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PROCEEDINGS,

Health and Welfare Conference,

JULY 21-26, 1957,

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Berkeley, 1957

INTRODUCTION

This year marks the tenth in an annual series of educational conferences presented jointly by the California State Federation of Labor and the Institute of Industrial Relations on the Berkeley and Los Angeles campuses of the University of California.

Because of the continuing interest in negotiated health and welfare plans, it was decided to devote the entire week of the conference to a discussion of problems in this area.

As these proceedings of the conference will show, a wide range of topics was covered during the week. It is hoped that the publication of the principal contributions to the debate at the conference will be of value to those vested with the responsibility of determining policy in a field of vital importance to all of us.

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OPENING ADDRESS

by

C. J. HAGGERTY

Executive Secretary-Treasurer
California State Federation of Labor

It is a pleasure to greet you at this important conference on health and welfare benefits, sponsored by the California State Federation of Labor and the University of California.

This conference is another recognition of the increasing importance of health and welfare plans in California.

This 1957 conference is the 10th in our annual weeklong labor institutes which were designed to achieve a more informed movement.

You will recall that last year at Monterey we sponsored a highly successful pension plan conference. Certainly, that conference was of direct benefit to organizations which have since negotiated pension plans for their members.

Through this 1957 conference we will demonstrate, in a practical way, how an alert, honest and progressive labor movement is helping working men and women and their union representatives in the solution of vital questions which affect the economic and social well being of the American people.

Our State Federation, like many other sections of the labor movement, does not seek to work alone in meeting the issues and problems of our time. We seek the cooperation and joint effort of industry, government and our teaching institutions because we recognize the unanimity of long range interest.

Though the sponsors of this conference are the California State Federation of Labor and the University of California, it is interesting to note that our program speakers and panel discussants are from labor, industry, government, the interested professions and those actually involved in the day to day aspects of health and welfare plans.

The significance of health and welfare plans in California Union agreements is well known to you, I am sure. Here are some additional supporting facts, drawn from a recent report issued by our State Department of Industrial Relations:

As of January, 1957, 83% of all employees working under

union contracts in California were covered by negotiated health and welfare plans providing some hospital, surgical or other medical care benefits. In 1950, less than one-fourth of this group was covered by health and welfare plans.

Plans to provide employees with various forms of prepaid medical care benefits have now been negotiated for the majority of union workers in 31 of the 38 industries in which union contracts are classified by the Division of Labor Statistics and Research.

More than a million California employees - 89% of those under negotiated health and welfare plans - have the full cost of their plan paid by their employers. A year previously employers paid the full cost for 83%.

The majority of employees covered by negotiated health and welfare plans (71%) work under contracts which specify a money amount the employer agrees to pay toward the cost of health and welfare coverage. The average employer contribution for health and welfare, computed from 775 contracts covering 764,000 workers and specifying a money amount is \$12.35 per month for a fulltime employee. This is approximately 8% more than what employers were paying on the average a year earlier. (Of course, you realize that these are average figures and as a result, in many union agreements the employer contribution is substantially more than the average indicated and in some instances somewhat less.)

There is a popular notion that health and welfare benefits in collective bargaining agreements came about rather accidentally and principally because of restrictions on wages during the Wage Stabilization period. While Wage Stabilization did give some added impetus to the growth of health and welfare plans during the war years it would have been inevitable, in any event, for health and welfare programs to become an integral part of collective bargaining agreements along with other issues like wages, hours, and other working conditions. The fact is that health and welfare benefits go directly to the heart of such basic needs as hospital and medical care, income during periods of disability and protection for the family when the breadwinner dies. These needs were and are so great that their partial or complete solution would be a must in any period.

Historically, the significant years in the development of negotiated welfare plans are these:

From 1942 to 1945 when the War Labor Board encouraged the development of fringe benefits.

1948 - When the NLRB ruled that pension and insurance benefits were subject to collective bargaining.

1949 - When the Presidential Board recommended the establishment of negotiated welfare and pension plans in the Steel Industry dispute.

1956 - When the States of Washington and New York enacted laws governing health, welfare and pension plans.

1957 - When our State enacted a law governing health, welfare and pension funds.

An issue that started out as a "fringe benefit" has become a front line matter which requires our attention and the attention of other responsible sections of the public.

There have been varying estimates as to what is being spent annually for health, welfare and related benefits. These estimates vary from \$20 billion to \$30 billion per year. For our purposes here it is perhaps sufficient to simply say that despite the staggering amount which is being spent for health and welfare benefits there are still many unmet needs. And experience has indicated that what is being spent could be used more wisely in many instances.

I realize that on numerous occasions during the past years there has been much publicity given to the so-called abuses which have developed in some health and welfare programs. But even the most anti-labor forces, interested in using any issue involving unions as a means of degrading them, have acknowledged that the vast majority of health and welfare plans are honestly administered.

Now, I think that a distinction should be made between "honestly administered" funds and those funds which are, in addition, "ably administered." Industry and union representatives may be handling the affairs of a health and welfare program with the highest integrity - and despite that, there may be waste and a failure to get the greatest value for the money available for benefits. In my opinion, this waste, where it exists, is due mainly to the lack of knowledge on the part of those connected with health and welfare programs. It is the purpose of this Conference to help give this necessary knowledge so that better benefits can be provided at, in many instances, lower costs.

However, we will not address ourselves in the Panel discussions to just the reduction of cost and better benefits. We will also discuss the variations in methods, unmet needs, and the various ways in which health and welfare problems can be solved.

We do not presume that there is only one way for providing health and welfare benefits on the best possible basis. We recognize that different unions and different industries may require different solutions, depending on their own needs. We do expect that with an informed exchange of ideas and presentations by qualified experts there will be a greater reservoir of information and practical

experiences on which everyone of you can draw to meet your own needs.

I expect that even the most informed representatives here will learn something in the course of the Panel discussions for we have deliberately planned the program in such a way as to lay before you various points of view on many subjects.

As your program indicates, we will discuss during the next week such key questions as Negotiated and Non-Negotiated Plans, Service versus Indemnity Benefits, Self-Insurance versus Insurance, Methods for Providing Better Benefits, Effective Administration, Relationships with Medical and Hospital Associations, New Forms of Coverage, Legal Aspects of Health and Welfare Plans and other related subjects.

We have been fortunate in obtaining as our speakers for this Conference outstanding people in their respective fields. The Panel discussants at each of the sessions are very well qualified to comment on the speakers' presentations. They will offer their own individual points of view, as well.

I hope that your discussions will be frank and penetrating. It would be unwise to assume that even at a most constructive Conference we will find the answers to all future problems. The fact is that the health and welfare field is a dynamic one. It involves a complex range which includes many needs and skills in meeting them. However, the exchange of views and the technical know-how which you will get at this Conference should be most helpful to the people we are all privileged to represent.

There are forces at work in America today who are interested in undermining the labor movement and the harmonious and constructive relationship which has been built up over the years by responsible unions and employers. These forces seek every pretext possible to accomplish their purposes. Unfortunately, they are sometimes aided by scandalmongers and newspapers who are more interested in dramatic headlines than in constructive accomplishments. However, we will not be diverted by those who really care little about the well-being and security of working men and women and their children. Neither will we stick our heads in the sand like ostriches and ignore real problems. Instead, we will carefully appraise our common problems and proceed with their solution in a practical way with the highest standards of ethical conduct and integrity. The result of such an approach will be a further long step on the road to a higher standard of living and increased security, health and happiness for all of the American people. That is the goal of our Conference and that is the goal we will achieve.

NEGOTIATED VS. NON-NEGOTIATED HEALTH AND WELFARE PLANS

by

Irving Pfeffer
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It is always a pleasure and a privilege for a university professor to come out of his ivory tower to present his views before a group which has the capacity to translate ideas into action. Today, the privilege is all the more valued because of the courage displayed by you in openly and publicly exploring what is undoubtedly the most controversial and delicate subject in the entire field of industrial relations at the present time.

There has never been a time in the entire history of the fringe benefits movement when Health and Welfare Plans have received more adverse publicity. Just about every group with investigative authority has been conducting hearings. Committees of both houses of Congress, the legislatures of at least six states, and the Executive Council of the AFL-CIO have all been engaged in studies of abuses in the administration of those plans. Ever since a routine New York State Insurance Department investigation of an application for an insurance agent's licence turned up evidence of the wholesale milking of a major benefits fund, the published reports have been establishing the astonishing degree to which corruption and ineptitude prevail in the administration of some Health and Welfare Plans.

Labor has borne the brunt of public outrage. The abuses of a relatively small number of union-administered plans have been made to appear to be evidence of the corruption of virtually all negotiated plans. The picture has been grossly distorted to the disadvantage of the organized labor movement. The statements of authoritative lobbyists in some quarters would lead us to believe that the non-negotiated plans, administered by management alone, are completely blameless in all of the scandals which have come to light. Indeed, it has been vigorously argued that only the negotiated health and welfare plans should be subjected to regulation on the ground that they are the only ones in which abuses have been found. The insurance industry argues that while negotiated plans should be required to operate in a figurative goldfishbowl, insurance plans should be exempted from any proposed legislation because of the expenses and inconvenience of filing information returns.

Any discussion of the pros and cons, or trends, of negotiated versus non-negotiated plans would be purely academic unless the basic issue of the comparative integrity of these alternative plans can be resolved.

There is no principle in the entire field of insurance which is more important than the principle of integrity of the fund. In the absence of competent and conscientious trustees, the most elegant and beautifully designed program is not worth the paper it's printed on. The actuaries and the attorneys are wasting their valuable time if the plan is to be drained by unethical administrators. Whether the plan is negotiated or non-negotiated makes no difference if the employees and their dependents who rely on the program are to be cheated by sloppy or corrupt trustees. I make no apology, therefore, in disposing of the question of regulation before turning to less pressing distinctions.

In the absence of disinterest, incompetence or collusion it would be exceedingly difficult for a welfare program to get into serious difficulty. Most of the situations which have been exposed have involved a kind of conspiracy between trustees, insurance agents, brokers, or so-called "consultants," union and management representatives, as well as insurance companies, whereby the principles of ethical conduct and fair dealing were ignored. Some union leaders have been guilty of improper conduct, but so have some management officials, some insurance salesmen, some "consultants" and some insurance companies. The indictment applies to all of the parties involved and not merely to one.

What is the bill of particulars? The list is a long one.

1. Disproportionate Expense Ratios. In far too many plans the share of the contribution dollar which actually goes to pay for benefits is unreasonably small. Too much is spent on "overhead expense" and the unnecessary build-up of large surpluses. In many plans it was shown that expenses consumed about 20 percent of contributions received, and in some cases expenses amounted to more than 50 percent. These high expense factors are to be found in negotiated and non-negotiated plans alike. There is very little reason why a plan of moderate size should not be able to pay out in benefits more than 90 cents for every dollar paid into the fund.

2. Profiteering. Excessive compensation for work performed and often, what is worse, substantial payments where no work was performed whatsoever. Expensive automobiles provided as gifts to fund officials and their families, unsecured and seldom repaid loans, and subsidies to finance projects having no connection with the purposes of the welfare fund were made to union officers in some cases. Some employers have been guilty of misappropriating the dividends derived from employee contributions. So-called "management fees" have been paid to insurance agents and brokers for alleged services which are normally provided by such producers or insurance carriers without charge. Many insurance companies have insisted on paying high level commissions year after year despite the fact that they were not warranted by the services provided by the agents involved.

Some insurance agents earn more than \$1,000,000 a year from the

commissions and fees received on their health and welfare accounts. \$250,000 from a single fund is not unheard of. For the insurance man this has been the gravy-train of the postwar period. Abnormal profits of this kind can only persist in an atmosphere of secret dealings.

3. Improper Administrative Procedures. Many of the plans in which serious irregularities were found were the victims of administrative procedures which were informal in the extreme. Expense vouchers were not prepared, checks could be issued with but a single signature, transactions were not recorded in the books and audits were never held.

Commercial bank balances amounting to hundreds of thousands of dollars were maintained with the funds drawing no interest whatsoever. This despite the fact that government-insured high interest yielding savings outlets are available. Many employers in non-negotiated plans have been guilty of investing the assets of the plan in their own businesses thereby making the security of the funds dependent upon the success or failure of the employer's business. This violates the first rule of a trustee's obligation to his trust.

Many employers have consistently refused to disclose information concerning the administration of their plans to those on whose behalf the plans were set up. Confidential rebates, kickbacks and shakedowns are more difficult to detect in the absence of a responsibility for trusteeship accounting.

Trustees have too frequently failed to discharge their normal managerial responsibilities as evidenced by infrequent meetings, failure to keep proper minutes of meetings, failure to attend and sometimes, by the delegation of full authority over the fund to the administrator.

Payrolls of some funds and of some insurance agencies have been padded with relatives of key officials resulting in waste and inviting collusive activities. In some cases required contributions were not collected from employers with a consequent loss of monies available for benefits. Finally we might mention that fund assets, such as automobiles and real property were sometimes held by fund officials in their individual names rather than in their representative capacities.

4. Poorly Designed Trust Agreements. Many of the trust agreements were drafted in such a manner as to invite irresponsibility. Excessive powers were granted to trustees going well beyond the limitations suggested by custom and prudence. Short-cuts designed to permit flexibility in administration led to invasion of many trusts for private purposes.

5. Discrimination. All too often the plans provided larger benefits

to union and welfare fund officials than those granted to the general membership. In what may be an all-time record, one fund controlled by the union manager and in which one of his sons was a director, another the attorney and insurance agent, and a daughter an employee, 32 percent of the total self-administered benefits were paid to 14 union officers and members of the executive board, over one-half being paid to the union manager alone. Discrimination in a somewhat different form was found arising out of a refusal by the administrators of non-negotiated plans to solicit open bids in placing their insurance contracts. Some carriers found that regardless of their ability to supply superior benefits and services at lower cost they could not gain access to the business.

It would be naive to assume that the long recital of sins spelled out in the various published reports no longer exist. Far too many health and welfare plans which have escaped investigation are still plagued by the greed of some administrators and the ignorance of many trustees. Too many employers insist on maintaining a black-out on the relationship between contributions and benefit costs in order to prevent union negotiators from learning the per hour value of the benefit plan. A major house-cleaning is coming, and it seems clear that much of the initiative will have to come from within the labor movement itself.

The AFL-CIO Code of Ethical Practices Regarding Health and Welfare Plan Administration has been the most significant and imaginative solution to the problem offered so far. This Code, adopted early this year, defines the obligations of trustees in simple and clear-cut terms. It requires complete audits and publication of the reports of health and welfare funds, it requires competitive bidding, and it prohibits conflicts of interest between labor representatives and insurance carriers or producers. The Code prohibits the payment of special compensation for union trustees and imposes severe penalties for breach of good faith. No sooner did the Executive Council adopt the Code but its provisions began to be applied to those unions in which the most glaring abuses had come to light. The Code is an excellent guide for union administrators, and a good start has been made toward its enforcement. It remains to be seen, however, whether the necessary policing activity will continue after the public shifts its interest to other problems.

The status of proposed legislation is difficult to evaluate because of the many thorny legal and constitutional questions involved. The State of New York presently has a statute on the books requiring the disclosure of financial information pertaining to the funds and providing for supervision by the Superintendents of Insurance and Banking. At least five other states, California, New Jersey, Ohio, Washington and Wisconsin have statutes in process. At the federal level, Senator Douglas' bill would provide for regulation by the Securities and Exchange Commission. The question whether the states will be permitted to attempt regulation in this area of federal jurisdiction is still an open one. Perhaps the suggestions

of John L. Lewis that the government study the tax exemption returns of the funds and the W2 forms of welfare fund personnel as well as enforcing the Taft-Hartley provisions may be given some consideration. One student of the problem has recommended that the enforcing agency be authorized to bring civil suits for improper conduct and that the law should make it easier for such suits to be brought by the victimized beneficiaries.

This much is clear. All parties have been guilty in most instances where wrongdoing was found. Employers as well as unions, insurance producers and consultants as well as insurance carriers. The issue of which type of plan has the greater integrity boils down to the question as to which of two women is the more pregnant. Honesty is not a relative thing. Inasmuch as integrity of the fund is the primary issue between negotiated and non-negotiated plans at the present time it was essential that the question be resolved. It seems to be a case of "let him who is without sin cast the first stone."

Let us turn our attention now to issues which are equally controversial but less hot at the present time. The negotiated plans, also called pattern plans, are those developed by unions and negotiated with a number of companies in an industry. Generally such plans are noncontributory, that is, only the employer pays for their cost and their benefit provisions are relatively standardized. Non-negotiated plans on the other hand, sometimes called conventional plans, do not generally provide for joint administration, are usually placed with private insurance carriers and have benefit provisions which vary according to the particular contract specifications decided upon by the employer.

While there are no reliable figures available, it is estimated that employer administered plans cover some 90 percent or more of all workers covered under health and welfare plans. In dollar terms, it is estimated that 1957 will see about \$4 billions being paid into life and accident and sickness benefits with the employers paying perhaps 3/4 of this amount. The aggregate sums involved are huge and are growing rapidly. The question of who will spend these sums and in what manner is at the root of the debate between negotiated and non-negotiated plans.

Perhaps the contrast between the two types of plan can be most clearly seen if we examine what appear to be the goals of organized labor in the health and welfare field--as well as those of management--and gain some understanding of how the goals determine, in large part, the means employed by these different kinds of program.

The fundamental objective of organized labor, it seems to me, it to achieve a substantial measure of personal economic security which will protect the individual and those who are dependent upon him against any loss of income arising from disabilities of any kind. The paycheck and the resources of the employee should be

guaranteed against losses caused by sickness or accident. This concept of economic security cannot translate itself into a formally defined set of limits. There can never be a state of rest--a point at which one can say we have enough--in labor's demands in this area of health and welfare. At most we can indicate the direction in which the movement is going.

In the field of medical care, organized labor aspires to have all medical bills, large or small, paid through the medium of health and welfare programs. To the maximum possible extent, the employee and his dependents should be freed from the burden of paying out-of-pocket costs over and above what the plan provides for medical care. In concrete terms the current emphasis is on comprehensive prepaid coverage of the Blue Cross type with 120 days of full cost semi-private hospital care. Coverage should include the full cost of miscellaneous procedures, medicines, X-rays and so forth incurred during a hospital stay. A surgical schedule with a \$300 limit, a \$5.00 in-hospital doctor's fee limit per day and full diagnostic coverage would round out the program.

Labor insists that there should be no deterrents placed in the way of early diagnosis, preventive care and treatment for either the employee or his dependents. This means that labor is unalterably opposed to the typical insurance concepts of deductibles, co-insurance schemes, corridors and the like. Because they feel that deductibles discourage prompt use, that the small but frequent illness develops bills which are a major concern to the worker and a large part of the total cost of his medical care, most unions have gone on record as being opposed to major medical insurance. Despite this opposition, major medical plans have grown very rapidly. At the end of 1956 it was estimated that approximately 7 million employees were covered by major medical plans. While only 5 percent of these were negotiated plans, they accounted for well above 5 percent of the workers covered.

