressed the importance of the involvement by members of the actuarial profession in national health care reform. During the first half of 1993, the American Academy of Actuaries organized several work groups to address specific health-care issues related to reform. I was a member of one of those groups which was chaired by Julia Philips. The group was known as the Standard Benefits Working Group.

Our group prepared a paper entitled, "Standard Benefits in Health Care Reform – The Impact and the Cost." The paper was prepared to provide state and federal legislators and policymakers with a practical guide to standard benefit plans. The paper did not exactly address specific policy issues, such as what to provide, who would pay, or how to balance the needs of the insured population versus the uninsured population. However, the paper did focus on technical issues raised in competing health-care proposals, such as plan design and cost estimation. The paper also gave sample cost estimates for four different standard benefit-plan designs. Working groups of the Clinton administration's health-care task force used the paper in their deliberations. Committee members of the United States House of Representatives and Senate requested copies to use in preparing for hearings on the administration's proposal as well.

For purposes of my comments, I am using the phrase *core benefit plan* interchangeably with standard benefit plan, basic benefit plan, and minimum benefit plan. As implemented by various states, a core benefit plan generally represents a minimum level of benefits that must be offered by each carrier. Historically, richer benefit-plan designs than the core level of benefits have been allowed by several states. However, in some states, the core benefit-plan design represents very rich coverage. Due to differences in common benefit-plan designs, state legislators often allow different core benefit plans for HMOs than they do for traditional indemnity carriers.

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Our work group concluded that the main reasons for implementing core benefit plans are to facilitate comparison between carriers (both in coverage levels and costs), to ensure a minimum level of coverage, and to control costs. Depending on the type of core benefit plan under consideration, there may be an emphasis on catastrophic benefits or preventive services. Preventive plans emphasize early detection of disease to prevent more costly treatment at a later date. Preventive plans offer coverage of preventive services at 100%, or with very little cost sharing. Common benefit-plan designs include coverage of primary-care physician services, well-baby and well-child care, mammography screening, and sometimes coverage of adult physical exams (possibly up to a maximum benefit). Catastrophic plans, on the other hand, often have high individual deductibles, such as $500 or $1,000. Cost sharing may be up to 20% along with high out-of-pocket maximums. Catastrophic options might be chosen by employers that wish to self-fund the amounts below the high-deductible levels or by employees who are in good health and who may have high-income levels.

Core benefit packages may be exempt from state-mandated benefit requirements. They may have internal coverage limitations. They may also have restrictions on premium rates. Although core benefit plans have been allowed in one form or another by several states for some time now, demand for them has not been very strong. Recent articles have indicated that core benefit plans that carve out coverage of state-mandated benefits and that have internal coverage limitations have not sold well. Some reasons cited for that observation is that the costs are still too high, the plans may not be desirable after the coverage has been stripped out, or at least after the coverage for certain benefits has been stripped out, and sometimes there is a requirement for an uninsured period before coverage can be made available.

Our work group identified several other disadvantages of core benefit plans. Employers may make the core benefit package their only offering. Expenses could increase for those employees who currently enjoy very rich benefit plans. Also, core benefit plans may limit imaginative approaches to plan design or to managed care. And, until credible experience develops, core benefit-plans may be difficult to price due to inadequate or conflicting data, the complexity of the benefit-plan design, the impact of antiselection and induced demand, the effect of managed health-care programs, and trends in utilization, costs, and population demographics.

Now I would like to introduce our two speakers. Rick Diamond is a life and health actuary for the Bureau of Insurance in the state of Maine. He is a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, a member of the state health committee and a member of the NAIC Life and Health Actuarial Task Force. Maine has recently enacted core benefit-plan legislation, and Rick is going to provide us with a summary of the legislative process.

Paul Shultz is vice president and manager of technical services for Towers Perrin in Valhalla, New York. Paul has been with Towers Perrin for 17 years. Prior to joining Towers Perrin, he worked as a lawyer. Paul will provide us with a summary of options available within the national health-care debate, with a primary focus on the Clinton proposal.

MR. RICHARD H. DIAMOND: I am going to talk about our experience in Maine with standardized plans for small groups. We have a requirement that just went into effect October 1, requiring all small-group carriers to offer two standardized plans. There were two phases in the developmental process of those plans. The first phase was the legislative process, which resulted in the requirement that the Bureau of Insurance develop two plans. The second phase was the rule-making process, through which the specifics of the plans were developed.

The original proposal was a bill advanced by the governor's office in 1992, which would have allowed insurers to offer a plan to groups with fewer than 25 employees, and, which would have covered preventive services but which would have been exempt from mandated benefits. The idea for that bill was based on two myths. The first myth was that covering preventive services would result in lower, overall costs. The second was that mandated benefits are a major cause of high premiums for health insurance.

The most costly mandates in Maine are those regarding mental health, substance abuse, and chiropractic benefits. Mental health accounts for less than 4% of claims; substance abuse accounts for less than 2% of claims; and chiropractic accounts for about 1% of claims. Those figures do not reflect any offsetting reduction in claims for other conditions. Groups of 20 or fewer employees were already exempt from the mental-health and substance-abuse mandates unless they were insured through an association or a trust. Therefore, the possible savings for those exempt groups from eliminating mandates was negligible. The possible savings for other groups from eliminating mandates was less than 7% of total claims. Additional savings were to come from reductions in other benefits. Similar laws in other states generally restrict availability of those plans; for instance, to employers that have not offered coverage in the previous 12 months. The governor's plan did not have such a restriction, for fear of encouraging employers to drop existing coverage for a year.

The governor's proposal was presented to the Maine legislature's banking and insurance committee. By way of background, both Houses in Maine are controlled by Democrats, but the governor is a Republican. During the previous year, the legislature had seen a bitter political battle over the budget and workers' compensation reform, which resulted in the shutdown of state government for about two weeks. In this climate, the legislature was not particularly receptive to any proposal from the governor's office. Furthermore, several committee members were philosophically opposed to weakening the mandates. They argued that employees should not be shortchanged just because those employees may work for a small employer. Since lawmakers had determined that mandates were desirable, they argued that they did not want to weaken the requirements, particularly not for such small savings. They pointed out that the majority of cost savings in the governor's plan came from reductions in other benefits and that there was nothing preventing insurers from doing this without legislation. The committee members were persuaded by these arguments and they killed the bill, but that was not the end of it.

That same year, the legislature passed a small-group-reform bill for guarantee issue and modified community rating. The governor was lobbied heavily by insurers, agents, and small business groups wanting him to veto the bill, and by Blue Cross and consumer groups wanting him to sign it. In the closing days of the legislative

session, the governor's staff negotiated with the bill sponsors for inclusion of a low-cost, standardized plan in the bill. When I say *negotiated*, I do not mean to imply anything as organized as both sides sitting around a table discussing the issues. For the most part, the negotiations consisted of people like me wandering the halls in the state house looking for the key players, all of whom were involved in several other bills of equal or greater importance (most notably the budget). We were looking for those key players to relay the latest proposals from the other side and to get their reactions to those proposals. The sticking point was that the legislators were unwilling to provide any exemption from the mandates, whereas the governor's office was unwilling to accept any bill that did not allow for some relief from the mandates.

Eventually a compromise was reached, which had the following elements. All carriers in the small-group market would have to offer two standardized plans: a standard plan and a basic plan. The standard plan was to be similar to plans typically offered to small groups. The basic plan was to emphasize preventive care and contain reduced benefits to the extent necessary to reduce the cost by 20%. Neither plan would be exempt from the state mandates. However, an understanding was reached that mental health and substance abuse would be covered at a lesser level in the basic plan than the minimum standard required in other plans. That was to be accomplished through rule-making. Unlike statutes (which must be enacted by the legislature), rules or regulations, as they are often called elsewhere, can be promulgated by the administrative agency to the extent authorized by statute. The requirement that mental health and substance abuse be covered is in statute, but the minimum standards for meeting the requirement were established by rule by the Bureau of Insurance. Therefore, it was possible to provide for a lesser standard in the basic plan without changing the statute. That satisfied the legislators' requirement that there be no weakening of the statutory mandate. The governor's requirement that the new law provide some relief from the mandates was also satisfied, because the new law would provide the authority for distinguishing the benefit level in the basic plan from the benefit level in all other plans subject to the mandates. The small-group-reform bill was amended to reflect that compromise, enacted by both Houses and signed by the governor.

The rule-making phase of the process consisted of two parts. First, the existing rules setting the minimum standards for mental-health and substance-abuse benefits were amended. Then, a rule was adopted establishing the two standardized plans: the standard plan and the basic plan. The existing minimum standards for mental-health and substance-abuse benefits had been adopted in 1983 and were out of date. The dollar amounts in the rules had been eroded by inflation. Therefore, it was proposed to update the standards at the same time the rules were amended to provide for lesser benefits in the standard plan.

In addition to increasing dollar amounts in the rule, several other changes were proposed. Through some sentiment that the advent of managed care and utilization review had greatly altered patterns for inpatient care, it was argued that while in the past the typical inpatient stay was 30 days (the minimum required to be covered under the rule), benefits were now being cut off after two or three days, if inpatient care was approved at all. The few cases that did last 30 days or more were truly catastrophic. Hence, there was less need for benefit limitations to control excessive utilization.

The following changes in the rule were proposed. First, increase the inpatient maximum for mental health from 30 to 60 days. Second, increase the lifetime maximums from $25,000 each for mental health and substance abuse to $75,000 for mental health and to $50,000 for substance abuse. Third, replace the inpatient coinsurance with a one-day elimination period. Fourth, treat two days of day treatment as one day of inpatient care. Day treatment was previously treated the same as outpatient care.) Fifth, increase maximum annual outpatient benefits from $1,000 to $2,000.

Specific standards were not included for the basic plan; an exemption from the standard rule was merely proposed. The basic plan benefits were to be established later. Like most states, if not all states, Maine has the Administrative Procedure Act, which requires an opportunity for affected parties to comment on the proposed rules. In some cases this is a mere formality, but in this instance, we truly wanted input on the proposed changes. Hearings were held and, in general, insurers argued that the proposals went too far, whereas mental-health and substance-abuse providers argued that the proposals did not go far enough. This was not a surprise. Mental-health providers also argued that mental illness should be treated the same as physical illness.

There were two areas in which most of the commentaries did agree. First, everyone liked the idea of treating two days of day treatment as one day of inpatient care. Second, everyone disliked the one-day elimination period instead of coinsurance; consequently, that idea was abandoned. Insurers also argued that managed care was not as pervasive or effective as had been suggested, and that strict limits on benefits were still needed. The proposed increase to 60 days for inpatient care was deleted. The proposed lifetime maximums of $75,000 to 50,000 for mental health and substance abuse were cut back to $50,000 to 25,000, respectively. And the proposed $2,000 limit on outpatient benefits was cut back to $1,500. Once these amendments were finalized, the next step was to develop the two plans, standard and basic.

The request for proposals was sent out to consulting actuaries for assistance in designing the plans and in evaluating the benefits to determine compliance with the required 20% differential between the two plans. The consulting firm worked with me and other bureau staff to develop the proposed benefit packages. It was clear from the start that at least two different sets of standard and basic plans would need to be developed: one for HMOs and one for indemnity carriers. One decision that had to be made was whether to develop different sets of plans for those groups subject to the mental-health and substance-abuse mandates and a separate plan for those groups exempt from the mandates. Remember that groups of 20 or fewer employees are exempt from those mandates, and groups of 21-24 employees, as well as employers with 1-24 employees covered through associations or trusts, are not exempt.

It was decided in the interest of simplicity to include the same level of mental-health and substance-abuse benefits for all groups. This did not put any undue burden on exempt employers, because insurers are free to offer other plans that exclude these benefits. The substance-abuse benefits included in the standard indemnity plan were the minimum required by the amended rule, but the mental-health benefits were

slightly richer than the minimum; that is, 60 days of inpatient benefits instead of 30 days and $2,000 of outpatient benefits instead of $1,500.