The insurance companies could not disagree more heartily with the unions on this issue. The insurer agrees that the goal is to provide full comprehensive care, but he argues that the cost of administering that which should be a part of the budget of the average person is too high. Routine, small, outlays for medical care should be made by the individual on his own initiative. When a patient visits his doctor and is billed for \$5.00, it is uneconomic for the \$5.00 to come from the insurance company when the cost of handling and managing the records comes to almost as much as the benefit paid. In the case of the larger disbursement there is justification for the insurance device because in that situation the overhead is a small part of the total cost. The insurance company officials argue further that most claims are small and the elimination of them would mean significant savings in costs on behalf of those who really have a need for important medical care. It is the long catastrophic illness which really needs to be taken care of through the insurance mechanism. Related to this desire to pay only the big bills is the

problem of abuse by covered employees and their dependents. Who is to say how much routine care a worker or his dependents need? How are you to control the malingerers and hypochondriacs if they are to be rewarded with medical care every time they choose to fake some minor ailment?

It seems paradoxical to some people that insurance companies should insist upon deductibles which deter people from seeking early medical care on the one hand, and yet these companies spend millions of dollars on advertising in an attempt to persuade people to see a doctor at the first sign of trouble.

The employer is anxious to expand the fringe benefits program in order to effectively compete for qualified employees but he must give first consideration to the effect of such programs on his profits. Consequently, management's goals consist primarily of holding the line on costs and trying to maximize employee efficiency at the same time. The employer tends to regard the health and welfare plan as merely another aspect of his personnel policy. On the issue of major medical insurance, employers tend to agree with the insurance companies with whom they place almost all of the plans which are set up on a non-negotiated basis.

In general the negotiated plans tend to be somewhat more venturesome than the non-negotiated plans. Bolder experiments in the fields of dental care, diagnostic services and preventive medicine are to be found among the negotiated plans. Prepayment nonprofit service arrangements are favored by this group of plans as well.

In the negotiated type of plan the noncontributory principle is emphasized on the theory that the fringe benefits are a direct substitute for cash wages and consequently the employee should not be asked to pick up any part of the cost because to do so would in effect be the same as if the employee was paying his own wages. Management is inclined to favor the contributory arrangement because it keeps the employees constantly aware of the impact of over-utilization on costs. Furthermore, employee contributions make possible the purchase of much more liberal benefits than could otherwise be made available. There has been a steady pressure to shift away from the contributory type of arrangement and the trend during the past year at least has been toward the noncontributory type.

The most important distinction between the negotiated and the non-negotiated plans lies in the method of administration. In the negotiated plan there is, characteristically, joint administration--indeed under the Taft-Hartley Law there must be joint administration. Both labor and management are able to review the experience of the plan and share in the decisions with reference to carriers, plan specifications, cost analyses and the distribution of benefits. This kind of control is invaluable from the standpoint of labor because it means that there is the opportunity for evaluating the plan in terms of costs. Renegotiation is a much simpler affair upon

contract expiration when both sides have the same facts at their disposal. Also, from a tactical standpoint, joint administration removes the inference that the health and welfare plan benefits are being provided through the good grace of management rather than as the fruits of collective bargaining.

From the standpoint of management the jointly administered arrangement has many disadvantages. While it is conventional to have joint administration on questions of eligibility or grievances, participation by the union in decisions relating to favored carriers, financing arrangements, etc. means giving access to information which could prove damaging at bargaining time. Management much prefers to have a minimum of interference in its decision-making activity. Additionally the unilateral plan permits full credit to be taken for the provision of the particular fringe benefits involved. It is of some interest that among the reasons given by insurance companies in opposition to compulsory reporting and publication of experience under their plans is the fear that unions will attempt to invade the surpluses and special reserves which have been accumulated. In essence they are contending that the less the unions know about the details of their plans the less likely are they to hurt themselves.

I believe that from the standpoint of the labor movement there is probably no more efficient method for achieving a more consistent pattern of negotiated, jointly-administered, effective health and welfare programs than the publication of as much information about individual plans as possible. The labor movement in California would do well to consider the establishment of what the attorneys might call a "boiler-plate" factory--a unified research center for the systematic collection and analysis of reports on all health and welfare programs, a single center whose published data would provide benchmarks for the guidance of trustees and negotiating committees. Analyses of effective provisions in contracts, statistical exhibits showing break-downs of administrative costs and experience would prove invaluable for administrators of health and welfare plans. I have in mind an institution which might function somewhat along the lines of the National Industrial Conference Board. There is an urgent need for an enormous amount of research in this area of health and welfare plan administration. Some preliminary studies of the kind I have in mind have already been initiated in this state, but we have hardly begun. Improving the quality of our health and welfare plans depends in large measure upon the availability of the relevant facts.

Summary

In closing, I would like to summarize some of the points which I have attempted to touch upon during the course of my remarks.

1. There is no question but that a substantial minority of health and welfare plans has been grossly mismanaged to the point where

legislative investigation was inevitable. However, the abuses which have come to light are not the sole responsibility of union officials. The connivance and collusion of insurance agents, brokers and so-called "consultants," insurance companies and inept and unqualified management trustees have also been to blame. While the press has given most attention to union administered funds, similar abuses are to be found among non-negotiated plans. Senator McClellan, Chairman of the Senate Select Committee on Improper Activities in the Labor and Management Field, has called for the supervision of employer funds on the ground that the record makes such legislation necessary. The guilty parties are not confined solely to the ranks of labor.

2. Negotiated plans remain a small proportion of all health and welfare plans. Part of the reason for this lies in the lack of information about the nature and significance of joint-administration on the part of union negotiators.
3. The labor movement does not favor the major medical approach to health insurance on the ground that the deductibles and coinsurance features are a deterrent to early care, and a comprehensive health plan should pay for the small bills as well as the large. Only a very small proportion of negotiated plans provide for major medical insurance.
4. The negotiated plans tend to be the laboratories where new types of coverage are developed. Particularly is this the case with pre-paid dental care and diagnostic services.
5. There is a steady movement toward the noncontributory principle in all of the different kinds of health and welfare programs.
6. From the standpoint of labor, the increasing importance of negotiated plans versus non-negotiated plans will largely be determined on the basis of the information available for bargaining purposes. There is an urgent need for extensive research to provide the guideposts for effective bargaining on health and welfare benefits.

In the final analysis there is no aspect of the health and welfare program which is more important than the development of an honest and efficient set of administrators. By comparison the technical distinctions between types of plan are of little consequence. There is a growing sentiment in labor for more effective internal discipline. This development coupled with the increase in our understanding of the problem of health and welfare should result in a major expansion of jointly administered negotiated plans during the coming months and years.

A HEALTH PLAN IN THE UTILITY INDUSTRY

by

Ronald Weakley, Business Manager and Financial Secretary
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Oakland, California

When I received the invitation to serve on this panel, it caused me to have mixed feelings. My understanding was that I was expected to make a short talk on a sample non-negotiated health and welfare plan and be able to answer simple questions on this subject matter. Then I saw the title of this discussion.

Although I represent a Union which deals with a major California employer whose hospital and medical plan is not contractual with our Union, any time I even hear of a benefit plan which is non-negotiated, I immediately bristle. I do not approve of "non-negotiated" plans. There is, I believe, need to discuss some reasons why some plans are "non-negotiated."

With that clear understanding, I shall proceed. First, a rough outline of our Local Union and its employers. We represent about 15,000 utility workers in public service covering gas, water, electricity, steam, telephone, construction and clerical occupations.

Geographically, we cover 48 California Counties and 10 Northern Nevada Counties. Employers covered by collective bargaining include Pacific Gas and Electric, Sierra Pacific Power, Citizens Utilities, California Pacific Utilities, Standard Pacific Gas Line, Key System Transit and Sacramento Transit Authority. Non-contractual representation occurs in the Sacramento Municipal Utility District and the Cities of Oakland, Berkeley and Alameda.

The utility industry has always had comparatively good employee benefit structures inasmuch as their employee relations policy had, as a cornerstone, loyalty to the employer through paternalism which included control of benefit structures.

As the industry became organized and unionism became a potent reflection of employee attitudes, concessions were made through collective bargaining. We now have a pretty high degree of contractual benefits such as pensions, sick leave, supplemental industrial accident benefits, group life insurance and hospital and medical plans.

The last stronghold of employer resistance seems to center in hospital and medical plans. Here, the cost factor and family involvement is such that progress toward joint action and union recognition has trailed other benefit issues.

Our Local Union, in its multi-employer group, has just about any single or multiple set of circumstances one can imagine on the subject of benefits. Nearly all are negotiated, most are contractual and a few are employer controlled.

For purposes of this discussion I will center on P.G.&E. and its Hospital and Medical Plan. For many years P.G.&E. was unorganized and did not, as an employer, provide any universal plan for hospitalization and medical care for its employees.

1937 saw a move to organize P.G. & E. To offset this move, a Company Union, the California Gas and Electric Employees Union, was formed. The Company Union defeated Organized Labor in an election in 1937. In 1939, the Company Union got into the hospital and medical subject and signed a contract with an insurance firm to cover its participating members. Failing to gain a 70% sign-up, the Company Union had to settle for a plan requiring a medical examination and a chronic and pre-existing condition exclusion.

Premiums for this plan cost the member \$1.95 per month, \$.85 per month for adult dependents and \$.50 for child dependents. At this time, there were about 400 members and about 75 dependents in the plan. Up to 1942, the loss ratio averaged about 75% and the number of participating members and dependents about doubled.

In 1941, Labor gained a foothold on P.G. & E. In 1942, the Company Union was dissolved by Government action. The Rod and Gun Club took over the plan and operated theirs and the former Company Union plan until 1944.

In 1944, the Pacific Service Employees Association (P.S.E.A.), a Company-wide educational, social and recreational group, took a hand and established, with Company support and partial financial participation, the P.S.E.A. Hospital Plan. The plan was underwritten by California Western States Life and administered by the P.S.E.A. and limited to the members of the P.S.E.A.

The AFL and the CIO meanwhile were organizing the system. The increase in Union organization found a like increase in P.S.E.A. activity in the field of hospitalization.

Membership in the plan rose rapidly, benefits increased and premiums rose over the years. Union pressures no doubt forced gradual benefit improvements.

In 1952, the I.B.E.W., having won a system-wide election for all physical and clerical employees, made the first real bid for a negotiated plan. Although negotiations included a proposal of 7¹/₂¢ per hour for health and welfare and a near strike situation developed, a contract was concluded under wage stabilization restrictions which left the health and welfare issue to future bargaining.

Some discussions were held but no real activity occurred until the joint

pressures of the employees and the Union resulted in a major change in the plan.

The change, in essence, was the institution of a Major Medical plan. Significant here was the willingness of the Company to ask for Union participation, the direct Company payment of \$2.00 per member per month toward his premium and the opening to all P.G. & E. employees and their dependents to the new plan regardless of membership or non-membership in the P.S.E.A., which continued to administer the plan.

The Union took a neutral position on the new plan and new sign-up, deferring its action until after the employees' response could be evaluated and until the next contract opening a few months hence. The sign-up was successful and the new plan went in early in 1957, with a participation increase of some 3,000 members.

In the recent 1957 negotiations, the issue again was placed on the bargaining table. The negotiated package, containing good wage increases plus major fringe improvements did not have room for a further consideration of money toward an improved and negotiated plan. The parties agreed to sit down during the contract term and to bargain on this separate issue. This will occur shortly.

The present P.S.E.A. plan covers (according to figures of March 1, 1957) 13,705 members (i.e. employees), 22,175 dependents, 962 pensioners and 525 pensioners' dependents.

Generally, it provides for a basic benefit set-up for members as follows: Hospital Board and Room, \$2, plus \$10 from the Wage Benefit Plan (which is a substitute for the State Disability Plan) for the first 21 days. \$12 per day from the 22nd to the 180th day. Special Hospital Services, \$1,000 (the Union feels this benefit is too high and may permit administrative discrimination). Ambulance, \$50. Surgical Operation Benefit, \$500 (the Schedule allows a maximum of \$225 for any single procedure and the \$500 maximum covers multi-operation procedures. The Union feels that the surgical fee schedule is unrealistic). Medical Care Benefit, \$500. Home Calls \$4.50 and Office or Hospital Calls \$3.00 (Union objects to the exclusion of the first 3 calls unless the employee is disabled and away from work, plus the unrealistic fee schedule). Diagnostic X-ray and Laboratory Examinations -- up to \$25. Additional Blanket Accident Expense, \$300. The Major Medical for expenses beyond the basic coverage is 75% coverage up to \$5,000 lifetime aggregate, plus a \$100 annual cumulative corridor.

Dependents get \$8.00 Hospital Allowance for the first 180 days. \$500 Special Hospital Services; \$50 Ambulance Benefit; \$500 Surgical Benefit according to schedule; \$150 Accident Expense Benefit and the \$5,000 Major Medical.

Office and doctors calls and diagnostic and X-ray benefits are not available for dependents.

Employee premiums are: Employee only, \$3.65 per month. Employee and one dependent, \$7.30. Employee and two or more dependents, \$10.95. The Company pays the balance of the cost which amounts to \$2.00 per member direct plus the indirect costs of P.S.E.A. administration, much of which is on Company time. Annual direct Company cost is in excess of \$360,000.

In general, the Union feels that the Company contribution is insufficient and that of the employee too high, the benefit structure is inadequate, particularly for dependents and the Union should have a voice in the administration of this or any other plan.

The foregoing illustrates the history of the employer-Union-hospitalization triangle which goes to the base of the trouble to date. Joint action has produced many plans superior to that I just outlined. We feel we are on the threshold of proper recognition and bargaining.

To return to the title of this subject under discussion, I believe that a negotiated plan is far superior to a non-negotiated plan in that Labor and Management, in each instance, has a sacred trust in getting the most for the premium dollar, protecting funds from administrative plunder, and jointly exerting pressures against the ever increasing pyramiding of costs of illness to the worker and his family.

SERVICE VERSUS INDEMNITY PLANS

By

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The opinions that I am about to express are my own and -- except where otherwise indicated -- not necessarily those of my sponsor. Also, I want to make it clear that they derive from observations of what is going on generally throughout the country and whatever I may say in a critical vein does not, of course, apply to the situation in California. It is well known that, in California, everything always happens for the best.

The choice of the best medium for the conversion of cash contributions into health benefits is not as simple and clear-cut as my topic seems to imply. The range of alternatives extends over a wide spectrum -- with the routine, limited, commercial indemnity plan at one end, the most highly-organized, comprehensive, group practice service plan at the other, and all sorts of combinations and variations in between. Somewhere within this spectrum the practical distinctions between plans that call themselves "indemnity" and those that call themselves "service" in form tend to fade or to disappear altogether.

Defects and abuses can exist, failures can occur, and horrible examples can be found at any point within this range of possibilities. The apparent structure of a plan is in itself no sure-fire guarantee of merit, except to the extent that its potential values and advantages are cultivated and realized in fact as well as in fancy.

There is as great a gap between the standards of an efficient, well-run indemnity plan such as that of the non-operating railway unions and indemnity plans of the kind that have lately attracted the critical attention of Congress, as there is between a genuine medical service group and a panel of company doctors retained chiefly for their proficiency on the witness stand in injury cases. Even to the most ardent advocate of the service concept, the relative merits of an indemnity plan with a realistic fee schedule and a low retention, and of a so-called service plan which contains an exorbitant schedule, built-in fee-splitting and no quality controls, are open questions at best.

Sweeping value judgments can be applied, if at all, only to specific plans -- not to whole classes of plans. They must, in any case, be based not upon the label alone but the actual contents of the particular package.

To complicate the matter further, the situation with respect to any plan is far from static. When, as some are now doing, indemnity insurance companies agree to reimburse the full cost of hospital services, without stipulated limits, they become in effect purveyors of service benefits. When a union tries to get a commitment from local doctors to accept as full

payment the indemnity amounts set forth under its plan, it moves away from the indemnity and towards the service principle. In fact, the attempt of indemnity plans to overtake the rising level of actual medical and hospital charges by the simple, costly and generally futile device of the stern chase through higher and higher indemnity schedules is really an expression of a basic urge for the equivalent of service benefits.

On the other hand, many "service" plans are showing the same readiness to abandon principle when the heat is on. Service charges, exclusions, "deductibles," and the provision of supplementary benefits on an indemnity basis are typical today of many plans which continue to advertise their "service" character. The failure to adjust or to remove income limits for service benefits means an increase in the number of their subscribers with no more than high-priced indemnity coverage. Their widespread flight from community-wide rates to the insurance companies' domain of experience rates in order to hold and attract preferred risks at the expense of those who need protection the most is further evidence of a primary devotion to business volume rather than to service in the broad sense.

One of the difficult factors in this whole picture is the human tendency, shared by trade unionists, to glorify one's own plan and to resist any suggestion that its performance might be improved upon. Regardless of the structure or content of the plan in question, those involved will more often than not argue that their particular program is "just right," the best in town. Advice to the contrary is not warmly received.

Now, while they can't all be right, no one who appreciates the realities of collective bargaining and the limits that it places upon full freedom of choice will feel in a position to disagree. The situation may be like that of the workman who received a bottle of bourbon from his boss for Christmas. When he returned to work after the holiday, the boss asked him how he had liked the whiskey -- to which he replied: "It was just right."

"What do you mean, 'just right'?" the boss asked.

"Well," he said, "if it had been any better you wouldn't have given it to me, and if it had been any worse I couldn't have drunk it."

So in that sense, many of these plans that may not look too good to some of us probably are "just right."

Now that I have sufficiently confused the picture with qualifications and reservations, I will try and draw some meaning from it. This is not easy. Sound principles and the pressures of apparent necessity too often conflict and no very clear pattern emerges.

Certain trends can, however, be discerned. Some of those trends are discouraging to those who care very much about whether and how well the real health needs of the public are going to be met. Others can be termed encouraging.

Among the discouraging trends is the sharp, prolonged and accelerating

rise in the cost of health services. If you separate the medical cost element from the overall consumers' price index, and plot the trend of medical costs over the last few years on the same chart with a line representing all other prices, the former will look like a guided missile taking off from White Sands. Medical care costs, particularly hospital charges, have gone up farther and faster than any other component in the cost of living, and the end is not in sight.

Discouraging too has been the failure of Blue Cross programs to develop their potential and live up to the responsibilities inherent in the community service principle. It is true that by the standards of size, volume and resources, Blue Cross plans generally are a great market success. This, however, only makes their deficiencies more disappointing.

Starting with the tremendous advantage of their hospital relationships, Blue Cross might conceivably have become the instrument for making the hospital a genuine community health center, the staffing and control base for a broad range of prepaid health services, radiating out through suburban branch centers, with home care and rehabilitation programs as well as ambulatory, diagnostic and treatment services, under the kind of institutional supervision necessary to the maintenance of quality and proper utilization all along the line. Instead, Blue Cross has confined itself largely within the four walls of the hospital bedroom, abdicating the service of other pre-payment needs, to the extent they are served at all, to agencies -- including those of the medical societies -- who do not plead so sincere a social purpose.

Where the bargaining and enforcement agents of organized medicine have raised an issue of jurisdiction in the definition of hospital services, the capitulation of the hospital, and consequently Blue Cross, has in too many cases been prompt and complete. Where a Blue Cross plan has ventured to offer some measure of broader out-patient or other coverage involving the services of medical personnel, it has done so in a manner calculated not to raise the eyebrows of the most militant professional defender of business-as-usual medicine, or to add anything very substantial to the quality or value of the goods already on the insurance market. When experience-rating and "co-insurance" devices are added to the Blue Cross performance chart, the similarity with commercial carriers becomes more significant than the difference.

I do not mean to suggest, by these strictures, that Blue Cross plans are inferior to the commercial insurance product. Within their limits, I think that in most areas they are better. But because they profess higher standards of responsibility to the public and because they could have done far more than they have for the public, they should be judged according to their pretensions.