The mental-health and substance-abuse benefits included in the basic indemnity plan were as follows. Annual inpatient days were limited to 30 days for mental health and 20 days for substance abuse versus 60-30 days in the standard plan. Annual outpatient benefits were $1,000 each for mental health and substance abuse versus $2,000 for mental health and $1,500 for substance abuse in the standard plan. Lifetime maximums were $10,000 each versus $50,000 for mental health and $25,000 for substance abuse in the standard plan. Those reductions added up to less than 2% of premium. That still left 18% or more to meet the required 20% differential. We did not want to rely on a higher deductible to make up some or all of the difference, because employees offered the basic plan are likely to be the least able to afford high deductibles. It was decided to require both plans to be offered with a choice of deductibles. Deductibles of $250, $500, $1,000, and $1,500 were required to be offered. In addition to those deductibles, other deductibles could be offered as well.

Two features accounted for most of the premium difference in the proposed plans: coinsurance and prescription drugs. The standard plan had 80/20 coinsurance, and the basic plan had 60/40. However, both plans had out-of-pocket limits of $1,000 plus the deductible. That provided some catastrophic protection under the basic plan, although it obviously reduces the premium savings. Prescription-drug coverage under the basic plan was limited by requiring copayments of $20 per prescription for generic drugs and $30 per prescription for name-brand drugs (a very minimal benefit). The remaining premium difference was made up by setting a $500,000 lifetime maximum versus a $1,000,000 maximum in the standard plan, a 60-day limit on inpatient hospital coverage, a $2,000 annual cap on diagnostic X ray and lab services, a $50 emergency room copayment versus $25 in the standard plan, a six-visit limit on chiropractic services versus ten visits in the standard plan, and exclusion of skilled-nursing-facility benefits.

The proposed HMO plans were designed to be comparable to indemnity plans. However, because there was no coinsurance, other means had to be found to make up the required premium differential. Therefore, the first five days of inpatient care under the basic HMO plan were subject to a $250 daily copayment, as opposed to a copayment of $100 per stay under the standard plan. Office visits were subject to a $25 copayment versus $5 under the standard plan. Other copayments were increased as well.

A public hearing was held regarding the proposed plans on April 7, and written comments were accepted until April 21. We received many comments resulting in several refinements to the proposed plans. One actuary asserted that the proposed basic plan had an actuarial value greater than 80% of the standard plan. However, no documentation was provided to support that assertion, and no one else expressed that view. In light of the detailed cost estimates done by the consulting firm, we felt comfortable that the 20% savings had been achieved. The same actuary argued that the proposed HMO plans were less generous than the indemnity plans and that they would give HMOs a competitive advantage. However, an HMO argued the opposite: that the proposed HMO plans were more generous than the indemnity plans, which

would create difficulties in competing for business and would invite adverse selection. Analysis by the consulting firm indicated that the latter was more accurate. Therefore, the level of benefits in the HMO plans was reduced by increasing copayments in the standard plan and by adding 80/20 coinsurance for inpatient benefits to the basic plan.

The proposed plans included a three-month-deductible carryover. One carrier argued that the carryover should at least be eliminated from the basic plan. We did not go that far, but we did reduce the carryover in the basic plan from three months to one month. The same carrier also objected to the proposed out-of-pocket maximum on the HMO plans, on grounds that it was administratively cumbersome and that it was confusing. We determined with our consultants that large, out-of-pocket expenses were unlikely under the HMO plans, thus the out-of-pocket maximum provision was removed.

One carrier argued that the proposed emergency room copayments were too small to provide a disincentive for overutilization of these services. We agreed and those copayments were increased.

There were a number of complaints about the design of the prescription-drug benefits. One carrier suggested that rather than have this benefit be subject to coinsurance in the standard plan and to copayments in the basic plan, carriers should be allowed to choose whether to use coinsurance or copayments. However, that would have undermined the intent to provide standardized plans. Another carrier argued that the proposed prescription-drug copayments in the basic plan were too high to provide a meaningful benefit. However, we felt that while limited, this benefit did allow significant coverage for certain high-cost drugs, and a more generous benefit was precluded by the need to achieve the 20% cost difference between the standard and basic plans.

Two carriers suggested that the mental-health and substance-abuse benefits be reduced or eliminated for those groups not subject to the mandates. However, as I mentioned earlier, carriers are free to offer such plans anyway. The Alliance for the Mentally Ill of Maine argued that the proposed mental health and substance abuse benefits were inadequate. Similarly, the Maine ambulatory care coalition recommended that mental health and substance abuse be treated the same as other conditions in the standard plan. A state legislator favored treating biologically based mental illnesses the same as physical illnesses. We rejected those recommendations because any such changes would have violated the statutory requirement that the standard plan be similar to those typically offered to small groups. However, the same legislator sponsored legislation that has since been enacted to require a higher level of benefits for a defined list of biologically based mental illnesses. That new law takes effect January 1, 1994, and we are in the process of amending the standard and basic plans to comply.

The Maine ambulatory care coalition suggested including coverage of certified rural health clinics and federally qualified health centers. That is required by law for Blue Cross, and in the interest of standardization it was included for all carriers in the standardized plans.

Perhaps the largest number of comments from carriers concerned the permitted exclusions. The proposed rule contained a short list of five exclusions, and several carriers suggested that they be allowed to include their standard exclusions. Numerous examples of abuse or excess utilization were cited that could occur without these restrictions. We felt that allowing carriers free reign to add exclusions would undermine the intent to provide standardized plans. However, we conducted an extensive review of the contracts used by several carriers, and we added several exclusions, as well as restrictions, within the benefit provisions to conform to plans typically offered. The final rule contains a list of 19 exclusions.

Some carriers pointed out that greater coverage of skilled-nursing facilities or home health care might reduce the use of more expensive care. Though the limits were not changed, a provision was added permitting coverage of services not specified in the contract if, in the carrier's judgment, this coverage would result in more cost-effective treatment. Many suggestions for definitions and for clarification of various provisions were incorporated in the final rule.

Last, in response to comments that the proposed July 15 effective date did not allow enough lead time, the effective date was changed to October 1. After the rule was finalized, we discovered that we had failed to include a dental exclusion. We were able to amend the rule to remedy this in time for the October 1 effective date. However, later in the process of reviewing policy forms filed under the rule (which has happened mostly in the last six weeks), we have found that despite all the refinements, there are still some glitches in the rule. As I mentioned, we are now amending the rule to reflect the new mental-health law, and we plan further refinements to the benefit provisions and exclusions as part of that process to clarify these areas. With that I will turn it over to Paul.

MR. PAUL T. SHULTZ: I am going to try to talk about health-care reform (with a strong emphasis on core benefit-plans and their role in health-care reform).

In President Clinton's speech (September 22, 1993), he said, "For the first time in this century, leaders of both political parties have joined together around the principle of providing universal, comprehensive health care. It is a magic moment, and we must seize it." Many of us in this industry share that enthusiasm, perhaps not for all of his details, but we share the enthusiasm for this moment and for the opportunity to resolve some issues that have been facing our society for many decades.

I want to try to take you through a series of building blocks. My primary focus is going to be on the Clinton proposal. However, I'd like to emphasize at the outset that, from my perspective at any rate, the Clinton proposal is very much the outer limit of what might actually be enacted. A variety of proposals have been introduced in Congress; no doubt there will be more. Except for the single-payer proposal, which could probably best be seen in the McDermott-Wellstone bill, the Clinton proposal probably is an extreme scenario. The final plan will more likely be some kind of an amalgam of Clinton's proposal and some of the other proposals, such as the conservative Democratic forum proposal under Coopers or the Chafee bill (the Senate Republican bill). But we are going to focus, for a while anyway, on the Clinton proposal, because it is probably the most detailed, and the most spelled-out and celebrated proposal at this time. It will probably be the basis for debate for quite a

long time. The legislation will probably be enacted sometime not too long before the elections in 1994.

We have identified six building blocks of the Clinton proposal. I am going to spend a little time on some, no time on others, and a lot of time on the most important ones, the ones that are most relevant to our discussion.

First, let us take a look at the concept of managed competition and talk a little bit about what is involved in it. Managed competition is a fairly complex array of different organizations, which requires the establishment of regional health alliances and corporate health alliances (for companies with 5,000 or more employees as set forth in the proposal), and the involvement of large employers, small employers, and individuals as well. Small employers and individuals would be required to purchase their health care coverage through regional alliances. Large employers would have the option either to go into a corporate health alliance or to go into a regional alliance. That would be a one-time choice on the part of the large employers. If a large employer opts into a regional health alliance, then that employer would be prohibited from changing to a corporate alliance at a later date. The regional alliances oversee and qualify the creation of health plans, which probably will turn out to be HMOs, PPOs, and insurance companies that qualify as health plans. Then, those health plans contract with providers. At the national level, an oversight board would be created, which would be called the National Health Board.

The National Health Board would oversee state systems. It would set the administrative standards for health alliances (regional and corporate) and also for all the health plans established in the various areas of the regional alliances. It would administer the global budget. It would review national quality data. It could recommend changes in the standard benefits package to the President and to Congress. And, it would develop a risk-adjustment system for the health alliances.

The regional health alliances have broad power to oversee the operation of the health plans and the delivery of health care for those who live in the area. They would be state-chartered, not-for-profit organizations. There would be at least one alliance per state, and the states would be charged with the responsibility of establishing them. They would have exclusive territories and they would compete only with the corporate health alliances. They would bear no financial insurance risk; all that risk would be passed on to the health plans. Their purposes would be to reduce administrative costs, to spread risk, and to increase the buying power of the people enrolled in a specific health plan. Their responsibilities would be to qualify health plans, to negotiate premiums, to monitor the price of health plans, to monitor the quality of health plans, and to monitor whether those health plans are maintaining solvency. They would engage in an effort to adjust the risk between the different health plans; that is, they would analyze the demographics of, and other factors related to, the health plans and then make adjustments in those risks. Therefore, they would have a great deal of power over the premium levels that the health plans would be able to charge.

They would be responsible for providing consumers with information concerning available health plans. They would also be charged with overseeing the compliance with the global budgets. They would serve small employers. They would serve part-time employees (all part-time employees would be required to be covered under the

regional alliance). All federal, state, and local government employees would be required to be included in a regional alliance. They would cover retirees under age 65. They would cover all self-employed individuals, unemployed individuals, Medicaid people and perhaps, at a later date, they might include some people from Medicare.

Under the managed-competition structure, major employers may also establish their own corporate health alliances (this is also available to Taft-Hartley plans). The threshold requirement for establishing a corporate health alliance in the Clinton proposal is 5,000 employees nationwide. That number will most likely be the subject of a lot of lobbying. I am sure that many of us would not be surprised to see that number reduced to a significantly lower number, perhaps as low as 500, 300, or 100 -- although one starts to wonder about insurance pools and risk sharing when that low of a level is considered. Corporate health alliances may select HMOs and insurance carriers. They may contract directly with providers. They may insure or provide self-insurance. They may also take a location where they have a small number of employees, such as in a remote city, and place that particular location in the applicable regional alliance. They have to offer the health plan that gives free choice of providers. In fact, the corporate alliance is required to allow all three choices contained in the Clinton plan. The corporate alliances would also be subject to global budgeting.

The next piece in the structure of managed competition that one has to consider is the health plan itself. The health plan actually consists of two aspects: the delivery system and the plan design.

The delivery system is intended to have various options. One piece would be vertically integrated, medical management systems, such as HMOs. In addition, a fee-for-service system, such as an indemnity plan typically offered by an insurance company, could be selected. Finally, a typical, managed-care network system with point-of-service delivery and either in-network or out-of-network options available to patients would also be included. The health plans would be required to be vendors of the standard benefits package. They would also be required to report on outcomes data and provide other quality-related information.

The other aspect of health plans is the plan design. The standard benefits package would have various basic requirements. The range of covered services in the plan would be quite broad. The standard package would have no copayments or coinsurance for preventive care, no exclusions for preexisting conditions, and no lifetime limit on the benefits included in the basic package. Under the Clinton proposal, health plans would be required to be in the form of either low-cost-sharing HMOs, or high-cost-sharing health plans (indemnity programs), or a combination plan (point-of-service (POS) with a PPO). Under the low-cost-sharing arrangement, copayments would be required for service usage, and the use of a provider would be restricted. Under the high-cost-sharing plan, deductibles and coinsurance would be required, and unrestricted use of providers would be allowed. Finally, the combination plan would incorporate both the in-network and out-of-network features.