It is depressing also to note the continuing bitter hostility of organized medicine to any suggestion that the methods of organizing, providing and paying for medical services that prevailed in the days of leeches and mystic potions can possibly be improved upon. There has been no weakening of medical society resistance to the proposition that those who pay the piper should have some voice in the selection of the tune.

Most of us have been discouraged by the recent disclosures of corruption and abuse in the operation of some health and welfare plans. But I think that most of us also agree that, if these conditions have existed, it is far better to have them out in the open, so that they can be corrected and prevented, rather than to continue to exist undisclosed.

On the encouraging side has been the slow but steady growth of, and increasing interest in, direct medical service plans that undertake to fill the broad gaps that other plans leave uncovered, to promote the principles of preventive medicine, and to improve the quality of prepaid medical care. While their rate of growth has been -- as one might expect in view of the obstacles -- far less spectacular than that of Blue Cross, Blue Shield and commercial insurance plans, I believe that they will continue to grow and to attract support long after other plans have reached their saturation points.

There have also been encouraging instances of effective cooperative effort among unions at the community level, representing a departure from the isolationist, go-it-alone tendencies that still too often stand in the way of constructive action. In the last analysis, the health care needs of working people must be met in the local community, where they work and live and where they must find the doctors, hospitals and other medical facilities necessary to the provision of good medical services. Working together, the trade unions of a community can do a great deal to improve the facilities available to them, and their position with the providers of services, that would be beyond the power of any single local acting alone.

One outstanding example is the multi-union Medical Service Plan of Philadelphia. Here 29 local unions of different internationals joined together to develop a program of complete ambulatory, diagnostic and treatment services, supplementing in most cases their existing hospital benefit plans, and operating through the medium of a wholly-owned labor health center. The success of this program has stimulated interest in the advantages of the local multi-union approach in other cities.

Another example with great potential significance is the community-wide program that is now in the developmental stage in the city of Detroit. Through the initiative and leadership of the United Auto Workers, a Community Health Association has been formed there with the object of providing genuinely comprehensive prepaid medical services. Enrollment will be open not only to unions but to all groups in the community.

I think that it is important that local unions and their members should be free to participate in programs of this type where they are available. Some are handicapped by being tied to a centralized national or regional plan, established either because of the pattern of bargaining or to realize the economies of volume in the purchase of commercial insurance coverage. It is possible to provide this degree of freedom, without sacrificing the main advantages of standardization and volume sought by the parent body in such cases, through the incorporation of the "local option" or "dual choice" principles. This would permit members in

communities where comprehensive service programs are available to elect out of the standard national or regional plan and into the local plan if they so desire.

As an example, the UAW agreements with the large auto companies now contain this option. This makes it possible for members to join such plans as HIP in New York, Permanente in California, or the coming CHA plan in Detroit, even though the agreements themselves set up a uniform national standard of benefits along Blue Cross lines.

The dual or multiple choice approach is, of course, useful and appropriate whether or not the plan is local, regional or national in structure. It has been adopted by a number of local unions in this State, and seems certain to become more widespread in the years ahead. All of the various recent legislative proposals for health insurance for Federal employees, for example, have incorporated the multiple-choice principle in one way or another.

There is today, I think, a greater understanding of the common problems and issues faced by all who work in this field, a strong desire for improvement, a willingness to consider new alternatives and to experiment with new approaches. This is the real key to progress. When and if we should reach the stage where experimentation is no longer tolerated, where the door is solidly closed to any new approach to the organization and provision of health services, we might as well convert our health and welfare plans back into cash pay, for they will not be worth the candle.

Underlying the question of service versus indemnity which, as I have said, is not always too clear or meaningful, there are certain issues which do have a profound bearing upon the values you buy for the money you spend on a health and welfare plan. One of the most basic is the issue of commercial insurance principles versus social insurance and medical care principles.

Insurance companies pay cash benefits, which are a very substantial help in meeting medical expenses, to millions of people, many of whom have no better means of protecting themselves. Nevertheless, in my opinion, the influence of commercial insurance companies upon the development of health plans generally has, in balance, been neither a wholesome nor a constructive one. Aside from the insidious role that some insurance agents and carriers have played wherever corrupt practices have developed in the operation of health and welfare plans, and the bad advice they have given to many honest but unduly credulous officers and administrators, they are responsible for certain devices which are today among the most serious obstacles to concerted progress in the health care field. I refer to the devices of "experience-rating" and "co-insurance."

Experience-rating raises a wall of isolation about each covered group. It conflicts with the principle of social insurance which calls for the pooling of risks and the spreading of costs over the widest possible area of the population. By this device, the commercial carrier attracts the preferred risk, with the lowest volume of claims and hence the highest

expectation of dividends. As a consequence, those groups which have the greatest need for protection are left out in the cold. This has made it more difficult, if not impossible, for millions of aged and retired persons to share in the benefits of the health insurance movement. It makes all the more necessary the enactment of legislation proposed by the AFL-CIO to finance health insurance coverage for the beneficiaries of the Old-Age and Survivors Insurance system through the Social Security Security Trust Fund,

I am aware that much of the demand for the further extension of experience-rating to other types of plans has come from some trade union sources. Nevertheless, I believe that such a demand is extremely short-sighted -- at least where it is made upon service programs that have undertaken to provide comprehensive benefits and to apply constructive controls upon unnecessary utilization and costs.

This is not just an argument against the pursuit of selfish considerations -- for the selfish interests of a particular union must and should prevail upon its leadership in most cases. But many groups who now believe that experience-rating serves their own best interests will sooner or later find to the contrary -- when, for example, they undertake to extend full coverage to their retired and disabled members and are confronted for the first time by the triple premium rate and a substantial change in their annual claims load.

Over the long run, the experience-rating practices of commercial carriers may well tend to be self-defeating. Those groups upon which the carriers concentrate their appeal -- the preferred, low-claims risks -- actually have the least need for the services of an outside carrier, particularly where their welfare funds have built up substantial internal reserves which duplicate the reserves held by the carrier. The growing practice of delegating claims work and other administrative functions to the insured further tends to nullify whatever reason the commercial carrier might have for its existence in the group insurance field. For, if each group is regarded as a self-sufficient entity; if experience-rating attracts chiefly those groups with a small prospect of unusually heavy claims; and if the administrative work is to be handled by the group's own personnel, then more and more groups will surely begin to ask the logical question: just what service of value does the insurance company perform in return for its profit that could not be performed as cheaply by the fund itself, on a self-insured basis?

I hold no particular brief for self-insurance as such. From the standpoint of the quality, cost and content of the actual medical services provided, a self-insured indemnity plan represents no particular improvement over a commercially-insured indemnity plan. But, if you want to play the experience-rating game for all it is worth, the way to play it with a vengeance is through the medium of self-insurance. Self-insurance is nothing more than experience-rating carried to its final logical conclusion.

"Co-insurance" is a trick word of the insurance industry which simply means that part of the total medical bill for which there is no insurance.

In the conventional type of cash indemnity plan, it means that while the carrier rigidly limits the extent of its own possible losses, the allegedly insured continues to face the prospect of an open-ended, unlimited liability for the remainder of the actual bill.

"Major medical expense" insurance, on the other hand, incorporates the co-insurance principle in a somewhat different manner. The carrier extends the limits of its liability to a broader range of expenses and a higher maximum amount -- usually \$5,000. In return, it requires the insured person to assume the full liability for some fixed initial portion of his medical expenses -- known as the "deductible" amount. Furthermore, he must assume a part of every additional dollar of medical expense, usually 25 per cent, up to the maximum limit of the carrier's liability, and the entire expense thereafter.

A statement of policy regarding major medical expense insurance was adopted not long ago by the AFL-CIO Executive Council. It reads in part as follows:

"The broader extension of 'major medical expense' or 'catastrophic' health insurance coverage. . . is neither a constructive basis for a national health program nor an adequate answer to the need for comprehensive prepaid health services. Unless accompanied by measures designed to aid in the development and expansion of direct medical service prepayment programs which emphasize preventive care and encourage early diagnosis and treatment, any effort on the part of the government to promote the 'catastrophic' insurance policies of private carriers can only lead to further inflation of medical costs and deterioration in the quality of medical care, while ignoring the most essential health needs of the public."

Co-insurance is defended by its advocates as an essential control upon excessive costs and the abuse or unnecessary use of medical services. This is an argument from expediency. Lacking any better means of controlling costs and utilization, the insurance carrier makes the hapless consumer the goat. Yet, of all the parties in the medical care picture, the consumer is least able to apply controls in an effective and discriminating fashion.

If there is such a thing as wrongful or excessive use of services and facilities (and there is), there is also such a thing as wrongful non-use, as represented by those who need medical attention but fail to secure it because of the cost barrier. By their very nature as deterrents to the use of medical services, co-insurance and deductibles are non-discriminating in their application. If they are effective in restricting the wrongful or excessive use of services, then even their most ardent advocates must concede that they are also effective in deterring those who really need medical attention.

The consumer, after all, is not a skilled diagnostician. The safest principle for him to follow is: "When in doubt, see a doctor." In advancing the necessity of deterrent charges, however, the insurance carrier says, in effect: "When in doubt, don't see a doctor -- take aspirin, or maybe Geritol."

The excessive use of medical services can only cost money. The failure to use medical services when they are needed can cost lives. This, in itself, should be a sufficient indictment of the principle that controls should be applied in a blind fashion through deterrent charges upon the consumer.

This does not mean that controls are not essential or that their importance can be ignored or discounted. They must, however, be applied to and by, not the ailing consumer, but the providers of medical services and care. They must be of such a nature as will promote rather than deter a more timely recourse to medical attention, of the kind that is needed, at the place where it can be most efficiently provided.

The way in which medical services are organized and paid for has a direct bearing upon the kind of controls that are required and the ease with which they can be applied. It is possible to have effective controls within a fee-for-service, solo practice system of medical care, but it is more difficult than under a group practice, salaried payment system. It requires a higher measure of professional self-discipline than most practitioners in this country have been willing to accept, for it runs counter to the natural pecuniary incentives that operate in a fee-for-service structure.

One such control is, of course, an agreement by doctors to limit their charges to the fee schedule provided by the plan. But even if such an agreement is successfully negotiated and enforced, it still leaves to be solved the problem of safeguarding the quality of and assuring the necessity for the services performed.

Controls upon the quality and necessity for in-hospital surgical procedures can be applied through such methods as those advanced by the American College of Surgeons and the Joint Commission on Accreditation of Hospitals. This calls for the establishment by the hospital of a so-called "tissue committee" or surgical control board to check upon all operations, as a requirement for the accreditation of the hospital. This serves as a deterrent to the performance of unnecessary or pecuniary operations, since the surgeon whose record, as developed by the committee, shows an unusually high rate of cases involving the removal of healthy tissue stands in danger of losing his hospital privileges.

The fact that large numbers of expensive and totally unjustified operations actually are performed and that this is no trivial or over-scrupulous safeguard is indicated by the results reported by the College of Surgeons, which show a sharp drop, by one-third to one-half, in the number of operations performed in hospitals after they have taken the steps necessary for accreditation. One hospital's surgery rates, with the same patient load, fell from 769 operations in one year to 298; from 305 appendectomies to 66; from 30 Cesareans in 556 births to one Cesarean in 652 births.

To unions involved in the administration of health and welfare plans, the importance of such measures, in reducing the cost drain while improving the quality of benefits provided, should be obvious.

After long experience with such abuses as unjustified surgery, unnecessary hospitalization, and services of inferior quality on the part of local fee-for-service solo practitioners, the United Mine Workers Welfare Fund tried a somewhat different approach to the control problem. Its medical directors adopted a rule that, except in emergency cases, consultation with an appropriate specialist to determine the necessity for the procedure would be required before any member patient was hospitalized. According to Dr. Warren Draper, the Executive Medical Officer of the Fund:

"The resulting reductions in the rate of surgical operations and hospital admissions were in some instances from 30 to 50 per cent, and the advantages to the patient of specialist consultation was found to be considerable."

The broader extension of the prepayment principle so as to provide care outside of, as well as within, the hospital will, if properly organized, also serve as a check upon the drain of unnecessary or avoidable hospitalization. Through the medium of out-patient clinics and health centers, operating as a functional part of the prepayment program, the emphasis can be shifted to preventive medicine and the early diagnosis and treatment of physical and mental disorders. Such a program can best be carried out through the medium of group practice, with salaried physicians.

The incentives present in a time payment system are more in keeping with the objective of high quality medical care than are the financial incentives that operate in a fee-for-service system. Trade unionists should understand this. You would not think it wise to place skilled craftsmen on piece rates in the production of an article requiring great care and pains, without also providing for a very tight inspection and quality control system. While some would maintain their standards and pride of workmanship, others would sacrifice quality in order to increase their quantity of output and their earnings. This quality consideration is one good reason why unions in the skilled trades have generally resisted piece rates and favored time rates.

The same tendencies and incentives exist in a piece rate or fee-for-service system of medical practice. The figures that I cited earlier show how, in medicine as elsewhere, adverse incentives produce adverse results in the absence of strong, systematic quality controls. The incentives present in a salary payment system are far more conducive to high quality care, of the kind indicated by the physical rather than the financial condition of the patient.

There are controls present in a properly organized group practice system which are lacking in solo practice. The process of selection of its members by professionals in accordance with rigid professional standards, rather than by the layman through random chance, is one such control. The fact that the entire group shares responsibility for the competence

and performance of each of its members, and each is accountable to, and has ready access to the counsel of, his fellows, also tends to raise the level of performance.

No one doctor, no matter how brilliant, is competent today to serve all the real or potential needs of all his patients. He must call upon the services of, or refer his patients to, other doctors on frequent occasions. The real issue is not whether the individual consumer should have available the services of a number of doctors. The issue is whether those doctors, representing the various specialities, should organize and function in a rational manner as a group, or whether they should function as independent businessmen in isolation from one another.

I am not suggesting, even in an academic or theoretical way, that there should ever be an end to the solo practice, ~~fee-for-service system~~, or that any one system should prevail to the exclusion of all others. The doctor as well as the patient should be free to choose his own brand of medicine. Where any system enjoys a monopoly, insulated by law, custom, or private power from competition or the challenge of changing times and needs, the quality of its performance is bound to deteriorate. The proponents of group practice prepayment plans are not seeking such a monopoly nor trying to stamp out solo practice -- rather, the boot is on the other foot.

Fee-for-service solo practice medicine will always exist as a valid and acceptable system. Other equally valid systems and methods of medical organization and practice, however, have an equal right to exist and to serve the public, free from the benighted harassment, open attack and subtle libel to which they have been too often subjected. Each system of practice and prepayment will function best and will be most responsible to the needs of the public if a state of competitive co-existence prevails among them, so that each is constantly exposed to the test and challenge of other alternatives available to the public.

As President George Meany stated it, in dedicating the Philadelphia labor health center early this year:

"We have no urge to dictate or to control the practice of medicine, for we know that we are not competent to do so. We want only to help bring into being the kind of programs and facilities that will attract the best doctors and that will bring out the best that is in them. We favor any method of organization and payment that will enable them to practice freely as their professional judgment indicates, with no economic barriers between our members and their services."

SERVICE VS. INDEMNITY PLANS

by

Arthur Weissman
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Before negotiated health and welfare plans came into the health insurance picture, the field was relatively neat and orderly with reference to service benefits and indemnity benefits. Insurance companies were on one side of the fence with their indemnity plans - paying benefits in cash to the insured, or to the hospital or physician as a credit toward the patient's bill. On the other side of the fence were the large service plans - Blue Cross and Blue Shield - which guaranteed specified types and amounts of services, and made payments directly to hospitals and physicians on a fee-for-service basis.

Although this division between indemnity and service was relatively clean-cut at that time, some fence-straddling had already appeared. Blue Shield plans had already established the combined service-indemnity idea, with service benefits for persons below a designated income ceiling and indemnity benefits for those above the ceiling. In some areas of the country, Blue Shield Plans operated on an indemnity basis. And Blue Cross had already entered the indemnity field with surgical indemnity riders.

When negotiated health and welfare plans appeared on the scene, both labor and management were barraged with preachings from both the indemnity and service camps. The lines were drawn between good and evil with both camps claiming good for their side of the fence and evil for the other side. The battle of words raged on and on. Eventually, the smoke lifted over the battlefield. When it lifted it revealed a strange sight: The indemnity team had moved over to the service camp, and the service team had moved over to the indemnity camp. It seems that this battle of words had its greatest effect upon the preachers, rather than on the congregations. For, while both camps were preaching, the negotiated health and welfare plans were needling both sides with demands for more comprehensive coverage.

The pressure from these plans for more comprehensive benefits led the indemnity plans, in some instances, to write open-ended cash reimbursement allowances instead of specified dollar allowances; for example, reimbursement in full by an insurance company for the bill for a ward bed patient - which is equivalent to a service benefit.

Similar pressures on Blue Cross led to deeper excursions into the

field of pure indemnity benefits for in-hospital care, certain types of out-patient care, as well as surgical care.

When, as in some communities, the Medical Society or some segment of the organized medical profession agreed to abide by an Insurance Company fee schedule for one or more Health and Welfare Plans, the effect was to convert such fee schedule benefits to service benefits.

The shifting of position continued. The service plans took over important features from indemnity plans - such as individualizing prepayment packages tailored to specification, rather than holding the line on a standard plan; the service plans embraced the indemnity plan ideas on experience rating and retentions; and, to complete the picture, the service plans nationally established their own insurance companies, and locally, in at least one major instance, affiliated directly with an insurance company.

It was no accident that hospitals in California came around to giving equal acceptance to the identification cards of major Insurance Companies as well as to Blue Cross and Blue Shield.

Now, the increasing interest of Blue Cross and Blue Shield Plans in major medical expense coverage leads to the belief that in this area too there will be a joining of the ranks of the major service and indemnity plans.

The converging of Blue Cross, Blue Shield and Insurance Company plans has substantially blurred the distinctions between service and indemnity benefits in these types of plans. It is sufficient to say that from the standpoint of the purchaser of health insurance, Blue Cross, Blue Shield and Insurance Company Plans are essentially similar in many important respects.

On at least one matter, these plans are in full agreement - namely, that they are fundamentally different from the type of plan which I represent - the Kaiser Foundation Health Plan. Incidentally, this is one subject on which there is general agreement, since we agree that our type of group practice prepayment plan is basically different from Blue Cross, Blue Shield, and Insurance Company Plans. Mr. Kirkland has outlined some of characteristics of our type of plan. During the question period, I shall be pleased to elaborate on this subject if you have questions along these lines.

I will not tell you that our Plan is better than the other plans mentioned. This is not my platform here. I will tell you that our plan represents a different approach to meeting the medical care needs of the family. In the Health and Welfare field there is a place for both types of plans. This has been demonstrated in all instances where dual or multiple choice programs have been offered to employees covered by Health and Welfare Funds. Some families like our plan; other families prefer the alternate choice plan which may be Blue

Cross, Blue Shield or an insurance company plan. After the initial selection, the opportunity is afforded periodically to each family to switch plans - to transfer from one to the other. Again, we see that some families like our plan and others prefer the alternate choice plan - demonstrating repeatedly that there is a place for both types of plans in the Health and Welfare field.

Neither we who work in prepaid medical care programs nor you, the purchasers of prepayment plan coverage, have all the answers to the question of how best to meet the health needs of workers and their families. Some of these answers will not come from the experts; they will grow out of day-to-day comparisons made by workers who have different arrangements under which they obtain their prepaid medical care, as in dual choice programs. This is one of the major reasons why the Kaiser Foundation Health Plan has the firm policy of accepting Health and Welfare Plan enrollment on a dual choice basis, rather than on a basis of 100% enrollment in our plan.

INDEMNITY vs. SERVICE

by

George C. Lucia
Assistant Executive Director
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When I was asked to serve on this panel, I understood it was composed of experts in their respective fields.

I immediately looked up the word "expert" and learned the following: "Expert" comes from two latin words. "Ex" -- something which is past its usefulness; has been. "Spurt" means a little drip under great pressure. Or, an abbreviation of the two, "A has-been under pressure." For this reason, I do not regard myself as an expert.

It is a real privilege to talk to you today. I feel especially grateful because it was the interest of union leaders in fringe benefits that caused the accelerated growth of prepaid health insurance during the past decade.

There are in excess of 105 million people protected by some form of hospital, surgical and medical protection. Today, people are demanding and their physicians are requiring for them more and more health care in hospitals.

Much of this care will be diagnostic and preventive in nature. The demand for comprehensive health protection, the search of the individual for security against the cost of illness, will be satisfied in one way or another.

The problem, therefore, is still to make it possible for patients to prepay the cost of care so as to make it financially possible for hospitals to carry their present load while meeting the ever-increasing demand for their services. This is particularly important in our rapidly-growing state of California.

One approach toward the solution of this problem is the traditional commercial insurance method of indemnification against the financial loss created by illness.

Insurance companies dabbled in the field long before Blue Cross. But, they expressed little interest in coverage for hospitalization until Blue Cross had pioneered the way and had demonstrated the fact that hospitalized illness was not only an insurable risk, even for dependents, but that people demanded the protection and would pay for it.

In entering this new field, commercial insurance companies applied basic insurance concepts of indemnity, of limited liability, of termination of coverage with a change of employment or retirement.

Their problem was to match premium dollars of income against dollars paid out in benefits, operating expenses, commissions, brokerage fees, taxes, reserves, and so forth. But, for the public, the need to have health care in an expanding economy is not easily satisfied in terms of dollars. The reason for this is an indemnity plan based on minimum averages does not provide for the unpredictable cost of serious illness or accident.

Commercial insurance companies have assumed no responsibility for solving the financial problems of the individual, except within the dollar limitations of their policies.

Insurance companies are mainly in the business to make money -- not to provide service benefits.

There is nothing wrong with making money. But, the nonprofit hospitals might well question whether or not the sale of their services should be the method by which profit is made.

The other approach is that of the nonprofit, prepayment service plans, which vary from group practice, such as health center programs and foundations available in some localities, to the nation-wide Blue Cross movement.

There are four criteria that Blue Cross Plans must meet. These criteria are all service centered.

1. There are the hospital service benefits as opposed to indemnity benefits.
2. There is the nonprofit service operation, as contrasted with profit-making operations. It is not coincidental that "service" appears in the corporate name of Blue Cross Plans. For example, Hospital Service of California -- Hospital Service of Southern California.
3. There is the service of enrollment representatives on a salaried basis, rather than on a commission basis.
4. There is the service of community-spirited citizens on the Board of Directors. These are men who receive no remuneration but who serve in the community interest, as contrasted with those who have a vested interest in the financial operation of the commercial insurance company.

These service criteria have resulted in an impressive record that Blue Cross has established in serving 54 million Americans -- one person in every three.

Year after year, Blue Cross Plans have returned a higher percentage of the subscriber dollar for benefits. This is perhaps the most telling argument for the Blue Cross basic philosophy of service as opposed to indemnity benefits.

The steady annual reduction in the percentage of Blue Cross overhead needed for administrative expense is well known. The average across the nation is only 7 per cent for overhead. The net result of this low overhead is that dollar for dollar the money paid into Blue Cross will provide more in return than the same amount could possibly provide under a commercial indemnity plan. Approximately 93 per cent of Blue Cross Plan income, on a national average, is returned to members in the form of current benefits.

The Blue Cross nonprofit community service plans have had two objectives over the years.

First, to provide a prepayment plan for financing hospital care.

Second, to help the community carry its social and economic burden, which hospitalized illness creates.

To reach these objectives, the following basic concepts have evolved.

First, the prepayment plan must meet the cost of hospital care for the member and payment must be made directly to the hospital which is under contract for its services.

The traditional insurance principle of indemnity against loss with reimbursement made directly to the policyholder has never even been considered, because a few individuals have ready cash for this contingency.

This concept of service benefits paying for the actual hospital care given the patient regardless of cost, was and still is, the cornerstone of the Blue Cross structure. Actually, this concept violated what was thought at one time to be a basic insurance principle.

Equal benefits for all members of the family -- not reduced coverage for the wife and children -- was a requirement of Blue Cross operation. (Between 75 per cent and 80 per cent of all benefits provided are for the dependents of the worker.) To the insurance industry, the idea of full coverage for dependents was considered fantastic.

Persons once enrolled must be permitted to continue in the plan regardless of change of employment, age or condition of health. This concept looked toward meeting the community need as well as the financial problem of caring for the patient. This idea, too, was considered unsound from the strict commercial insurance viewpoint.

The plan, like most hospitals, must operate as a nonprofit service organization.

Sickness and injury that make hospital care necessary represent personal tragedies, often catastrophic, which people motivated by religious and humanitarian impulses, have always tried to alleviate.

Upon these principles, the Blue Cross movement in America has been built. Principles developed to make it possible for the individual to pay for needed care in advance, to help the community solve the costly social problem which to a large measure has been a community responsibility since the dawn of the Christian era.

The actuarial safeguards of limited dollar liability of hospital indemnity insurance, which often leave a major part of the hospital bill unpaid, of termination of coverage when the employment or insurability change, which tends to deny protection to people when they need it most, all these financial safeguards were not sought by Blue Cross.

In return for providing service benefits, Blue Cross was given a preferred position through contract establishing the credit of its members at the hospital upon presentation of an identification card.

Without financial worry on his part, the member, in effect, has a passport to all the health restoring facilities of the modern hospital.

And, at the same time, the system eliminates the financial worry of the hospital as to how and when the bill will be paid.

Today, in this period of inflation, the problem of financing hospitals and meeting the community's need for health care protection, is greater and far more complex than it was a few years ago. It has been said that more medical progress has been made in the last 25 years than in the previous 25 centuries.

This advance in medical science, with the accompanying basic changes in the practice of medicine, have greatly increased the use of hospitals -- both as to the number of patients served and as to the volume of ancillary services provided to each patient.

At the same time, the hospitals have been forced to become competitive in the market place -- not only for personnel, but for all services and supplies. The upward spiral of cost has, therefore, necessarily been steeper in hospital administration than in other industry.

A cost per patient day, which a few years ago, would have been inconceivable, is now inescapable. The result is some indemnity plans which were limited a few years ago, are even more inadequate today.

When hospital costs go up, the fixed amounts pay less of the hospital bill. The patient with such a limited program must make up the difference from his own pocket or borrow it.

For example, if a hospital charges \$20.00 per day for a three-bed ward, a service plan must pay that amount. But, if an indemnity policy allows only \$14.00 per day for room charges, the patient must pay an

additional \$6.00 per day for each day he is in the hospital.

If the extras, such as operating room, X-ray, laboratory services and supplies, cost \$350.00 or \$550.00, Blue Cross pays that amount -- not part of it, leaving a balance due.

I am not suggesting that a solution to the problem precludes indemnification. It was Nelson Cruishank, Director, Department of Social Security, AFL-CIO, who said recently, "Even the cash indemnity plans that characterize the great bulk of health and welfare plans negotiated in collective bargaining agreements, limited as they are in their scope and objective, has made an important contribution to meeting this need."

He said further, "The aim of the trade union movement in negotiating health insurance plans is to relieve their members of a serious cost burden while providing them with better medical care. This aim cannot be met by simply putting more cash in the hands of the members. It cannot be met by cash indemnity or reimbursement plans, which do not, in fact, either insure or prepay any fixed and predictable proportion of the individual's actual medical expense.

For an indemnity plan to remove the financial barrier between a patient, the doctor and the health facility, it must be realistic and as comprehensive as possible by being related to the cost of the services.

In the past, the major criticism of indemnity benefits has been that they are inadequate. Where they are great enough to meet the financial needs in time of serious illness, they can serve as one answer to the problem.

The potential weakness of indemnity benefits is that in time of inflation, which we are experiencing today, they can in short time become out-of-date. Surgical and medical schedules, which are sufficiently comprehensive with maximum limits, have proven their worth in providing union members with benefits against the unpredictable doctor bill.

Where surgical and medical indemnity benefits have failed to meet the needs of the consumer, they have invariably been unrealistic and inadequate in amount.

SELF-INSURED VERSUS INSURED WELFARE PROGRAMS

By

Martin E. Segal
Consultant, Welfare and Pension Funds

The growth of health and welfare plans and increasing public attention has naturally raised the question of whether the best benefits are being provided at the lowest cost.

Objective studies indicate that savings in health and welfare plans, regardless of whether those plans are insured or self-insured, can be effected in many instances. In some of these instances savings can be effected by the elimination of practices which represent abuses, i.e., excessive retentions, excessive administrative expenses, excessive fees and commissions, and so forth.

Leaving aside savings that can be effected by the elimination of abuse, additional savings can be obtained by arranging the benefits on a scientific basis whereby certain legitimate costs can be reduced further. It is in this area that the general question of self-insured versus insured health and welfare plans arise.

Unfortunately, there has been a serious lack of impartial and objective information on this problem. In some instances the persons responsible for furnishing inaccurate information are trying to serve their own selfish and commercial interests. In other instances, it is simply a matter of inadequate knowledge.

In any event, generalized statements on this subject should be avoided. The fact is that in some situations self-insurance is desirable; in others it is not. Each situation must be analyzed in terms of the specific facts applicable.

This morning we will review the most important factors to be taken into consideration when evaluating whether a welfare plan should be on an insured or self-insured basis. (I discussed the pros and cons of self-insurance or insurance for pension plans at the April 1956 conference on "Pensions In Collective Bargaining" -- and the views expressed have been summarized in the publication which was issued after that conference.

It should be noted that the factors taken into account when considering the advisability of insuring or self-insuring a welfare plan are significantly different from those taken into account by considerations given to insuring or self-insuring a pension plan. This morning we will limit the discussion to the most important questions which trustees of a welfare plan should consider in determining whether that program should be self-insured or insured. May I say in passing that where there are "service" benefits a comparison between self-insured and insured

arrangements is more complex -- and I will cover this subject in the discussion period which is to follow.

A welfare plan operating on an insured basis functions as follows:

1. An agreed upon premium is paid to an insurance company. The premium is based on the plan of benefits and the composition of the group to be insured.
2. A contract of insurance is entered into between the welfare fund and the insurance company. The contract spells out the mutual obligations of the parties.
3. Benefit payments are paid directly by the insurance carrier or by an employee of the welfare plan authorized to sign checks for benefit payments drawn against the insurance company's bank.
4. At the end of each contract or insurance year, the insurance company accounts to the welfare fund and indicates the amount it received in premiums and the amount it paid out in claims or is due to pay for claims that were incurred during the policy year and are still in the course of payment, unreported or pending.
5. In a normal situation the premiums paid to the insurance company generally exceed the claims incurred by the company for a given year. Insurance companies will charge premiums which, in their opinion, will be sufficient to cover claim payments and the insurance company's expenses.

The key question then is what happens to the dollars that represent the difference between the premiums received by the insurance company and the benefit claims paid or due to be paid. What normally happens is that the insurance company deducts from the difference an amount designated as the insurance company's "retention." The remaining balance is then returned to the welfare fund in the form of a dividend (if a mutual insurance company is involved) or a retroactive rate credit (if a stock insurance company is involved).

The question of "retention" -- the amount retained by the insurance company out of the premiums paid to them will be discussed in detail shortly.

First, let me give you an example of what I have just mentioned. Let us assume that a welfare fund paid a premium of \$500,000 to an insurance company for a particular contract year and that the claims paid and incurred in that year were \$350,000. Let us assume that the insurance company's retention is 5% of the insurance premium, or \$25,000. As the difference between the claims and the premium was \$150,000, the insurance company would then deduct \$25,000 from this amount and return a dividend or retroactive rate credit of \$125,000 to the welfare fund. The net insurance cost for the year would be the total of the claim payments (\$350,000) and the insurance company retention (\$25,000), or \$375,000.

Theoretically, at least, regardless of whether a plan is insured or self-insured, the same amount of benefits would be paid out under the same plan of benefits. Therefore, in appraising whether a plan should be insured or self-insured, from a cost point of view, a detailed and impartial analysis should be made to determine how much a self-insured plan would save, net, when the insurance company's retention is eliminated. Also, an impartial and objective analysis should be made of the additional responsibilities which the trustees and the welfare fund would assume in a self-insured program.

In essence, the insurance companies state that the advantages of an insured arrangement are:

1. The trustees and the welfare fund are free of pressure for the payment of claims, since in the final analysis the insurance company is responsible for the decision as to whether a claim should or should not be paid under the terms of the contract.
2. The welfare fund, under an insured arrangement, has as its maximum obligation the premium for the particular policy year -- regardless of the amount of benefits which may have to be paid, in some instances more than the amount of the premium for that particular year.

The advocates of self-insurance state that, eventually, the advantages of such an arrangement is that there is a savings to the plan by the elimination of insurance company expenses.

You realize, of course, that many basic aspects of administration of self-insured and insured welfare plans are the same. For example, both types of plans have the responsibility for collecting and recording employer contributions and maintaining eligibility records to determine whether claimants are entitled to benefits payments.

Both self-insured and insured plans have the problem of investigating disputed claims. In an insured plan these investigation facilities should be provided by the insurance company. A self-insured plan should have an independent means of investigating disputed claims, if claims are to be paid on the basis of merit rather than pressure.

In the case of the disputed claims that go to litigation there must be legal representation for the plan if, in fact, the claim for benefits should not be paid because the claimant for benefits is not eligible. In the case of insured welfare plans the insurance company provides this legal representation. In the case of self-insured plans the welfare plan must provide its own legal counsel for such litigation.

Now, you know that the net cost of insurance or retention in a particular welfare fund will vary considerably, depending largely on the size of the group and the type of benefits provided. In evaluating savings which can accrue to a self-insured fund a detailed and impartial analysis must be made of all items which go into an insurance company's retention. These items consist of the following: premium taxes,

contingency reserve charge, charge for administration, commissions, and allocation for profit or surplus of the company.

Let us examine each of the factors included in the retention to determine how much each represents and the extent to which such costs might be saved in a self-insured fund:

Premium Taxes

Premium tax rates vary from state to state. Self-insured plans do not pay a premium tax at the present time. It can definitely be stated, therefore, that premium taxes which insurance companies pay and which self-insured plans do not pay definitely represent a plus by way of savings for the self-insurer.

Contingency Reserve Charge

The insurance companies include in their retention a cost item or factor known as a charge for "contingency reserves and risk sharing." The insurance companies use this money as an additional source to meet catastrophic occurrences and in recouping losses under policies. The contingency reserve charge will vary depending on the particular plan of benefits.

While a self-insured fund will undoubtedly want to establish special reserves for catastrophic occurrences, these reserves are on hand earning interest in a self-insured plan. Some insurance companies do pay interest on these reserves. Others do not. Where an insurance company doesn't pay interest on these reserves, and where a self-insured fund would get interest on these reserves, the interest received would be a savings to a self-insured plan.

Charge for Administration

Another factor in an insurance company's retention is for administrative expenses. The precise amount of this charge will vary depending on the type of benefit provided and the procedure agreed upon for administering the claims and making premium payments to the insurance carrier. The processing of certain types of claims require greater expenses than others -- particularly when the processing expense is related to the amount of benefit payments. For example, it is certainly less costly, percentagewise, to process a single life insurance claim for \$5,000 than it is to process many medical expense benefit claims totaling \$5,000.

The administrative expense charged by an insurance company in its retention also includes the insurance company's expense for printing of booklets describing the plan of benefits; printing of insurance certificates and claim forms; allocation for overhead for claims investigation facilities; legal expenses involved in the litigation of

claims; and other items of a similar nature.

The administrative expenses charged by an insurance company in their retention will vary depending on the size of a group, extent of administrative services provided and the plan of benefits involved. A self-insured fund will have the same kind of expenses but not necessarily the same amount of expenses. For example, a self-insured plan will have to print a booklet describing the plan of benefits and claim forms for the processing of claims. Whether a self-insured plan can do the same things at a lower cost depends on the size of the group and their general purchasing skills. In some instances some savings in administrative expenses can be achieved by a self-insured plan as compared with the administrative expenses included in the retention of an insurance company in an insured welfare plan. In other instances the insurance company's administrative expenses may be less.

Commissions

In almost every instance where investigation has shown mismanagement or corruption in welfare funds, improper or excessive commission practices are generally found among other abuses.

Some so-called "actuarial consultants" interested in switching insured plans to a self-insured basis, because that earns a fat fee for the consultant, have tried to blow up the question of commissions and have sought to mislead trustees of welfare funds as to what savings would be effected as a result of commission savings.

Most major insurance carriers pay commissions in accordance with what is referred to as a "decremental scale." Commissions are based on the amount of annual premium payment received by the insurance company from the policyholder. Under a decremental scale the amount of commission payable decreases percentagewise as the amount of annual premium increases. The commission scales are generally set up on a basis whereby a higher commission is paid for the first year that the policy is in effect and a lower commission is paid for each "renewal" year. Such commissions may also be leveled off by taking the first year commissions and the commissions payable for the nine renewal years and divide by ten so that the same commission amount is paid in each year.

Commissions are not a gift from an insurance company to the consultant or broker who is servicing trustees in a welfare fund. Actually, the commissions are payment from the welfare plan because it is out of the premiums paid by the welfare plan to the insurance company that the commissions are paid. Commissions should not be paid except where services are rendered. Otherwise there is a waste of this portion of the insurance company's retention. Of course, trustees should know what commissions they are paying, via the insurance company, each year.

One might ask how "rackets" and "kick-back" can develop with regard to commissions if the commissions are for the comparatively low amounts

indicated in a recent study issued by the Foundation on Health, Medical Care and Welfare, Inc. (Copies of that study are available here for you.) The answer is that in the welfare funds where abuses developed, special arrangements, with the consent of the insurance carrier, were entered into to increase the amount of commissions normally payable. For example, one device is to "separate" policies for commission purposes. Normally, in determining the amount of annual premium for commission paying purposes, the premiums for all policies should be combined. In this way commissions start with the percentage at the top of the decremental scale just once. But, some agents take commissions on each policy separately -- and not on a "combined" basis. This kind of an arrangement produces higher commissions than when the policies are combined.

I have long advocated the abolition of compulsory commission payments or charges by insurance carriers on jointly-administered, collectively bargained welfare funds. It is our belief that the trustees of such funds should be free to select the consultant they wish to advise them and to pay for services received, on a fee basis. However, where commissions must be included in the retention it should be considered in the fee charged for the services.

We have also recommended, over the years, that when a welfare fund is to be insured and an insurance carrier is selected, there should be a complete disclosure to the trustees of the amount of commissions to be paid by them, via the premiums paid to the insurance carrier.

It is naive, and obviously self-serving, for anyone to argue that when commissions are paid, the person receiving them is automatically beholden to the insurance company. As we have seen, the commissions come via the insurance company but from the welfare fund's premiums. Since it is really the trustees who are paying the commissions, they obviously have a deep interest in seeing to it that they get service which the Fund requires, in exchange.