The low-cost-sharing plan would have no deductible, a $10 office visit copayment, a $5 per-prescription copayment, and no hospital copayment. The out-of-pocket maximums would be $1,500 or $3,000. In contrast, the high-cost-sharing plan

would involve a $200 or $400 deductible, a separate $250 deductible for drug expenses, and a 20% copayment except on preventive-care services. The similar out-of-pocket maximums would be $1,500 or $3,000. The third type of plan, the combination in-network and out-of-network plan, would have similar restrictions.

The Clinton plan would represent a mandate for both employers and individuals. Employers would be required to pay for and to cover all employees. Employed spouses would be subsidized by their own employers, which would be somewhat of a change, because an employed individual who is covered under his or her spouse's plan currently does not incur any cost on behalf of his or her own employer. A family would be required to enroll under one plan. Last, the plan would not include an employer mandate for retirees.

Though the plan would have no employer mandate for retirees, it would have an interesting proposal regarding pre-Medicare-eligible retirees. Those retirees would be placed in a regional system and provided with very liberal subsidies. The plan would call for the government to pick up 80% of the cost of an individual. The retiree, or the company, in cases in which the company provides postretirement medical benefits, would pick up the other 20% or so. I say, "or so," because that remainder could be either a great deal more or a great deal less than 20%.

In any event, the opportunity to have retirees covered under regional alliances on this heavily subsidized basis is very attractive to major employers that historically have faced very heavy postretirement medical liabilities, particularly since the application of *FAS 106*. It is a very controversial issue, too, because the initial cost estimate for this particular provision was fairly low, but other people are saying that the cost could actually be quite significant. Initial cost estimates were $4.5 billion over a five-year period. The Clinton administration revised that estimate and suggested the cost might be as high as $6 billion. Other studies have suggested it could be as high as $10 billion or more. This issue is being reconsidered by the administration. One thing that the government may do is drop the subsidy level from 80% to something lower. One number that has been discussed is 70%. However, the administration may even go so far as to drop the benefit from the proposal completely.

An employer would be required to provide coverage for all employees who are full-time (30 or more hours per week). The employer would also be required to provide coverage for part-time employees (between 10 and 30 hours per week) on a prorated basis. If an individual works 10 or fewer hours per week, then that individual would not be considered an eligible employee, and the employer would not be required to cover that employee.

The employer contribution requirement for full-time employees would be 80% of the weighted average premium applicable within a particular regional alliance. Employer contributions for part-time employees would be a prorated contribution of that average premium. Employers may contribute more than the required 80% or even provide full coverage for their employees if they choose to do so. Employers with fewer than 50 employees, and whose employees have an average wage of less than $24,000 per year for a full-time worker, will be eligible for subsidies that put a cap on the total premium contributions. If the average wage for a full-time employee is less than $12,000, then the required employer contribution would be limited to 3.5% of

payroll. That percentage increases through graded levels to a maximum of 6.5% if the average full-time employee's wage is between $21,000 and 24,000.

Table 1 is an illustration of how the premium would be calculated for a regional alliance offering four health plans: HMO A, HMO B, an indemnity plan, and a PPO. Let the single premium for the four health plans be $1,600, $2,000, $2,100, and $2,300, respectively. Let the enrollment of all the persons in the regional alliance be exactly 25% in each of the four different plans.

As a result, the weighted average premium cost is $2,000. The employer, therefore, is obligated to pay a contribution equal to 80% of the $2,000, or $1,600 for each full-time employee. An enrollee in HMO A would pay nothing, because his or her employer would be required to pay $1,600 for every employee. For the second, third, and fourth plans, the employees must pay the difference between the premium for that plan and the $1,600 contribution made by the employer, so the employee contributions would be $400, $500,
and $700, respectively.

The Clinton proposal would require four different premium levels: one for an individual, one for a couple with no children, one for a single parent, and one for a couple with children. In the example shown in Table 2, for a particular health plan, the estimated premium would be $1,800 for a single person, $2,800 for a single parent, $3,200 for a couple, and $4,200 for a family. The employee contributions would be 20% of that premium and the employer contributions would be 80%.

TABLE 1
Contribution Illustration

	HMO "A"	HMO "B"	Indemnity	PPO
Single premium	$1,600	$2,000	$2,100	$2,300
Enrollment	25%	25%	25%	25%
Weighted Average Premium Cost: $2,000				
Employer contribution (average x 80%)	$1,600	$1,600	$1,600	$1,600
Employee contribution	0	400	500	700

The employer contribution would actually turn out to be less than the 80% of premium because of the way in which it is calculated. The 80%-of-premium amount would have to be divided by the average number of workers per-coverage category to develop the true employer premiums. Assume that the average number of workers for service categories are: 1 for single persons, 1.2 for single parents, 1.5 for couples with no children, and 1.7 for a family.

TABLE 2
Premium Contributions Under the Clinton Proposal

	Single	Single Parent	Couple	Family
Estimated annual premium	$1,800	2,800	$3,200	$4,200
Employee contribution (20%)	360	560	640	840
Employer contribution (80%)	1,440	2,240	2,560	3,360
Average number of workers per coverage category*	1.0	1.2	1.5	1.7
Adjusted employer contribution per full-time employee	1,440	1,867	1,707	1,976

*Will be based on data for each regional alliance.

As an example (see Table 3), the employee contribution for a one-worker family would be $840 and the employer would pay $1,976 (80% of average premium divided by 1.7). For a two-worker family, the family again pays a maximum of $840, but the employer of each spouse would pay $1,976, which would result in a total of $4,792.

Another example is shown in Table 4. Suppose a one-worker family has children who work part-time: one works 20 hours per week and the other works 15 hours per week. The employer for the full-time employee would pay $1,976. The employer for the child who works 20 hours per week would pay $1,317. The employer for the child who works 15 hours per week would pay $988. The family still has to pay its maximum of $840.