In evaluating the possible savings in commissions, as part of the insurance company's retention, if a welfare plan is self-insured, the trustees should compare the amount of commissions paid with the amount of fee which will be paid to the consultant, if the plan is self-insured.

Allocation for Profit or Surplus of the Company

Very few insurance companies actually label as profit that item which does appear in one way or another in an insurance company's retention. And, mutual insurance companies take the position that they don't have any "profit" but rather an "addition to surplus." Sometimes the profit or addition to surplus is under an item in the retention known as "all other expenses" or "risk charge."

The amount of profit included, or the amount of addition to surplus, can vary considerably from fund to fund and from one insurance carrier to another. If the trustees of a welfare fund go through the process of

competitive bidding in selecting an insurance carrier the lowest net cost carrier will probably be the one allocating the smallest amount of profit or addition to surplus. In any fair comparison this item, whatever it amounts to, should be taken into consideration in evaluating possible savings.

Where trustees of a welfare fund want to have an analysis made of the advantages and disadvantages of self-insurance it is clear that this analysis must be prepared by someone who is impartial and qualified by experience and integrity. He must be able to function as a consultant in both an insured or self-insured plan, without additional cost to the welfare fund.

In a situation where an impartial analysis shows that self-insurance is desirable, the following safeguards must be established:

1. A self-insured fund should establish the necessary reserves for normal as well as abnormal claims experience. These reserves should be calculated on a sound actuarial basis.
2. The trustees must be firm in making certain that they are not exposed to political pressure for the payment of benefits.
3. The advice of legal counsel should be sought with respect to the establishment of a self-insured plan as well as all other operating legal ramifications.
4. The trustees should be prepared for the fact that a self-insured plan places greater responsibility on them. In some instances it has been demonstrated that the additional responsibility is worthwhile because of the savings involved.
5. Consideration should be given to the possibility of self-insuring certain benefits and insuring others in the total benefit program, depending on what is best for the welfare plan.
6. In evaluating the possibility of self-insurance of hospitalization, surgical and medical benefits, adequate weight must be given to privileges which exist in certain service plans like the right of the employee to convert to an individual policy when he leaves the group, identification cards which ease admissions to hospitals or to medical service groups and so forth.

In considering this overall question the trustees should ask themselves these fundamental questions, after the impartial and detailed analysis is submitted:

1. Does the study reveal that the group is large enough to consider self-insurance?
2. Are the reserves adequate to guarantee the benefit payments?

3. Will the benefits be adequately, fairly and impartially administered?
4. Are the savings to be affected worthwhile?

It is not possible to make an honest categorical statement to the effect that self-insurance or insurance is more desirable for all welfare plans. Each plan must be carefully analyzed in terms of its own cost and need and there must be a careful appraisal of advantages and disadvantages from both an immediate and long range point of view.

INSURED vs. SELF-INSURED WELFARE PLANS

by

Clarence Tookey
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If I were to argue against the arithmetic of possible savings through self-insurance, you would know that I was even a worse actuary than I am.

However, whenever I get into this particular controversy I remember a problem in Physics which I had in high school over fifty years ago. We were asked which dropped faster in a perfect vacuum -- a bullet or a feather. Now the scientific answer is that they will each drop at the same rate.

However, at that time there were no perfect vacuums. Perhaps there are none yet in spite of the great advance in scientific methods and engineering know-how.

I'd like to approach this question from a practical angle. I won't argue the most obvious -- that is that small plans need insurance and big plans do not. All the small plan gets out of the insurance company is pooling with other small plans to get the benefit of the law of averages. There is no reason why they must go to an insurance company provided they can get along without a policeman on the corner. They could combine in one large trust and get the same law of averages. However, neither employers nor unions are always willing to do this -- they don't trust one another and may well ask why one case with young healthy lives should carry another case of old men whose insurance may require an employer contribution of twice as much as the case with younger lives.

Remember that the insurance company can pool heterogeneous risks with different costs provided they average out. When a self-insured trust pools risks it automatically gets into the insurance business. It is still true, however, that if a number of medium size bargaining units are willing to get into bed together, they can come out with an average experience that is just as reliable as it would be in an equally large case of homogeneous risks.

Therefore, I would like to examine the savings that are theoretically possible provided the "perfect vacuum" could be attained.

Now the insurance company has certain fixed costs, most of which are taxes -- State and Federal. The two added together will amount to approximately 3% of the average cost of a welfare plan -- a little more

or a little less depending on how much life insurance is included.

For large plans the insurance company will want about $1\frac{1}{2}\%$ for risk, profit (what an unholy word), and agent's finders fee. If the agent or broker is doing a real consulting service, the commission may be higher. If he is doing no service work, it may be less.

I am assuming here that we have a self-administered case where the functions of premium collection, certificate issues and claim payments are performed by the administrator. The insurance company will pay for booklets, printing certificates, etc. or the administrator might do so. In any case the administration fee for these services will not be affected by insurance or self-insurance.

So we end up with about 5% which might theoretically be saved by the welfare plan provided consulting and actuarial services are free. These are not free and some consideration must be given to their quality when they are cheap.

For example, on a case of about 3,000 lives, a consultant offered to put in self-insurance for a fee of \$3,000 per year plus 90¢ per member, or about \$5,700 per year. This is about 1.6% of the premium. The insurance company's retention on this case is 8.6% so the saving on this case, which is relatively small, would be 7%, assuming it could operate on a self-insured basis. The actual experience is that after four years of operating in the black the year ending June 1, 1957 showed a deficit of \$14,500 which is about 4% of premiums. I would not pick this case of about 3,000 lives as large enough to avoid periodic fluctuations although actuarially the medical insurance should average out. The medical claims exceeded premiums by over \$23,000 or about 8%.

I would like to give two other examples of very large cases. One welfare case which we recently lost to another company, at a rate which may well be less than claims alone, had over 30,000 workers involved and perhaps 100,000 persons covered, including dependents. In one year the loss ratio increased 15%.

In another case, which is not a welfare fund, with over 20,000 persons involved the hospital and UCD in employees increased 40% in one year and the hospital on dependents, together with X-ray and medical on employees, increased well over 10%.

Now the average increase has been under 5% and one would suppose that with such large numbers we would be safe from violent increases due to the law of averages.

I wonder how many consultants would recommend setting up the necessary contingency reserves to provide against these unforeseen fluctuations where the trustees were insisting on the highest possible benefits for the dollars contributed by the employers.

Remember the insurance company must back up its actuarial forecasts by

hard money. I can't imagine the trustees going back to the consultant and asking him to share the embarrassment resulting from unforeseen developments.

It is true that many consultants are extremely conservative and would recommend low benefits until one-half year's cost was in reserve. However, that means that the employee would receive 5% less benefit for ten years just to create a reserve. By then his family is grown and he does not need the protection so much. Here I think we enter the realm of real insurance. Should large welfare funds withhold benefits today so the next generation shall profit, or shall they get all they can for the premium dollar with an insurance company taking the risk?

I have another argument for insured plans which I don't believe in myself and that is using the insurance company as a subsidy. The other day we lost a medium size case due to another company bidding well below our average claim cost for the past several years. Certainly for at least one year that trust has a bargain and if insurance companies can be found that wish to give their surplus away it would be foolish to contemplate self-insurance. Frankly, I am ashamed of any business which openly operates at a loss. I think you folks in labor will agree with me that such a situation cannot improve the position of the worker. I would like to pay you folks this tribute -- you have never as a group suggested that you did not feel that the "laborer was worth his hire."

Now I would like to examine this savings which "in the theoretical vacuum" can save 5% in cost to a welfare fund. The major part of this goes to taxes. We have in nearly all states a premium tax which goes into the general fund. Now suppose we knock ten million dollars out of the income of the State of California. What will happen? None of you imagine for a moment that California is going to reduce its state expenditures ten million dollars. It means a cigarette tax or a liquor tax or some other tax that will be paid by your members. This tax will be increased by federal and state income tax, since, I assume, you Union representatives will add the savings on welfare funds to wages which are taxable.

On medical care costs, we insurance companies now pay over 1% to Uncle Sam. The federal budget will not be reduced because a self-insured plan avoids federal income tax by going self-insured. The public will pay and organized labor and their dependents are a very large section of the public.

I have said nothing about pension plans. In this area the consultant and bank trust departments have represented up to 40% savings on self-insured plans as compared with insured plans. Again the bulk of any saving which is closer to 12% numerically than 40% is largely due to federal income taxes and premium taxes. Incidentally, federal income tax on insured pensions is based on the interest rate of the carrier and amounts to about $\frac{1}{4}$ of 1% interest. Even this saving is in the "vacuum" as I know of a recent case where a large corporation changed from an insured plan to a bank trustee self-administered plan to find that the interest earned on funds in the trust was less than had been

credited by the insurer after paying its income tax. At the moment the interest market is favorable to self-insured pension plans but will it always be favorable? Also, who picks up the check if longevity of older people is increased? You all know the strides made in medical science in the last ten years. An additional two years in average longevity will have a most adverse effect on non-insured pension plans.

Should the worker carry this risk or should it be passed along to an insurance company?

Frankly, I think the argument for self-insurance is much less effective today than it was five years ago. There are several reasons for this:

- 1) Competition between carriers is much more active -- many carriers will quote at little or no profit.
- 2) Most of the large group writing companies can give the finest service that can be obtained at as low a price as it can be given.
- 3) We are past the stage of experimentation. We know pretty well what the factors behind welfare costs are.
- 4) We have learned by bitter experience that the largest cases do not have a smooth level claim experience. There is a substantial risk in all of them which must be borne either by the insured individual or by an insurance company. Why carry your own risk if you can have insurance?
- 5) When we depend on tax saving for welfare plan economies, why not put them all into Blue Cross and Blue Shield who pay no taxes? Yet commercial carriers have competed with Blue Cross and Blue Shield over the years, each type of carrier contributing to the social benefit and welfare of the public.

I have said nothing about possible epidemics and catastrophic losses. We have not had any for a long time but they may occur. My own company has put every dime earned on hospital and loss-of-time group insurance into an assigned surplus account as a hedge against the day when we will have something happen.

I would like to say a word about what will happen if, God forbid, we should have a depression and unemployment.

- 1) In 1944 when peace was declared in Europe we were on the risk on the California Ship Building Company at San Pedro. The day after the shipbuilding contracts were canceled there was a line three blocks long in front of our claim window. A reserve of \$35,000 was put out in claims in a few weeks' time.
- 2) A few years ago when Kaiser went out of the automobile business, Continental Motors, which had furnished the engines, had to

lay off a large proportion of employees. Loss-of-time and hospital claims rose about 50% immediately.

So, any of you who decide on self-insurance, be sure that you accumulate substantial contingency reserves before you go on a pay-as-you-go basis. And, remember that the reserves you are building up will come out of the benefits paid to present claimants. Also remember that tax saving is a fallacy unless the state and federal budgets can be reduced.

MARINE COOKS & STEWARDS - PACIFIC MARITIME ASSOCIATION
PLAN FOR DIRECT PAYMENT OF WELFARE BENEFITS

by

George Elner, Administrator
MCS-AFL-PMA Security Funds

As a representative of the Marine Cooks & Stewards - Pacific Maritime Association Security Funds, I am not going to argue the advantages or disadvantages of "self-insured vs. insurance" programs in connection with health and welfare benefit payments. In the first place, I am not an expert on insurance and, secondly, we do not use the term "insurance" in connection with our direct payment of benefits. We do not believe that it is insurance in any sense of the word.

I would like to give you an example of what a comparatively small union (8,000 members) has done in a short time towards reducing the cost of providing health and welfare benefits.

The Marine Cooks & Stewards have a negotiated welfare plan agreement with a multi-employer group, the Pacific Maritime Association. It is administered by a board of trustees (two union and two employer) who hire an administrator. The name of the organization paying benefits is Stewards Security, Incorporated. The Fund is financed by a 75¢ per man-day employer contribution, plus a 1% employee contribution made by employees of non-California companies.

History and Development of the Fund

In the latter part of 1950 a welfare agreement was set up for the Stewards' department on the Pacific Coast between the employers and the now defunct National Union of Marine Cooks and Stewards. This agreement provided for limited benefits which were all insured. In 1952 the original insurance carrier dropped the account because of poor experience. The Fund acquired a new insurance carrier who had the account for four years. On February 1, 1956, a change by way of a new union, the Marine Cooks and Stewards Union-AFL, came about with new trustees. The new trustees took a look at what they had inherited. Insurance bids were acquired from four insurance companies. All four bids were lower in all respects than the existing contract. After some calculation, based on records of four years' previous experience, the trustees decided to reject all bids and cancelled the existing insurance contract. Since that time, we have continued to pay substantially the same benefits, with the same eligibility rules for benefits, directly out of the Fund Account.

Benefits Available

The benefits include:

1. Survivor's Benefit of \$2500 payable direct to the designated beneficiary.
2. Disability Benefit, or time loss, which matches the California Disability Insurance for members employed by out-of-state companies.
3. Hospital Comfort benefit of \$1 per day for in-patients.
4. Medical and Hospital Care for wives and children which includes \$14 per day hospital room and board, hospital extras up to \$300, a \$400 surgical schedule, doctors' office visits after the first call \$4, home and hospital doctors' visits \$5, diagnostic laboratory and x-ray benefit \$50, \$300 supplementary accident benefit, and a maternity benefit of \$240.
5. A plan to provide medical care for members receiving pensions which is a guarantee of \$1000 per fiscal year per pensioner for any type of medical care, provided the charge is approved by a "port physician".

Advantages of Direct Payment

After a little over a year's experience under the Direct Payment Plan, we feel that we have accomplished the following:

1. We have saved at least \$40,000 which was formerly paid to the insurance carrier in the form of retention, commissions, and loss of interest on funds held by the insurance company.
2. Our administrative cost has not increased over what it was under the "insured program". We are still administering the Fund at less than 4.5% of income. This represents the total administrative cost for the Security Program, the Pension Fund, the pooled Vacation Fund, and the keeping of financial and student records for the training school.
3. We are also able to give personal service to members by assisting them in making application for claims and other related matters. Claims are paid immediately.
4. The Union has gained additional prestige because of the fact that the benefits are paid direct and do not flow through a middle-man.
5. The trustees have gained flexibility in the sense that they can change the type of benefits quickly to suit the needs of the members, and increase or decrease benefits as funds are made available.

6. Over 95¢ of each contribution dollar is returned to the members in the form of benefits or placed in reserve for future benefits.

Conditions Necessary to Success

We feel that this direct payment plan would not have been successful without the following conditions.

1. Sufficient funds to establish reserves for possible catastrophic losses.
2. The establishment of firm rules of eligibility and benefit schedules and sticking to them.
3. Keeping the members informed by publishing a yearly audit and, also, monthly reports.

Conclusion

We feel that the direct payment benefits under the above conditions have been successful with the Marine Cooks & Stewards. Although it may be a selfish approach, it has worked for us. Such questions as the quality of medical care and the high cost of hospital care are matters that can only be resolved by the organized cooperation of many welfare funds. The Marine Cooks & Stewards Security Funds are willing and anxious to cooperate in any practical way to assist in improving the quality of medical care and reducing the cost of hospital care.

HOW TO IMPROVE VALUES AND REDUCE COSTS IN HEALTH AND WELFARE PROGRAMS

By

Carroll Lynch
Health and Pension Fund Consultant
San Francisco

We are all familiar from reading our newspapers and listening to our radios and television sets that the latest theatrical production put on by our legislative bodies and augmented by press might be called the "Health and Welfare Follies." While it is true that many unsavory activities have been uncovered, it is also true that the emphasis has been placed on the relatively few programs conducted in a corrupt manner and that little or nothing has been said about the funds handled by people of the highest integrity. This emphasis on the corrupt and lack of emphasis on the honest has led to a serious distortion on the part of readers and viewers. The plain fact is that much more is being wasted than is being stolen. The waste which occurs is usually the result of a misunderstanding as to what properly goes into a Health and Welfare Program and a failure to take steps to diagram the procedure so that the best possible result is obtained. I think it safe to say, that this is what happens frequently when programs are homemade rather than blueprinted in advance.

As you may have noticed, the subject of my paper today is "How to Improve Values and Reduce Costs in a Health and Welfare Program." This obviously requires an X-Ray look into what are satisfactory values and what are true costs. Each of these steps will be taken up in some detail. I hope the detail will not turn into a lullaby.

Each of us may expect that in the not too distant future public bodies will be looking at and reporting on the activities in the various health and welfare funds. Perhaps more important is our personal desire to fulfill our obligation to those who place their confidence in us. Since the monkey is on the back of all those connected with funds, perhaps it would be wise to find out how big a monkey and how we can kick him. Suppose we start with the basic concept of our obligation in health and welfare funds. I think it's generally agreed that the common objective of those responsible for the fund is to provide the employees covered with a maximum amount of protection and security that the money negotiated will purchase. Before this objective can be achieved, however, an understanding of the concept of cost in a welfare program is essential.

On an average basis the cost of the welfare program equals the amount of benefits paid plus the money required to deliver these benefits to the insured employees. Once a plan of insurance has been established, the amount that can be paid in benefits to the insured employee is fixed. The variable in the cost picture then is the money that will be required to deliver the benefits. Basically there are two opposite solutions to achieve the objective. (1) The benefit program can be provided through

the purchase of insurance contracts from insurance companies, non-profit hospital organization or non-profit surgical-medical organizations or a combination of one, two or three. (2) The benefit program can be self-insured, that is, benefit payments can be made directly from the assets of the health and welfare plan and there is no insurance carrier involved. The decision to insure or self-insure may have an important bearing on the ultimate cost of the plan. The ramifications of this very important subject, however, are discussed as you know in another paper at this conference. This paper, therefore, will consider only the cost aspects of the plan that is insured. Much of the following that you will hear is merely the ground plan without all of the details necessary to examine these problems and this is due to a shortage of time. If any of these fundamentals interest you, you will find a much more completely diagrammed study recently published by the Foundation on Employee Health Medical Care and Welfare Incorporated, a non-profit foundation sponsored and financed by the I.A.M. and U.S. Industries, Incorporated.

A few moments ago, we said that in order to evaluate costs we must determine what they are. There are in essence two kinds of costs. These costs are related to the premiums paid. First, there is a gross monthly premium, which is in most situations a deposit, and this is called the gross cost. The second and more important cost is the net cost. This net cost is the premium paid to the carrier, less claims, less any refund the carrier may make because of favorable claims experience. The amount of money which is retained by the carrier after all dividends and claims have been paid is the true cost of the program.

Several items go into the initial premium determination for the group. Some of these factors are (1) the scope of the benefits, (2) the sex of the employees (with an increasing number of women, more claims will be paid, and the rates must be higher), (3) the ages of employees; these determine the Life Insurance rate and may have an effect on the premium rate for the other coverages, (4) the number of employees who have dependents, (5) the size of the group (an insurance company may discount its initial rate for reasons of lower cost of handling plus the fact that mathematically, the loss ratio can be more accurately projected on large numbers than on small.)

In spite of studies made on these various factors, however, different insurance companies will quote different rates for the same plan of benefits on the same people. This is partly due to the insurance carriers' varying estimates of losses and cost and may be due to the rates which they have filed with the insurance commissioners of the various states. Here, of course, a word of caution. We are not talking about the kind of rating with a carrier which is substantially below all the other carriers' quoted rates. Let's check out what happens when the carrier is one whose practice is to quote very low initial rates in order to get the fund as a customer with the expectation that the trustees will pay for a substantial needed rate-raise at the end of the first or subsequent policy year in order to continue with the same program benefits. Obviously, if the trustees have decided on the benefit program because of the low cost of the special-low-rate-carrier and at the end of a given period this carrier

and others want more money for the same benefits, it is then incumbent upon the negotiating parties to come up with more money or to reduce the benefits -- not something calculated to make the fund popular with either the union or the employers.

Experience rating is applied in most group insurance contracts to the actual claims incurred by the group and the insurance company's expense charges chargeable to the group. If the claims and the insurance company expenses, known as retention, fall below the premiums paid for the year, the group experience is said to be "favorable" and the excess premium beyond the total of claims and retention is refunded in the form of a dividend or rate reduction. If the claims plus retention exceed the premiums paid to the insurance carrier, then the experience will be called unfavorable and the insurance company has incurred a deficit for the year. This deficit, however, will generally be carried forward to the experience of the subsequent years in which the insurance company will attempt to regain its loss. In some instances, funds have been able to get an insurance company to absorb all or part of these losses.

After the first year of experience, premium rates are also experience rated. The same two insurance companies who quoted widely divergent rates for the first year will now find their rate calculations somewhat closer together. This again points up the importance of the retention in terms of the true cost of the plan to the fund. With all of these factors to bear in mind, it is certainly obvious that the initial rate charge by the carrier is only one of the factors to be considered in the determination of which carrier shall be selected. The word retention comes constantly into any discussion of cost relating to these funds for the reason that it is one of the fundamental elements in determining the true cost of the insurance. The insurance company's retention means expense charges like (1) premium taxes, (2) administration costs, (3) claims handling and investigation expenses, (4) commissions and other acquisition expenses, (5) contingency reserves, (6) risk charge, and (7) profit. It is true that some of the items which go into retention are paid by the insurance company to the state and federal government as premium taxes and to others for commissions and miscellaneous expenses. But in any event, these dollars are not returned to the fund.

The item of claims reserves, too, is a basic concern of those purchasing or maintaining health and welfare funds. There is frequent confusion on the part of people dealing with the subject of reserves between the items of claims reserves and contingency reserves. Contingency reserves are those reserves set up by the insurance company out of its retention and are required to be maintained by law as part of the insurance company's overall company-wide reserves. We are talking about claims reserves which, if properly negotiated, are held to the credit of the policyholder. Fundamentally, these claims reserves are held for the purpose of paying obligations of the insurance carrier at the time that the policy is terminated. It is obvious that in the existing contract there will be unreported claims, claims in the process of settlement and claims which are already in existence under the contract, but unpaid. It's fundamental, but the Board of Trustees must contract with the insurance carrier for

the ownership of these reserves if they are unused following a limited period subsequent to the cancellation of the policy contract, otherwise, if there were excess reserves they would be retained by the insurance carrier rather than returned to the fund.

Now as to shopping for benefits: Needless to say, the scores of insurance carriers doing group business vary substantially in their practices. For example, their manual premium rates and methods of applying these rates differ. Generally, these rates are based on each company's own experience in the field and the thinking of their actuarial departments. Their actuarial departments are ultra-conservative and they don't bend the odds too far when they look at their own tote board. Therefore, over a period of years, a great variety of initial rates will be quoted for the same plan of benefits and the same set of employee data. It is interesting to note too, that actuaries have their favorite horses. Some of them, for example, like to ride a building trades program. Others will prefer a metal trades group. This in part explains why two carriers when asked to bid on subsequent cases of practically the same size and composition, will vary so considerably as not to look like the same bidder. In retentions too, we find great variance among insurance carriers. Even again, when we are talking about the same plan of benefits and the same group of employees, there are many reasons for this. Some carriers operate more efficiently than others and as a result, have lower administration cost chargeable to the policyholder. Some pay lower commissions. Some have higher profit margins. Some may have had such poor company-wide claims experience that they are attempting to recoup their losses from new groups. Some charge higher contingency reserves. The carriers' practices with respect to claims reserves vary too. Some companies are very conservative in their approach and throw an extra loading in their reserves, over and above the amount they have calculated will actually be needed for the outstanding claims liability. Others do not return unused claims reserves in the event a policy is terminated. These differences in practices with respect to rates, retentions and reserves highlight the need for proper competitive bid taking at the beginning of the fund's existence and through the years from time to time and a proper analysis of bids.

As we said, the need for competitive bidding has been highlighted by descriptions of the varying practices of insurance companies with respect to important items. This competitive bidding, when properly handled, will enable the buyer to determine and evaluate, (1) the initial premium cost of the bidding companies, (2) the retention charges of the companies, (3) the benefit provisions and limitations of the contract offered, (4) the claims reserve practice of the companies, and (5) the administration and claims facilities. Before taking these bids, however, the trustees must have a plan of benefits in mind to serve as a basis for the bidding procedure. This can be done best by having a competent analysis made of the approximate average initial rates that will be charged for various plans of benefits. On the basis of this analysis, the trustee should be able to adopt a tentative plan that will fit in with the fund's budget. The essence of the competitive bidding situation is the specification letter.

In order to make its best bid, an insurance company must have detailed knowledge of the plan of benefits and the group involved. And all of the companies bidding must have the same set of facts. This specification

letter should provide, among other things, a complete description of the size and character of the group, ages, number of females, number of employees with dependents, and so forth. It must detail the assumptions to be used by the insurance companies in estimating its expenses and retention. It must specify whether the accounting will be done on what is called a short-form method. It must specify whether a draft book system of claims handling will be used; it must tell the insurance carrier the insured claims to be assumed and many other things. Each of these is detailed so that an answer may be asked for and given by the carrier with respect to these.

You may be sure that unless an insurance company is asked for a detailed projection of its retention, you will never get it. Additionally, you will not receive a description of their formula used in determining the reserves for outstanding claims unless you ask. And certainly unless you ask the question you will not be answered as to the disposition of unused reserves. There will be a deep silence. These and many other searching questions are asked in the specification letter.

Next we come to the analysis of bids which is based on the bidding company's response to our specification letter. Naturally, these replies should be in the form of sealed bids with stamps indicating delivery to all parties concurrently. A deadline should be set so that there is no possibility that one carrier could have information about another's bid. The analysis of bids, while a very lengthy and precise kind of procedure, is essentially a comparison of the data furnished by the insurance companies. We have stressed the fact that net cost equals claims plus retentions, and, of course, if we assume the same benefit program, claims should be the same no matter what insurance company underwrites the program.

There are, however, other important considerations. The initial premium rate quoted by the company with the lowest retention may exceed the maximum the fund can afford to pay. Many such determinations will have to be made by the trustees on the basis of judgment, rather than arithmetic. In each case, however, the judgment decision will be based on available facts, rather than guesses, prejudices or whims. The discussion of retention in the analysis of bids is always significant because it brings up considerations, such as the interest earnings which may be available to the fund in the payment of a lower premium cost, as opposed to a higher premium cost with a lower net retention. Such things as reserve practices must be delineated in the analysis of bids as must be the ownership of claims reserves. It must be determined whether the estimated amount of claims reserves is excessive in the first instance. It's obvious that the company proposing to charge excess reserves is depriving the fund of the use of money which could be used either for interest earnings or for additional benefits.

The claims facilities should be carefully explored. The companies' experience in the field is an important one. The difference in the administrative services to be performed should be analyzed. Let's now talk about other cost factors. It may be advisable for the group, if it

is small, to combine with another group in order to obtain the benefits of lower costs. It's essential for the board to determine that commissions shall be kept at a minimum. The policies should be combined for commission purposes. The trustees must decide whether to use a self-accounting system, and a draft book system. These may result in greater service to the beneficiaries and result in dollar savings to the fund. If the trustees are thinking of changing carriers in an existing fund, this possibility should be weighed against the new acquisition expenses of a different insurance company, and the criticism of changing carriers. Of course, insurance carriers should never be changed without a new specification letter, new competitive bids and new analysis.

This brings the fund to the annual review of the health and welfare program. The annual review must summarize the benefits paid and the claims experience and the worthwhileness of the program. The annual review requires a detailed statement of experience of the insurance company, showing premiums, itemized retention, claims paid and reserves. The statements must be analyzed and compared with the figures compiled by the fund office, on premiums, on claims paid. The retentions and reserves must be reviewed in light of the insurance company's original proposals. An evaluation of the claims experience must be made to determine the propriety of the insurance company's rates. The annual review must contain an analysis of the fund's finances, the balance between the fund's income and expenses, the adequacy of the economic reserves of the fund, a projection as to whether there is adequate operating surplus for the purchase of new benefits, or possibly extension of eligibility. As part of the annual review, there must be an evaluation of the administrative procedures and the costs of these procedures.

The need for a meaningful printed annual report to members and contributing employers and other interested parties is becoming more and more apparent. Some of the health and welfare funds have been publishing these for a number of years and in recent months, the AFL-CIO code of ethical practices specified that such annual reports should be distributed to the members and the contributing employers. The purpose is to disclose fully to the interested parties, the status of the fund. Such an annual report should include a review of the benefits paid during the year, a detailed statement of income and expenses, and a statement of the financial status of the fund. There should, of course, be included a CPA's statement. The report should outline the changes that have occurred in the benefit program during the year and it should, of course, contain other meaningful data.

In summary then, we will improve value and reduce costs by understanding the elements which affect them. The fundamentals are the premium rates and the experience rating, (which applies both to the first year's experience of the fund in general and to the premium rates for subsequent years).

We talked about the retention of the companies. We talked about the importance of the disposition of claims reserves. In discussing differences among insurance companies, we found that even on the same benefit program,

insurance companies' rates vary, claims reserves practices vary and retentions vary. This highlighted the need for taking competitive bids. The analysis of bids traced all of the responses of the insurance companies to the searching questions asked in the specification letter itself. The specification letter asked the companies the things the trustees wanted to know about how the insurance company would handle the fund's money, what portion of it would be kept, how much would be set aside for claims reserves, who would own the claims reserves and other such information.

We saw the need for an annual review -- and the purpose of the printed annual report.

Throughout the procedures outlined, we have seen the need for judgment decisions on the part of the trustees. Fundamentally, these decisions are on a practical, down-to-earth basis. So, let's address ourselves to our decisions.

VALUES AND COSTS

John D. Thomas
Assistant Vice-President
Marsh and McLennan-Cosgrove and Company

The subject of this discussion this afternoon is "How to Increase Values and Reduce Costs of Health and Welfare Plans." This is certainly a noteworthy objective and it is one which conscientious trustees are constantly striving to accomplish.

We agree with everything that has been said this afternoon by Mr. Lynch; however, it seems to us that there are three principal areas which should be constantly watched in an effort to increase values and reduce the cost of any health and welfare plan.

The first of these is in the area of the Fund operation and its administrative procedures. Any savings that can be effected in Fund administrative costs will of necessity be small in relation to the total Fund income. However, if these administrative procedures can be streamlined, it is possible that 1% or more of the total contributions to any Fund can be saved and used for the purpose for which any program is established, that is, to provide benefits for the covered employees and their dependents.

We think that the trustees should periodically review eligibility requirements to be sure that they are workable and practical and do not require an excessive amount of record keeping. Claim handling procedures are also susceptible to streamlining and often times considerable savings can be made in this phase of plan operation. Some funds have the problem of collecting delinquent employer contributions and this often requires substantial expenditures of time and money. We have been experimenting in several cases with the use of a "Check-O-Matic" type system wherein the employer authorizes his bank to honor a pre-dated draft which he has given to the Fund administrator. It is too early to tell whether or not this will completely alleviate or solve collection problems in the instances where we have used it but it certainly has cut down on the number of delinquent employers. If you are having problems of this nature, we certainly commend this system to you for consideration.

The second major area in which Fund money is expended is in the dollars which are kept by your underwriting organization for its expenses, reserves, and profit. This applies equally whether it be an insurance company or service organization. As Mr. Lynch has pointed out, proper competitive bidding among companies, together with competent technical counsel and advice can very often reduce this cost of providing benefits by several cents out of every dollar collected by the trustees. Competitive conditions change and it is our recommendation that trustees periodically check through their consultant or broker to be sure that they are always receiving the lowest net cost available for the service that is being rendered to their Fund by an insurance company or service organization.

The third area in which values can be increased and costs can be cut is in the proper distribution and utilization of the benefit payments made by the welfare plan. While this offers the biggest potential savings, it is the area in which very little work has been done.

By this we do not mean that legitimate claims should be questioned or denied. Certainly the purpose for which any of these Funds is established is to provide benefits to the Fund beneficiaries and this objective should always be kept in mind. However, we have found that through periodic claim studies, we can determine exactly where the Fund's claim dollars are going, and whether or not these dollars are being utilized to the best advantage. Often times these studies are very revealing and only through the use of such a study do the trustees realize the benefits which the plan is providing. In some instances we have found that an undue proportion of benefits are being paid to certain suppliers of medical care. We have found that it is necessary to carry on a constant educational program both among the Fund beneficiaries and among the hospitals and doctors to be sure that proper value is being received for the monies expended. The medical associations have expressed a desire to cooperate in these educational programs and we have found that a lot of good results are obtained if the proper relationship can be established with the doctors and the medical societies. There is still a lot of work to be done in this field, however, and it will only be through a constant intelligent active approach on the part of welfare fund trustees, consultants and brokers, and the medical profession that the problems inherent in voluntary health programs can be overcome.

Most workers and their families are now covered by welfare plans and the trustees of the vast majority of these programs have done an honest, conscientious job in providing benefits. Thus, if we are to increase the value and reduce the cost of our welfare programs, we must all continuously work to provide a better utilization of the benefit dollars paid from such Funds.

THE PROBLEM OF SPIRALING COSTS IN WELFARE PLANS

by

Bernard B. Berkov
Pension and Welfare Plan Consultant

Some years ago, most labor leaders and many of us who were then concerned with the problems of distributing medical and hospital services were convinced that only a system of national health insurance would attain the objective. This objective, of course, was then, as it is now, to provide for everyone, irrespective of the size of his income, necessary medical and hospital care of a high quality.

As we now confront the situation in which union welfare funds find themselves and consider the total effects produced by the tremendous growth of these plans, we are tempted to feel again that an intelligently conceived system of national health insurance would have produced better and more lasting results. I realize that labor has never really abandoned its advocacy of national health insurance. I also realize that in the present political climate the possibility of such legislation is very remote.

I do not want to minimize the great importance of the development of techniques and methods in recent years. Many millions of workers and their dependents are protected by plans which provide medical care benefits which they did not previously have. Very serious problems, however, have developed concurrently.

We have had some excellent discussion here, today, by various speakers in connection with the panel subject "How to Increase Value and Reduce Costs in Health and Welfare Plans." I am very skeptical, under the conditions which exist presently, of the possibility of producing the results implied in this title. Previous speakers have described ably how plans should be put out to bid, how extraneous or excessive insurance company costs may be reduced, how commissions should be kept in line and how to develop more efficient methods of administration. We have also heard a thorough discussion of the factors involved in insured versus self-insured plans and the possible savings that might be effected by the choice of one method or the other.

I am certainly in accord with all of the suggestions for a business-like, diligent administration of these plans. I am afraid, however, that at this particular time most of the remedies proposed are approximately as effective as attacking a forest fire with a water pistol.

We have heard how savings in the neighborhood of 3%, 4% or 5% in overall costs might be achieved. We have, however, sitting in this room, trustees of welfare plans which have had loss ratios as high as 200%, and are faced with potential rate increases of similar magnitude. These plans cannot be rescued by relatively minor adjustments in insurance company retentions or by small administrative cost savings.

The single most important factor in our present dilemma has not been touched upon. I refer to the problem of inflation. We are faced with an extremely sharp increase in the cost of hospital and medical care services. We cannot expect, in the face of a creeping, continuous increase in the costs of everything else, that costs of medical care should remain stationary. The physician has the same kind of pressure on him to increase his personal income which exists for everyone else. Hospitals, too, must pay more for the services and materials which they purchase. The important point here, however, is that the inflation of medical and hospital costs has increased at a much greater rate, in recent years, than is the case with other costs. According to publications of the American Hospital Association, hospital room and board rates have approximately doubled in many areas in the past nine years. Hospital miscellaneous costs have increased even more sharply. Physician's and surgeon's fees and drug costs have also advanced steadily, though perhaps not as sharply as hospital rates.

The very welfare plans, which labor has fought so hard to achieve, have been in part responsible for this increased cost. By producing a pool of many millions of dollars not previously available for medical care, these plans have helped create an inflationary pressure and thus in part defeated their own purposes.

This is certainly not the fault of labor unions which fought so hard to provide their members with these benefits. Labor is not in the position to control the prices of the services and materials which it needs.

Many labor unions are caught, today, in an impossible position between the increasing costs of their welfare plans and the need to maintain, in their collective bargaining agreements, a proper relationship between the so-called fringe benefits and the all-important wage scales. The answer does not lie in negotiating more and more money which, in turn, is rapidly absorbed by hospitals and doctors.

Labor must increasingly seek other methods of providing medical care for its members. Voluntary service plans should be expanded and greater use of these plans should be made. Above all, labor should turn in the direction of creating its own medical centers and hospitals. As you know, this development has already taken place in many communities in this country. Through such labor health centers it is possible to provide good quality medical care in a

controlled cost situation. As yet, however, only a very small number of workers' families are covered by these centers. Some of the many millions of dollars, which welfare plans have to a large extent dissipated in inflated costs, could have been used to bring into being permanent facilities. These centers would be additions of real importance to the communities in which they are constructed. Properly organized medical centers could continue to provide care even during periods of economic depression and unemployment. Furthermore, and perhaps most important, such centers and voluntary service plans can do much to assure good quality care. The expenditure of millions of dollars in today's typical insured plan, with its fee-for-service, solo practice aspects, does nothing to create new medical and hospital facilities and certainly provides no control over either the costs or the quality of the services which the worker and his family receive.

REMARKS ON EFFECTIVE ADMINISTRATIVE PROCEDURES

by

Daniel W. Johnston
Economic Counsel for Labor Unions

It is a real pleasure for me to have the opportunity of discussing administrative procedures with you. I would like to discuss the administrative procedures from the point of view of Trustee procedures, which include the rules of procedures and administrative principles adopted by trustees. Unions, employers and trustees have for some time been considering certain principles or codes of procedural conduct on the establishment and control of health and welfare trust monies. Negotiated health and welfare trust agreements provide that the trustees are responsible for the administration of the trust and plan. There are various aspects to such administration, and, on each aspect, trustees have in various cases considered certain effective procedures which make for more efficient trustee administration. We might first consider effective procedures which trustees have found in controlling all of the trust fund money. Joint control by the employer and union trustees is imperative, and trustees have found that they must avoid assigning the control of any funds to any one trustee or administrator or agent so that at all times all of the trustees know of expenditures and the purposes for such expenditures and have prior knowledge and have given prior approval to such expenditures. In many cases, trustees have relied upon the trust department of institutions rather than upon individuals in the control of the funds and handle the trust fund as a custodianship through the bank.

In this connection, we might mention the principles embodied in the new California Health and Welfare Program Supervision Act. This Act places the supervision of negotiated health and welfare plans under the State Insurance Commissioner and requires full reporting of all income to the trust and of all expenditures.