All payments total $5,121 to be paid to the regional alliance. Those payments would result in a subsidy by people who are working. Those subsidies would allow coverage for some people who would not pay as much as they should. However, all payments and coverages are intended to work out evenly in the end.

TABLE 3
Premium Calculation Examples for Family Coverage

	One-Worker Family	Two-Worker Family
Family pays	$840	$840
Employer A pays	1,976	1,976
Employer B pays	N/A	1,976
Health alliance collects	2,816	4,792

TABLE 4
Premium Calculation Examples for Part-timers in Family

	Employer A Pays	Employer B Pays	Employer C Pays	Family Pays	Health Alliance Collects
Full-time employee	$1,976				
Part-timer (20/30)		$1,317			
Part-timer (15/30)			$988		
Total	$1,976	$1,317	$988	$840	$5,121

I am going to move off of that building block now and talk a little bit about where the money is going to come from to pay for this program. Revenue sources include the premium cost sharing, such as what we just described. In addition, between 1996 and the year 2000, the Clinton proposal outlines cuts in Medicare of $124 billion, in Medicaid of $114 billion, and in other federal health programs of $47 billion. New tax revenue of some kind is estimated at $51 billion. The only specific tax that was mentioned in the Clinton speech was what he called "sin" taxes, but other taxes may develop as well. These are all Clinton administration estimates. The Congressional Budget Office has not yet made its calculations. The costs of this proposal are a big issue, and they have been a topic of considerable discussion since this proposal came out. We will no doubt see a lot of heat in the political scene on that part.

Another relevant revenue issue is the taxation of these benefits. There have been some questions during the last several years concerning how much of a health-care benefit would remain excluded from the employees' income and how much would be deductible. Under the Clinton proposal, the standard benefits package is fully deductible by the employer and is excluded from the income of the employee. Benefits in excess of the standard benefits package would continue to be deductible by the employer and would be excluded from the employee's income for the first ten years. Benefits that are added after the beginning of this year would be denied an exclusion from the income of the employee in an attempt to try to start to give disincentive to providing additional benefits beyond the standard benefits package.

Supplemental benefits might include adult dental coverage or vision care. Flexible spending accounts used by some employers would no longer be tax effective because of the future exclusion of so many benefits from tax. So pretax health contributions through flexible benefit programs would end. (That is specifically spelled out near the end of the Clinton proposal.)

With regard to the health budget, one of the sources of revenue would be to enforce a federally imposed cap on health spending. The cap would constitute the CPI plus 1.5% in 1996. That cap would decrease by half a point each year until 1999. The CPI would be the limiting factor for the increases in health-care benefits.

Let's talk about the federal and the state roles. The federal level, that is the National Health Board and other agencies, would have several objectives. Some of them would be to set a minimum benefit and contribution level, to administer the global budget, to develop reporting mechanisms and specify the information required for

reporting for the states, and to establish some performance-based quality-management systems and improvement systems. Another area that many people have been concerned about for many years is trying to get a higher level of reporting. There is a strong possibility that a reporting bill may be introduced, or may already have been introduced in Congress, which may actually be adopted as a near-term fix to try to start the flow of information on outcomes and on quality to try to develop a greater level of information. The administration has found that it is very much handicapped by lack of good, solid information in the health-care area. There may be an attempt even before health-care reform is adopted to try to start collecting information on a local basis.

In this proposed system, the states would also have various responsibilities. They would be obligated to select the type of health insurance system that they want in their states. They would be permitted to establish a single-payer system in the states, should they wish to do so. Alternatively, they could encourage market competition. The states would also be able to regulate providers; that is, set the all-payer hospital rates and regulate the reimbursement of physicians. They would be charged with setting up premium collection mechanisms. They would establish territories for the regional alliances. A state might decide to have one regional alliance or many regional alliances. It is possible that they may, in some cases, opt to collect taxes and impose other assessments on self-insured plans. They would also be charged with setting the solvency requirements on the health-care plans.

As we come to the conclusion of our picture of health-care reform as proposed by President Clinton, I want to reemphasize that there are many other proposals. For example, by comparing the Clinton proposal with the Senate Republican proposal introduced by Senators Chafee and Dole, one would note some very significant differences. The employer mandate is not present in the Senate Republican approach. They rely on tax deductibility as a strong incentive to get people to offer these. Health alliances would be established on a voluntary basis, and they would be able to compete within regions. There would be no global budget. They would also offer an alternative; employees and employers could establish something called a medical savings account to try to have individual involvement in saving for medical expenses.

Again, there are a variety of proposals, and we will find it most interesting to see what the amalgam will turn out to be as we go forward in the health-care-reform debate.

MR. SANFORD B. HERMAN: Rick, how are the basic plans selling? We at Guardian had been involved with some experiments in Virginia and Oklahoma where these were set up as voluntary programs for insurance companies. A few of us got in. There was marketing material from the states. There was even a tax subsidy in Oklahoma, and really none of this sold.

I also have a question that relates to the federal reform. As an insurance department actuary, how do you feel about the health-care plans and having this new layer of entity looking at solvency? Do you think that there is going to be any conflict or pushing aside as a result of this?

MR. DIAMOND: Regarding your first question, we do not really know yet how they are selling. The rule just went into effect October 1, 1993, and so it is too soon to say. I guess we expect them to sell a little better in our system than in other states where there are restrictions where only an employer that has not had prior coverage within a certain period is eligible. The basic plan will be a lower-priced plan than what is mostly on the market, but whether that will make it attractive, I do not know.

Regarding your second question, that is certainly a concern, and it is one that is questionable at this point as to how all of that is going to work. An NAIC committee is looking at those issues and working with people in Washington. We hope that those concerns will be addressed in the final product.

MR. ALAN N. FERGUSON: You did not say anything about rates. Are these community rates that vary by age, sex, health, prior experience, or what?

MR. DIAMOND: Under our small-group-reform law, which applies to these plans as well as to all others, they are guaranteed issue, and rating is not allowed based on health status or claims experience. Rating is permitted based on age, gender (although gender is going to be prohibited after December 1), smoking status, industry, and geographic area within a cap, which currently is plus or minus 50%. The law provides that this band will decrease each year until it reaches zero, after about four or five years.