Trustee administration includes the responsibility for all monies in connection with the trust fund, which includes consideration of retention agreements, commissions and policy refunds based upon experience, and also includes a full knowledge and control over investments of reserves and the establishment of reserves. We believe it to be an equal obligation on the part of trustee administration to ensure through the member beneficiaries that all monies are directed toward maximum benefits for the members. This includes consideration and direction of insurance carrier retentions, administrative costs and commissions. As you may know, the National Association of

Insurance Commissioners has issued a preliminary draft of a Code of Ethical Practices with respect to the insuring of the benefits of the union or union-management welfare and pension funds. While we are not in accord with all of the details of the recommendation, we would like to point out that this is the first national approach to an official code of ethical practices for insurance carriers. The recommended Code includes recommendations on standard commissions, retentions and full reporting to the trustees by the insurance carriers, including a detailed breakdown of retention agreements and retention monies. I might point out for your consideration that suggestions in connection with this preliminary draft can be made any time prior to the intended final consideration in December of this year.

The question has often been raised as to whether or not the trustees are responsible for employer contributions to a trust or whether their responsibility commences at the time the money is received by the trust fund. It is our thinking that the trustees have the responsibility for all monies owed to the trust and that to overlook the rigid enforcement of collections to the trust would in effect be a gift of trust fund money to employers who failed to contribute as required by the contract. I believe that the trustees have the obligation to enforce collection procedures or to make certain that collection procedures are enforced by the parties to the collective bargaining contract. There are three general methods of enforcing payments to the trust, namely: union action under the collective bargaining agreement, or referral to the State Labor Commissioner, or legal action by the attorneys for the trust fund. We do not believe that the new provision in the State Labor Code is designed to make a bill collector out of the State Labor Commissioner's office and that the Labor Commissioner's office should be used with discretion and not as a blanket referral of all delinquent accounts. While the trustees have the primary obligation to see that payments are made, in many cases the union party to the contract enforces agreements through collective bargaining. However, the final obligation is that of the trustees, and many trustees have found it desirable to utilize the legal procedures under the trust agreement and legal action through the trust attorney in collecting those accounts which are not otherwise collected by the union under its collective bargaining agreement.

We assume that the administrative details in connection with the administration of a jointly negotiated health and welfare fund are at all times the responsibility of the trustees and any delegation of administrative duties should not also delegate the responsibility or authority of the trustees. We also assume that the objective of a joint employer-union trust agreement is to give the maximum protection to the members of the fund and to operate the trust fund to give the best possible service to the members. In connection with these assumptions, we would like to make the following comments. If the above objective be correct, then we believe

that the administration should not be delegated to the insurance carrier because the trustees and their administrative employees or agents should at all times be looking for new developments in the field and should act as the representative of the members to obtain maximum benefits under the policy. In most cases, the trustees are representing the members of the fund in consideration of medical costs and fees charged over and above the benefits of the insurance policy. Consequently, we do not believe that the trustees can complete the administrative responsibility if such be delegated on a so-called frozen basis to the insurance carrier.

There is also considerable discussion concerning the role of salaried or agent administrators and the relative values of each. A determination of trustees as to whether to have a salaried administrator or agent administrator depends in part on the size of the trust and the number of members. We believe that the agent administrators should be on the same basis as a salaried administrator and should at all times be responsible to the trustees without any separate rights or authority from those administrative duties as delegated by the trustees. Consequently, we have seen certain problems arising in the field from administrative contracts with agents setting up separate rights and authorities under such a contract. We do not believe that the agent administrator should have any guarantee of employment or income over and above what a salaried full-time administrator would have. In those trusts where the salaried or agent administrator works at the will of the trustees in the absence of a long-term contract, it has been our experience that the administration has been smoother and has carried out the intentions of the trustees more satisfactorily than separate agent administration under a contract.

The negotiated health and welfare trust and plan is a new phase of labor relations and carries many problems and many considerations for the future. Administering an insurance policy is not the end of the job. There is need for consideration of procedures for providing service to the members in connection with medical fees over and above the benefits of the policy and many other aspects of medical care for trustees' consideration in the future. We are in what could be called a first phase of negotiated medical care and, as a result, trustees look to the first available type of medical care, which, in most cases, is the reimbursement approach through an insurance policy. The growth and development of the field of negotiated health and welfare trusts will depend a great deal on the adoption of efficient administrative procedures and responsibilities which will allow for changes and improvements in this new field of medical care, which at all times will look toward providing the best available medical care for the members of the plan.

THE CEMENT MASONS' FUND

by

B. Y. Baker, Administrator
Cement Masons' Health and Welfare Trust
Fund for Northern California

Every Fund has two prime interests which are shared by field and administrative office. One is income. The other is benefits. Both present knotty problems.

Let us discuss benefits first because, although it is important, income is only the means to an end. The justification for a Fund's existence lies in the benefits afforded to participating employees.

Given income sufficient to meet the schedule of protection, what is so administratively difficult about paying the benefits? The employee files a claim and the Fund office sends him his check -- or so one might think. However, it is not as simple as that. There are dozens of hazards along the route to reimbursement.

Let's face it: the average employee is not concerned about health and welfare until he himself or some member of his family has a disability. Perhaps he hasn't attended a Union meeting in years; he may have tossed away the last insurance booklet sent him. From either of these sources he might have obtained some preparation for the time when illness struck. But he didn't and now, poorly grounded in what is required, he submits his claim to the Fund.

Our claim form, we think, is simple. We revised it a few months ago to make it even simpler. Results? Well, we have about 2,250 insured employees, plus their dependents, on our rolls; we process an average of 300 completed claims a month. And yet, most of the time, we will have 100 claims pending in our files -- claims which are held up because something vital is lacking. For example:

The employee hasn't signed the claim form; the employee's wife has signed the claim form; the employee has sent in the form without first securing the doctor's certification; the form arrives with the doctor's portion complete and the employee's section a blank; we need the doctor's detailed bill, and have only a statement; there is a conflict in diagnosis ... to cite a case from our files, the doctor says the man is suffering from an anxiety neurosis, and the employee states he had a common cold. And so on.

We want to pay the money and we can't. Frequently, the employee himself is not at fault. The hospital will report that an assignment

was taken, but no assignment is attached. Or the hospital, on an assignment, accepts the signature of a dependent when only the signature of the insured employee is valid.

Doctors, too, bear some responsibility for delays in payment. Weeks may elapse between the time the employee drops off his claim form with the doctor's nurse or secretary, and the day she completes it for the doctor's signature. I'm sure that with so many insurance companies in the health and welfare field, each with its own type of claim form, doctors would welcome a uniform claim blank. This might speed up handling.

So much for the administrative problem as regards benefits. What to do about it?

Speaking for our Fund, we try to educate and inform along with processing claims. For instance, in all but the simplest of cases, we send a memorandum describing exactly how the claim has been paid. We break down the hospital bill; we note how many doctor's calls were reimbursed and why some weren't; we show the amount allocated for diagnostic benefits; we try, in general, to make clear just how the employee stands money-wise on total bills and Fund compensation of those bills.

All this is time-consuming but we think it worthwhile. The time we spend on explanation may come back to us later when the employee files another claim and, on this occasion, has a better understanding of our operations. At the least, we hope he won't forget to sign the claim form.

We do other things, too, to keep employees happy. Ours is a small Fund and we have a good many visitors dropping in to pick up claim forms or to discuss their physical troubles. We're always glad to see them. They're welcome. In fact, I would say that any person working in the health and welfare field who doesn't have a little of the "do gooder" in him is pretty well out of place.

Also, we make a special effort to pay off fast. Nothing is more discouraging to a claimant than to have to wait an undue length of time for reimbursement.

Finally, we keep a complete statistical record of each claim, and if payment seems below what we had anticipated we have no hesitation about arguing the matter with the insurance company. Claims can be complicated; we endeavor to get the maximum payment under our policy.

Inevitably, of course, there will be claimants who are dissatisfied with their checks. Again, this is because of lack of information about the Fund, and what it provides in benefits. And, again, we try to educate.

Individual instruction is a slow process, however. So we encourage

the interest of the Union locals in all phases of the Fund's operation. Our chief group contact with the business representatives occurs monthly when we dispatch a letter which may deal with some special aspect of benefits, or with non-reporting employers. We hope that the information imparted through these letters will in turn be passed on to the members. In our opinion, there should be the closest possible identity of interest between field and Fund.

Next, let us consider the second major problem common to most Funds -- that of the delinquent employer. In 1955 our auditors found that 5.65% of the employers whose books were examined had under-reported to the Fund. This percentage has improved somewhat since that time.

When an employer fails to report altogether, or fully, there are two losses: 1) in income to the Fund, out of which better benefits could be purchased; 2) to the employee who depends on reported hours for eligibility.

Our Fund follows two procedures in detecting the employer who has under-reported his employees. In the first place, we are averse to denying a claim out of hand simply because the employee appears not to have sufficient hours for eligibility. Our rejection of a claim on such grounds is only tentative. We invite the employee to tell us if he has worked a greater number of hours than those we have on record and, this being the case, to furnish us a list of his employers. In this way we can pinpoint the forgetful contractor and write to him. Rarely do we fail to get favorable results.

Secondly, at the turn of our eligibility period, we send to the Union locals a breakdown of the total hours reported for each of their members. Often the business agent can tell at a glance which of his members have not been fully reported. Some Funds, I know, mail to all employees an individual notice of the hours reported on their behalf. We think well of this system but when we tried it the novelty of the idea soon wore off; too many employees were content merely to note they had enough hours to qualify. We find the business agent and secretary more reliable sources of information in turning up under-reporters.

But what of the employer who does not or will not report at all? It is he who presents the nagging and always current delinquency problem. Our Fund has 1,250 employer accounts and our delinquents, old and new each month, run approximately 4%, or about 50 out of the 1,250. This may not seem like many, but I can assure you it is plenty; however, it is better than the 300 delinquents we were carrying two years ago.

Like other Funds, we send these employers delinquency notices when they fail to report on the due date. We write them personal letters. We telephone. Each month, and twice within the space of two weeks, we inform the Union locals of the non-reporters: first, by a break-

down of the delinquents in their particular areas; and again, two weeks later, by a master list which enables them to check the success of their attempts to bring the non-reporters into line. Why do we go to the Union locals with this data? Because this is their problem as well as ours, and a responsibility they accept. So, depending on the circumstances, they contact the delinquent employer in person, phone him, adopt such measures as may be summed up under that innocent phrase, "economic action." Or they may cite the employer before the Building Trades Council.

But quite often the problem comes back to the Fund office. For one reason or another the Union local has been unable to secure the compliance of the employer.

When field remedies fail, and other administrative efforts have been exhausted, our Fund has recourse to the Labor Commissioner. In the past fifteen months we have filed 57 complaints with this state office, and in most cases have obtained relief. Labor Commissioner hearings are time-consuming; sometimes there are two or three rehearings, or an appeal to the District Attorney's Office. For all of that we consider them eminently rewarding. Furthermore, we are grateful to the Labor Commissioner for help so many times given.

Delinquency is a continuous problem. Bring one account up to date and another goes in arrears. Delinquency must be attacked vigorously and all the time; otherwise a Fund's delinquency list will snowball and it will soon find itself buried in an avalanche of frozen accounts.

My personal opinion is that one little picket is better than a dozen delinquency notices and personal letters. One little job action, properly executed, will get results in hours whereas other measures may require weeks. But, as I have said, circumstances will dictate which method should be adopted. The prime essential is complete cooperation between field and Fund.

EFFECTIVE ADMINISTRATIVE PROCEDURES

by

C. Bruce Sutherland

Administrator

Carpenters' Health and Welfare Trust Fund for California

The term "Effective Administrative Procedures" should not be limited in concept to the physical and internal procedures of the administrator as such, but should rather include the proper functions of the trustees (both labor and management), the consultant, legal counsel and the administrator. Even the concerted action of all of the above parties will not give to a Health and Welfare Fund effective results without the complete cooperation of the various local unions and district councils covered by the plan as well as the cooperation of the various employer associations subject to the plan. In fact, effective administrative procedure is the end result of the diligent, honest and willing cooperation of all of the parties involved.

It has been said that the continuing actions and decisions of the trustees is the essential element in effective administrative procedures. While I agree, in principle, that the responsibility of the trustees cannot, or at least should not be delegated, I disagree with the premise that a trustee of a Health and Welfare plan should be expected to be all things at all times. Unless the trustees see fit to act in their capacity on an almost full-time basis they will be forced to delegate authority to responsible and trained personnel of their own choosing. The cold hard fact is that the great majority of the trustees are men with positions already demanding great time and effort. In addition to the above, it is, I believe, axiomatic that regardless of the background of the various trustees, competent and specialized advice is essential. Effective administrative procedures will not be forthcoming without the advice of competent insurance consultants familiar with all phases of group insurance operations. It is equally necessary that competent legal counsel be retained to advise the trustees on all legal ramifications of the Trust Agreement and the operations thereof. Efficient internal operating procedures cannot be effected without competent administration fully aware of accounting, cost accounting, electronic computing, general procedures, etc.

As I have said before, a trustee or a group of trustees cannot be expected to be all things at all times.

The ultimate result of truly effective administrative procedures may be summed up by the term "Maximum Benefits at Minimum Costs." In order to achieve this end it is clearly the responsibility of the trustee (on the basis of specialized and professional advice) to

review, on a continuing basis, any and all charges made against the Fund in the course of its operation. Such decisions as: are the fees paid to insurance consultant and legal counsel realistic and in conformity with the services rendered?; are stated premium figures of the carriers realistic and competitive?; are retention figures realistic and in conformity with the existing contract with the carrier?; do year-end dividend figures correctly reflect the claims experience of the Fund?; are reserves adequate and realistic?; are of the utmost importance and must be looked upon as the constant responsibility of the trustee.

In order to insure "Maximum Benefits at Minimum Costs" the issue of compliance by the subject employer cannot be ignored. In some industries of a more stable nature (e.g., Maritime shipping) this may not constitute a major problem. In the construction industry, however, delinquencies constitute a major loss of revenue to the Fund unless properly controlled by the appropriate parties. It has been previously stated that the major responsibility for enforcing the Trust Agreement rests with the trustees. With this position, I find that I must also disagree. The Trust instrument was established by the Collective Bargaining Agreement. It is, in fact, the creature of the Collective Bargaining Agreement and it is, therefore, the responsibility of the collective bargaining agents (the various representatives of labor and the employer associations) to enforce compliance. From a practical standpoint the only recourse available to the trustees of the Fund in demanding compliance is through legal action either in the courts or through the offices of the Labor Commissioners.

Both of these procedures are costly and time consuming. The effective policing arm of labor can accomplish in a day what would require months through legal procedures.

What may be considered effective administrative procedure for one Health and Welfare Trust Fund cannot be necessarily considered proper procedure for a Fund of a different industry or different size. Each has different and unique problems. As an example, you will recall that the previous panelist indicated that his Fund faced a collection problem from 26 employers within his jurisdiction and that his delinquency situation was substantially less than 1%. In the case of the Carpenters Health and Welfare Trust Fund for California the mailing list of regularly liable employers exceeds 6,000. The effective delinquency situation approximates 7%. Policing this sort of a problem over a 100,000 square-mile area calls for procedures considerably different from the case mentioned previously.

All of the above problems, and their corresponding solutions, will be of no avail despite the diligence of trustees, consultant, legal counsel, administrator, labor and management without the further cooperation of the claimants and their families. It is the further responsibility of the trustees to properly disseminate information to the beneficiaries of the Trust so that they might be aware of their benefits and their individual responsibilities under the Trust.

"Effective Administrative Procedures" will be the ultimate result of the complete cooperation of all of the interested parties mentioned previously with the main objective in mind of affording "Maximum Benefits at Minimum Cost" to the beneficiaries of the Trust.

SUPPLEMENTAL BENEFITS IN HEALTH CARE

By

Helen Nelson
Division of Labor Statistics and Research
California Department of Industrial Relations

Good morning. I bring you greetings from Maury Gershenson, Chief of our Division, and the thanks of all the staff for your excellent cooperation in supplying us with copies of your contracts and your benefit plans and in responding each summer to our Organized Labor Questionnaire. We do sincerely appreciate your help.

In contrast to the speakers you have heard in the earlier days of this conference, I am not an expert on any particular phase of your health and welfare plans. I can address myself to you only as a sympathetic observer and recorder.

As most of you know, one of the many things our Division does is to measure and report the progress of labor unions in improving the standard of living of their members. It was natural, therefore, that we began to follow the development of negotiated health and welfare plans several years ago. As a matter of fact, we issued our first report on health and welfare provisions in California union contracts in 1950.

I shall try, in opening today's discussions on health care, to report back to you on some of the information you have supplied to our Division for analysis. Also, it has been pointed out to me that a disinterested observer, because he has a broader perspective than the participants, can at times make observations of value to the participants. In other words, the Conference staff said when they invited me, "Don't make it all statistical. Give us some of your observations." So in addition to reporting back to you, I shall also make some observations, and you may judge their value.

We have a whole room full of IBM machines in our office and have set up a procedure whereby we go through every contract as soon as we receive it and translate many of its provisions into signals the machines can digest. In 1950, we added a new notch to this system, so to speak, and whenever we received a contract which said that the parties agreed to initiate a health and welfare program, we fed a special code into the machine and it counted a new health and welfare plan. We have reported almost annually since that time the number of workers covered by contracts that include a health and welfare provision.

Now, we statisticians are sticklers about definitions, as I'm sure you are aware, and our Division takes great care to make its reports accurate and reliable, so we soon began to feel we ought to have some definition

of a health and welfare plan. We couldn't get much help in framing one. The phrase, health and welfare, combines two of our most attractive words, two of the warmest and most welcome words that might have been put in combination, and everybody else seemed to understand what they mean.

I must admit that in the course of inquiring we did encounter one cynical fellow who defined a health and welfare plan as something that makes you feel good because you've got it until you need to use it.

This year when we made our annual count of the number of workers in California under union contracts with health and welfare plans, we concluded that even though we might not be able to define what a health and welfare plan is, we should be able to identify what is not a health and welfare plan. So we decided that before we would count a contract as having a health and welfare plan, that plan must provide some medical care benefits. This tightened definition eliminated 56,000 union workers we had previously been counting as having a negotiated health and welfare plan. But more than a million remained: 1,158,000 California workers had some medical care benefits provided under the terms of their union contract in January of this year.

The employer contribution for these members varied from one-half a cent an hour to 15 cents. From this wide range in cost, it is certain that the benefits must vary a great deal. It must depend, then, pretty much on one's point of view which benefits are considered basic and which supplemental. Some people would consider all benefits except hospital and surgical as supplemental benefits. Others would mean those benefits provided directly by the trust fund that are in addition to and outside of the contract with the insurance carrier. I am certainly not going to attempt here to define or identify what specific benefits are supplemental. I am going to assume that this phrase, like health and welfare, has a connotation -- not a definition -- and that it means those benefits we don't now have but would like to have.

For most union workers in California this adds up to a long list of outpatient services. It means such common needs as dental care, eye care, all necessary visits to the doctor's office, regular physical examinations and other preventive services, drugs and medicine. It also means some in-hospital services -- special duty nursing, for example.

We are told by reliable sources that, throughout the nation, insurance is meeting only about one-fourth of our medical bills. The proportion is undoubtedly much higher for California's union members, but we all know that it's far from 100 per cent. Interest in supplemental benefits represents an effort to close that large gap. Even more important, I think, this interest arises from a knowledge gained from experience -- a knowledge of what your health care needs are and what services can be of most benefit to the members. This interest is heartening because it signifies that we are getting beyond that first heady stage of sudden success.