MR. FERGUSON: This range of 50% applies to what? The age band?

MR. DIAMOND: The combination of all variations for age, smoking status, industry, and geographic area. The provision will not automatically decrease. It would require further action by the legislature, because it put a sunset provision on that cap. If the legislature acts this coming year to remove the sunset, then the range would decrease to 33%, then to 20%, then to 10%, and finally to zero. But if they do not repeal the sunset, then the whole 50% cap would come off July 1994.

MR. FERGUSON: So the answer is for the state and federal governments to prohibit aging.

I would like some comments from the panel or the audience on some of the ideas in the Clinton plan that you have described. One of the things I find mind-boggling is the scope of the regional health alliances. They will be new bureaucracies that will be totally untested. They will have to collect all the premiums, which will vary enormously. Consider three different levels of benefit plans, five different plans offered in an area (in California I think there are seven HMOs and three PPOs being offered in the small-group plan), and four different levels of employee contributions or employee rates. Those numbers multiplied together total 60 different available options. The employer may have to determine premium amounts for 60 different levels of contribution, collect those amounts from the payroll and submit those amounts to the regional health alliance, which is then going to distribute them back to the plans. I do not think it is necessary to have monopolistic regional health alliances. I do not know why we cannot just have managed competition, the basic idea from the Jackson Hole group.

One of the other things in the plan that I find mind-boggling is the idea of regulation of rates, I think there is a 20% margin, which is another job for the regional health alliance. How is it going to determine what the weighted contribution is? Is it going to do it for year *X* knowing what the distribution is between plans, then put a factor in for growth, and say that is what is going to be the 80% level for the next year? Why not let the employer choose? If the employer pays a sufficient level of contribution, then do not give the choice completely to the employee. If the employer is contributing at least 50% of the cost, then the employer can give the choice of one or two plans. I could go on, but maybe you would like to comment.

MR. SHULTZ: That sounds like a good speech; I wish I could give that one. I agree with all your comments. My own personal prejudice, not the position of my firm or anyone else, is in favor of managed competition. I think that by leaving this to market forces, we have already seen quite a significant change in the way costs are increasing. I think that we can make great strides further in that direction. The one problem with that is that there are still many uninsured individuals who have not been picked up, and we still need to find a way to get at that. But certainly from my perspective, managed competition has been effective, managed care has been effective, so let that continue. Some people within my firm argue with me about that. Their arguments are that the health-care industry is a different kind of model, that within the health-care industry the providers are not responsive to the usual market forces, that there has been no counterbalancing, which is why we have had runaway inflation, and that it just will not work. They say that is why we need monopolies and that is why we need global budgets.

One of the other proposals has been to have competitive regional alliances; this might be a useful way to try to keep the fat out of that system.

MR. ROBERT J. ARONSOHN: I had a question on the competition part of the managed competition. If an alliance is negotiating with the different providers, what incentive would a physician have in charging a lower rate than what may be prevailing? Would the physician's utilization increase if a lesser fee were charged for the same service, assuming the outcome would be the same as another physician with a higher overhead? What will push prices down?

MR. SHULTZ: For one thing, many doctors are finding that they really need to get into networks. Increasingly, doctors are finding that if they are not in a network, they don't get as much business. But, if you lead a doctor into a network and capitate the services that he or she provides, then he or she is probably going to be accepting a lower rate of compensation. In general, I think that the medical profession is being told by society that it needs to be paid less, that it is not worth what it used to be paid. This is a bitter pill for the providers, but that is what we are bringing to bear with the new proposals. Employers have been bringing it to bear through managed care. The government wants to bring it to bear through global budgeting and through national regulation. In a sense, we have been doing that for years through Medicare with the fee caps that have been imposed on hospitals and on doctors.

MR. ARONSOHN: Would all the physicians agree on a certain rate? Would they get together and say that they will accept "this" rate for "this" procedure, or "this" rate

for giving a child a vaccine or for some other easily defined service? Are they all going to get together and agree?

MR. SHULTZ: That is one scenario. That is how some people have been recruited into networks. Some firms have been involved with helping carriers set up a network, which the carriers develop by getting quality doctors in an area or a region to agree to accept a lower fee. Part of the providers' reason for accepting that arrangement is that they are assured of a patient base. In other words, they will accept a lower price in return for volume.

MR. ARONSOHN: What if one physician has a higher overhead than another physician, for staffing or whatever reason, or maybe he or she is a sole person in one practice, then will that physician be forced out of business because he or she cannot really afford to charge a lower amount?

MR. SHULTZ: One of our ideas is to try to force efficiency by providers. If someone has overhead that is too high, he or she should learn to become more efficient. That is kind of a hard message, but it is the one I think as a society we are giving to the doctors and to other medical professionals.

MR. DAVID A. SHEA, JR.: Mr. Diamond, I am not aware of the relative cost in your state for mental-health and substance-abuse benefits, given the inpatient day limits on those benefits, coupled with the relatively low lifetime maximum benefit. Was that seen as an either/or scenario? That is, could the lifetime maximum be reached before the 30-day limit was reached? Also, could you comment on the fact that the lack of a strong tobacco lobby in your state allowed rates that varied by smoking status, but not by health status?

MR. DIAMOND: Regarding your first question, I think certainly on the basic plan, if that is what you are referring to with the low lifetime maximum, the lifetime maximum would be reached before the 30-day maximum would come into play. That was not really something that received a lot of attention, but I think that is probably an obvious result.

Second, it is true that we do not have a strong tobacco lobby. However, I do think that the tobacco lobby is fairly strong nationally, but we are not involved in this particular debate daily. The feeling on the part of the legislators was that smoking is something over which people have some control. Therefore, they thought it was fairer to penalize people for smoking and reward them for not smoking. Whereas, it would not be fair to penalize or reward someone based on health conditions over which they have no control. There was some debate this year. The initial law was passed in 1992, and in that law, there was no limitation at all in rates by smoking status. That was reviewed again this year against the backdrop of various other antismoking measures that were being considered in the legislature to restrict smoking in public places, such as in restaurants. One legislator, who was on the Banking Insurance Committee and who was a smoker, was upset. In defending smokers' rights, and to appease her, smoking was moved into the 50% caps. In practice, we have seen that nobody is really doing it, particularly in the small-group area where nobody was really doing it to begin with. Even in the individual area, where this law is going to be applied as of December 1, few people seem to be doing it. We have

not seen all the companies' rates yet, but the ones we have seen, even the ones that used to rate by smoking, are not doing it under this. I am not sure what the reason is for that.

MR. PHILIP HAVERSTICK: Mr. Shultz, in your outline under the state roles, you say that the states may dictate physician reimbursement. I am concerned about how fee-for-service is going to work under this plan. Is there going to be some kind of a fee-for-service network for which the doctor will sign up and agree to abide by, say, a strict fee schedule that the health alliance imposes? Will the concept of usual, reasonable, and customary charges disappear? Will the states perhaps do different things? What could you tell me about that?

MR. SHULTZ: To be honest, I do not have a really clear understanding as to what the Clinton proposal would do on that. My recollection of the proposal is that it is not too well spelled out.

MR. HAVERSTICK: I did hear in Mrs. Clinton's testimony some allusion to a fee-for-service network. She did not elaborate on that, and I am not able to find out anything else.

MR. FERGUSON: The plan requires fee-for-service plans, at least one per state. However, the state can vary that plan, just like it can put in the single-payer system.

MR. SHULTZ: Can it set up its own schedule?

MR. FERGUSON: The fee schedule is not stated. It just says that there will be fee-for-service plans. In answer to the last question, you could have McGraw-Hill's fee schedule or something based on that. However, I predict that fee-for-service will disappear. I do not see how it can survive in this system. That is not altogether a bad thing. I mean, that is fairly reasonable.

MR. SHULTZ: I have one question for you on that, if I may. We may predict the demise of fee-for-service, but at the same time, 40% of health care is being provided through Medicare, which allows a fee-for-service basis, admittedly much capped.

MR. FERGUSON: It is totally inadequate.

MR. SHULTZ: It probably is inadequate. But my guess is that as long as Medicare continues to thrive as a separate payment structure, there will be some fairly strong support for fee-for-service, though it will probably diminish.

MR. FERGUSON: That could be. I think one of the beneficial effects of the debate on this plan is that providers are, as he just indicated, banding together and responding to the need to find ways to cut the rate of increases in costs. This debate also creates great opportunities as well as great challenges for us in the insurance and consulting business to find new customers.

MR. HAVERSTICK: I just want to make one more comment. The thrust of my question was in thinking about Medicare. That is a fee-for-service system. But of course, doctors are limited in what they can charge any person, whether they accept

assignment or not. So it seems to me that this system that may go into effect, Clinton's plan, may have something like that, and doctors are not going to be too happy about it.

MR. SHULTZ: That would be very logical to expect to see something like that. Again, the plan is vague on that; perhaps purposely vague on that. If you just read fee-for-service in general you would say, "business as usual." But I think you are correct to be suspicious that there probably would be some form of a schedule that would be imposed, whether it be reasonable and customary (R&C), or R&C with caps. It is not clear and it very logically might turn out to be an extension of what is under Medicare.

MR. JOHN W.C. STARK: One of the things that our state and many other states have is the "any-willing-provider" laws that really dilute any attempt at networks. Have you heard or seen anything from the states or the federal level that say these things will be abolished?

MR. SHULTZ: I believe a couple of paragraphs in the Clinton proposal which indicate that those laws would be overridden, preempted, and set aside. I believe there is also an exception for some exceptional circumstances, but it is not spelled out. Do you recall that Jan?

MS. CARSTENS: No, I do not. However, I do believe that most of the provider organizations have strong lobbying contingents. I think that if the "any-willing-provider" laws were preempted, then more than likely, certain groups of the contingents would band together.

FROM THE FLOOR: Mr. Shultz, was I correct in understanding what you said about the Clinton plan, that in families in which there are several workers, even a couple, or a couple with some children, that each individual would have to pay and that each individual would have to pay at a higher rate than a single individual?

MR. SHULTZ: No. There is one payment for the entire family, which would be that 20% payment. Only one member of a family, or a combination of family members, would have to pay that total amount. If five people are in a family, then the employer of each of those persons, assuming that they work more than ten hours a week, would have to make a payment into the health plan that was selected for that family. That payment would be determined based on that very complex set of formulas that I tried to describe to you in an example. The point is that all employers would have to pay for their employees, whereas the family pays only once.

FROM THE FLOOR: One corollary of this is that the dual coverage is eliminated. In the past, a husband and wife could each be covered by a separate plan, and that would allow various managed-care elements of one plan to be thwarted by the fact that the other partner had a plan. So whether there was out-of-pocket or not, by the time you threw the two things together, they had 100% coverage. And even in terms of things like utilization review, penalties, things of that nature, they really did not matter, because they were able to afford it. So forcing them into only one plan should lead to some cost savings. On the other hand, there is going to be a conflict,

because the family members are going to have to choose which one of the plans they want, which may lead to some family strife.

MR. SHULTZ: I guess this is a follow-up. There will be no more coordination of benefits, and there will be no more opportunity to make money on being sick. However, you may need to have a family mediation service to select the health plan.

MS. CARSTENS: *How often will they calculate the average number of workers per* family?

MR. SHULTZ: That is probably one of those devil-in-the-details questions. But my guess would be that they would have to do that once a year. Although I understand that there has been some discussion in Washington about maybe moving some of these once-a-year cycles to every two or three years. Somebody may even decide that it makes good economic sense, from the point of view of the application of resources, to recalculate at intervals of greater than one year and that the rough justice answer in doing so is just as good as the rough justice answer of doing it once a year. So I would say that the answer to your question is that it is not clear yet, to my knowledge, how often that will be done.

MR. JAMES S. KLAUSEN: Who do these family members pay their 20% to? Do they pay it to their employers and they pass it on? Or how does that work?

MR. SHULTZ: It gets to the health plan. Now, whether it gets to their health plan through payroll deduction or through the regional alliance, I do not recall specifically how that floats. My recollection is that the health alliance is intended to be the conduit of many of these funds, so it probably goes to the health alliance. However, it very well may go through a payroll-deduction mechanism as well.