The entry of unions into the field of health and welfare plans is less than ten years old. You entered the field suddenly. During wage stabilization days, unions were encouraged by official public policy to ask for health and welfare benefits, and employers since 1949 have been required to bargain on your demands. It wasn't like the 8-hour day, the 40-hour week, and union security which were won only after decades of bitter struggle. By comparison, health and welfare came easy. It was felt to be good for the economy. It was good personnel policy. It looked attractive in the employer's "tax picture." It was almost a "come and get it" situation. It came upon the insurance companies suddenly too.

Generally speaking, up until ten years ago the principal experience the insurance companies had had with writing medical care insurance was in writing individual or family policies. From their experience in selling health insurance policies to individuals and individual families they knew, of course, that if they wrote a policy providing doctors' visits for treatment of arthritis or diabetes that individuals with arthritis or diabetes would buy the policy and that individuals without diabetes or arthritis would see no reason to. Since an insurance company is in business to stay in business, they wrote, instead, primarily hospital insurance surgical insurance because in their experience the possibility of hospitalization and surgery were more unpredictable so far as one individual was concerned and they were, therefore, "insurable." The hospitals had also established their prepaid hospitalization program under the banner of Blue Cross.

So it is perfectly understandable that hospital and surgical were about the only wares the sellers had on their medical insurance shelves when all of a sudden they had thousands of customers of group medical care insurance. Almost without exception, hospital and surgical were among the first benefits union members obtained under their negotiated health and welfare plans.

Now in California this circumstance had more complicated consequences than in most places. Insurance companies do business nationally, and California was almost unique at that moment in history because it had a State disability insurance program. Disability insurance provided the worker with a weekly check when he was unable to go to work because of illness or injury, and it also paid a daily hospital benefit when he was hospitalized.

Whenever I meet someone from another state labor department he almost invariably asks about the California State disability insurance program. He wants to know how we came to have it. And when I recount how it appears to me that we got it, he usually shakes his head sadly over the chances for one like it in his state and concludes that Californians are just lucky.

I tell him how, when California started its unemployment insurance program, it was thought wise to ask the employee to make a contribution, as well as the employer, in order that the workers would feel a responsibility

for the fund and would have a voice in its administration. This was different than in most states where only the employer contributed. But after the unemployment insurance program had operated a few years, opinion changed. During World War II, a period of high employment, legislation was introduced to eliminate the employee's contribution. The employer then would have a greater bargaining power, so to speak, in establishing the rules for payment of unemployment insurance. I explain that employers in California have a strong incentive to reduce withdrawals from the unemployment insurance fund because they are taxed for unemployment insurance on an experience rating basis.

"So," I continue, "legislation was introduced to eliminate the employee's contribution to unemployment insurance. Jack Shelley was in the State Legislature at that time. (Now he's a Congressman in Washington.) Jack Shelley came from the labor movement, and he knew that the law said that in order to get unemployment insurance a worker had to be ready to work, able to work, and available for work. He also knew that many workers at times were very willing to work but not ready and able because they were ill. He and Neil Haggerty and some of the other people who understood the situation recognized an opportunity for the workers to create their own insurance pool with their own money to provide themselves with some income when their wages stopped because they were ill and to pay some of the hospital bill when they were in the hospital. They succeeded in getting the legislature to pass legislation requiring the employer to continue to collect the contribution from his employees but to pay it into the workers' own fund. The law also requires that an employer must transmit the money to the State pooled fund and cannot make a contract with a private insurer without the consent of a majority of his employees." It is at this point in my account that the representative from the other state shakes his head sadly and says: "We'll never get anything that good."

Be that as it may -- when most of your trust funds bought their first health insurance, what was on the market and readily available was mostly hospital and surgical coverage. The trustees had money in their pockets and had been sent to the market to buy. California's State disability insurance program didn't help with the surgeon's bill and didn't cover the whole hospital bill. So the first items that went into the union health and welfare plans were hospital and surgical benefits. The policies being sold weren't readily adjustable to an unusual situation like California's and most often they went into effect without regard to and in addition to the benefits available from the State disability insurance fund. At the very beginning then, most trustees used some of their money to duplicate a type of coverage the members already had. In a very real sense the hospital benefit in union plans is truly a supplemental benefit, supplementing the basic hospital benefit almost every worker has under the disability insurance law.

We don't know what the current status is, but when we made our study, in 1954, of all the union health and welfare plans in northern California we found that 78 per cent of the workers under those plans had hospital

benefits from their union health and welfare plan separate and in addition to the hospital benefits under the California disability insurance law.

At least at that time, and probably still, most union members with health and welfare plans had two hospitalization policies: one, they pay for themselves under the State disability insurance law; and, one, their employer pays for under the union health and welfare plan. It would appear that hospital insurance is so basic a benefit that most of us want to buy it twice.

Yet, if hospital benefits are all the coverage a member has and he needs medical care, he'll go to the hospital to get it, if he can get in. Caught out in a storm, unprotected, a person will get under whatever shelter he can. As a result, the cost of many types of services that standard medical practice would consider as outpatient services is being paid by plans which pay no outpatient benefits. The patient checks into the hospital and receives the outpatient type of service as a hospital extra. The union plan and the State plan then each have a claim for hospital benefits and have provided -- but by very expensive indirection -- an outpatient benefit.

This problem is not confined to the union plans. I was riding in the bus from the Los Angeles Airport to the Biltmore recently and couldn't help overhearing a conversation between two men who, by their conversation, identified themselves as the sales manager and the advertising manager of some company. I heard the sales manager say to the advertising manager: "The doctor said if I didn't go to the hospital, I'd have to pay about \$35, but if I could spare the time to go to the hospital my insurance would cover it." So, says he, "I made an appointment and I took my brief case. They had a desk in the room, I worked all day and was interrupted only once. Some young intern came in and said: 'I see you're not going to miss a day's work' and I said: 'Not if I can help it.' As a matter of fact, I got more work done than if I had been at the office."

Listening to this conversation set me to thinking and to doing a little mental calculation.

There are $4\frac{1}{2}$ million persons drawing wages or salaries in California today and around 1,160,000 of them are under union negotiated health plans. That's only about 25 per cent. Moreover, there is little indication at present that this ratio will increase substantially, for employment in California is increasing at a faster rate than union membership.

Even this 25 per cent is a high figure from one point of view. The proportion of workers under jointly-administered plans is somewhat less. Some of the largest negotiated plans are administered solely by the employer. The plans which you, as union representatives, participate in administering probably do not cover much more than 20 per cent of all the California workers. This is only one in five, a definite minority.

Perhaps, then, the time has come for you to look up from your own plans and take a long look at the entire field of medical care programs. It might put your problems in better focus. For while you have been busy buying and administering your health and welfare programs, others have been busy too.

One of the newest developments is a health and welfare plan for the dependents of uniformed personnel in the Department of Defense. The Department of Defense is perhaps more management-minded than most governmental units, and they have recognized the value of providing good health and welfare benefits in recruiting and retaining employees. Beginning the first of this year, the Department of Defense began picking up the tab for the hospital and surgical bills of all the dependents of our men in uniform. In California, the surgeons submit their bills through the California Physicians Service to the Department of Defense according to an agreed-upon fee schedule and accept the fee as full payment for the service rendered. Hospital bills are channeled through Blue Cross. There are an estimated 240,000, that is almost a quarter of a million, persons in California covered under this one plan. Compare this with the largest one of your plans, which covers about 100,000.

We have another new government program scheduled to begin operating in October under which outpatient medical care benefits will be provided for persons receiving old-age assistance from the State, for children on aid to needy children, and the blind. Responsibility for the policies of this program rests with the State Social Welfare Board and the administration is now being worked out by the State Department of Social Welfare and the county welfare directors. There are approximately 470,000, or almost one-half a million, people in California who can soon begin receiving some outpatient medical care services under this program.

These two new programs will therefore cover almost 3/4 of a million persons. There is no count today of the number of plans you have established to cover your members and their dependents, but we believe an estimate of 500 different plans would be conservative.

Under the circumstances, it is almost inevitable that these two large new medical care programs will affect yours. The types of benefits they provide and the methods employed in providing them are bound to have some effect upon your plans. The first one can, in specific cases, duplicate some of your benefits. The second, the new program of medical care for public assistance recipients seems at firsthand little related to the union health and welfare plans. But it will surely seem ironic to you and also to your older members if, as you succeed in raising the income of your retired members so they do not have to be dependent on public welfare assistance, you also deprive them of outpatient medical care.

An even more important fact to consider about these two new programs is that practically all of the 700,000 beneficiaries are new and additional customers for the services of privately practicing physicians. The armed forces dependents were formerly receiving medical care at our military

installations and the public welfare recipients were, by and large, either receiving no medical care or were receiving free medical care. Thus in this current year by just two new plans there will be added 700,000 new customers for private medical care in California.

Let's try to take a quick and summary look at some of the other existing medical programs. The two we have discussed are paid for by the taxpayer, the so-called Medicare program for dependents of armed forces personnel and the medical care program for public welfare recipients. In addition to these, there are at least two other long-established tax-supported government programs -- Aid to Crippled Children, and Vocational Rehabilitation. Both of these programs procure medical care, physician's care and hospital services on a fee-for-service basis, operating under a fee schedule which is accepted as full payment.

Paid for by employers, we have two other major programs: Workmen's Compensation Insurance, which provides full medical care to workers injured on the job; and non-negotiated health and welfare programs. We don't know with certainty, but it is very likely that non-negotiated employer-financed plans figure larger in the California picture than negotiated ones.

Another source of support for medical care which has grown rapidly in the last ten years comes from the voluntary health agencies. Among these many agencies, there were six which each raised more than \$5 million last year. The National Foundation for Infantile Paralysis topped all the others by collecting more than \$52 million in voluntary contributions last year. Now with the Salk Vaccine available, and available where necessary at no cost, one would think that this \$52 million would go a long way toward caring for any future polio cases. Again, we don't know what the status is today (I assume it's much different now that the Salk Vaccine has been perfected), but in 1954 when we made our survey of the benefits provided by union plans in northern California, we found a majority of them, 57 per cent, were buying polio insurance.

Yet, with all these programs and all these institutional providers of medical care, we are told the individual is still paying most of his medical costs himself. When one of your members needs some specific care, depending on a complicated variety of circumstances, he may be eligible under one, two, even three different programs, or he may have to pay for it himself. And in many, many instances he's not sure beforehand which situation he is in. When you look at present day medical care this way, it begins to look like some of those games you play at Las Vegas. It's like a game of double or nothing, except that there are so many more combinations of chances.

To take one illustration -- A wife who is employed, and more than a third of them now are, could be eligible for hospital benefits under her own union plan. She most likely is also eligible as her husband's dependent from his plan. She is also eligible to file her claim for hospital benefits under the State Disability program. This makes three claims for hospital benefits. As for income protection while she's away from work, she may have paid sick leave provided under the terms of her union agreement.

Almost 1/3 of the union workers in California do. If she does, her employer will continue her salary during at least part of her illness. If she doesn't have sick leave, she will be eligible for the weekly disability cash benefit under the State disability insurance program. Thus in addition to some income maintenance, she can possibly be paid three different ways for hospitalization, and twice for surgery, if she has an appendectomy.

However, should she have arthritis and need physicians care, therapy treatments and cortisone, she may have to rely on Heaven for her protection just like the working girl of yore.

When you look at present-day medical care through this wheel of chance, you begin to wonder who, if anybody, is establishing the odds and who is running the house.

Perhaps it will be necessary to try to make some new rules of the game before you can add many new chances.

It was seller's market when union health plans began, and as the number of customers for medical care insurance increases it becomes more and more of a seller's market. Even when we add all your plans together -- and its only the statisticians who see any reason to consider your plans all together -- you are a minority of all the customers.

The field of health and welfare is a new one for you, but the role of spokesman and representative is a familiar one.

The interest I have seen at this conference confirms my belief that you will attack your problems in this field as you have in many others before. Look back on the development of your negotiations with management. In many situations where you first had no contract, and next individual contracts with each employer, today you have a master contract. Where once many locals each bargained separately with an employer association, today you conduct joint negotiations.

By comparison, your negotiations for health care are still in the stage of the open shop.

When you assumed responsibility for the conditions of employment of your members, you adopted a whole variety of approaches. Some matters you concluded were so basic for all workers that you joined in statewide political action and succeeded in enacting a law covering all workers. Some you concluded should be negotiated with employers -- on an area basis, an industry basis, or a local plant basis -- depending upon the circumstances.

To gain the best medical care for your members will require the same kind of probing analysis and decision on each type of health care. For example, I get the impression that there is much interest in providing medical care benefits for your retired members. If your efforts in other fields serve as a precedent you will sooner or later counsel among yourselves and

decide how organized labor can best do this over the long run. In each individual plan? By a joint retirement plan among all negotiated plans? By a statewide program for all workers? By adding medical care coverage to the National Security program? Or in still some other way?

I have noticed that any talk of "supplemental benefits" is usually in terms of specific health care -- dental care, physical examinations, eye glasses, for example. Is the increasing discussion of supplemental benefits the beginning of negotiating for health care?

As you come to formulating your demands in terms of health care, and negotiating in terms of health care, some new avenues of approach may be revealed.

If you think in terms of health care instead of money, you can perhaps more easily solve the expensive duplication of coverage that presently exists and convert the savings into more health services.

You can find more direct ways of providing outpatient benefits -- and these may reduce your hospital costs.

When you do negotiate on health care instead of cash payments for your members, you will know that it is not the insurance industry which provides health care. It is the medical profession, the dental profession, the hospitals, and all the ancillary medical care vendors -- who provide health care.

You will realize that your relations with these vendors of medical care are affected by the relationships established between them and other groups in the community. And you will find these other groups in the community have a common interest with you in developing relationships which can give your members more complete health care.

But it is in terms of health care and with the vendors of health care services that you must negotiate if your union health and welfare plans are to be negotiated health care plans.

It has been said here that the medical sciences have advanced more in the last 20 years than they did in the preceding 20 centuries. Your union plans have, on the average, been in existence only about five years. This is only the beginning. As you go on and succeed in working out means of providing your members with the health care services modern medicine now can render, your health and welfare plans will become increasingly worthy of the union label.

SUPPLEMENTAL BENEFITS UNDER THE LOS ANGELES
JOINT EXECUTIVE BOARD HEALTH AND WELFARE PROGRAM

By

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Los Angeles Joint Executive Board of Hotel and
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Los Angeles

I must speak from personal experience here and say that I regard medical care and hospitalization as the basic health and welfare services we provide for our members; any benefits beyond these probably fall into the category of "supplemental benefits." On this assumption, the following are the supplemental benefits we have deemed it of primary importance to negotiate and establish for our members in Los Angeles since the inception of our plan five years ago.

(1) Individual choice of plan. Each member of our Joint Board unions have an individual choice between a service-type plan provided by Kaiser Foundation (Permanente) which covers the member, spouse and dependent children, 19 years of age and under, with complete hospital and medical care in and out of the hospital, and an alternate type plant, for which we pay the same monthly premium, which is a reimbursement plan secured through an insurance company. This provides more limited benefits. The alternate or reimbursement type plan covers generally most of the hospital, doctor and surgical bills in the hospital of the member and his dependents.

The main shortcomings of the Alternate Plan in relation to the Kaiser Plan lies in its failure to provide any care for dependents outside of the hospital, except in cases of accident. Under our Plan each member has this choice of plan when he first becomes eligible and annually, all members are given an opportunity to vote on which plan they want for themselves and their families for the coming year.

It may be of interest to you to know that for the year 1956, 86 per cent of our members chose the Kaiser Foundation Plan as against 14 per cent choosing the Alternate Plan. The Alternate Plan, of course, provides free choice of doctors and theoretically, free choice of hospital but, as everyone knows, this is a fiction because the patient can only be treated in the hospital to which the doctor of his choice is certified. Generally this is confined to one or two hospitals.

(2) Our Los Angeles Hotel and Restaurant Employee Plan provides for complete dental care for our members and dependents including costly orthodontic care for dependent children. Early in our planning, we recognized that the dental health is an important part of general physical health and a serious financial exposure facing all members and should be

made available on an employer-paid pre-payment basis as part of our Health and Welfare Plan. Our dental facility has been in operation for three years and has been an outstanding success. Recently Dr. Abbott Kaplan of the Extension University at UCLA was commissioned to supervise an audit of the quality of professional services rendered, and retained for these purposes the services of three outstanding men in the dental profession, both locally and out of state. Tests and checks were made under scientific random sample conditions which reflected the overall quality. The result of this examination and tests gave our plan a rating equal to or superior to the average provided in private practice in this area at rates substantially below the veteran fee schedule.

Our dental plan is not financed by the payment of a premium on each eligible per month, but for actual chair hour service performed.

In the past year the average cost per patient has been approximately \$71 per person, with an annual budget expenditure of a little less than one-half million dollars. However, the services rendered are substantial and are listed in detail in the enclosed health and welfare financial report which is also a summary of services rendered and has just been published for 1956.

(3) Our plan provides for \$1,000 life insurance for the member and \$500 life insurance for each dependent, with the exception of children up to age 6 months where the amount is reduced to \$100.

(4) We are in the planning stage of providing free legal services to our members and dependents. There will be exceptions for certain types of legal services, such as traffic violations except where personal injury is involved or where a jail sentence is mandatory upon finding of guilt. Experts from UCLA have completed an exhaustive survey showing the need for this service among our members. A random sample of some 600 members out of a total membership of 22,000 was made. The interview consisted of 17 pages of questions and reflect, we are advised, within an error possibility of 5 per cent, the actual legal involvement of our members for the past year.

In the year just past our members spent approximately \$400,000 for legal services. This includes attorney fees, court costs, bail bonds, but not fines. After discounting 50 per cent of the cases of legal involvement which were connected with misdemeanor auto violations, there still remained sufficient involvements to give us grave concern. For example, every two out of three members faced a legal involvement during 1956.

Based on this survey, we believe that we can finance a comprehensive legal program as planned, providing for most of the needed legal services, with certain safeguards to protect the fund from abuse, at a cost not to exceed 2¢ per hour per employee to be paid for by the employer.

The types of exclusions we have in mind are:

- (a) all cases of misdemeanor auto
- (b) public liability auto where private insurance policies provide for legal attorney fees

- (c) defendant actions in child support cases
- (d) cases involving a landlord where the member is a landlord.

The plan is primarily planned to cover the major legal cost items, such as serious criminal defense where average cost for competent counsel through trial and appeal ranges from \$10,000 to \$20,000.

While we are primarily concerned with these major catastrophic exposures in planning for legal care, we are cognizant of the importance of preventative legal assistance which is provided by legal consultation. We are contemplating covering legal consultation with some safeguards against cranks and nuisance plaintiff actions.

Another area that we are concerned with is cases of personal injury where, under present practices in the legal profession, an injured person pays attorney fees up to 40 per cent of damages awarded by a jury or court. We feel that this is "blood money"! Attorneys feel entitled to this because of the number of cases they lose compared to the number they win. However, a reasonable fee should be satisfactory to most attorneys, for they would be guaranteed the same fee in each case, win or lose.

Retirement Benefits.

- (a) We consider continued health and welfare coverage for the member and his dependents after retirement to be of primary importance. Generally, most plans have eligibility rules tied to hours of employment so that, inadvertently, members when they retire, lose eligibility at a period in their lives when it is most needed.

After age 65 for an individual or a couple to purchase hospitalization and medical care insurance the cost is prohibitive. We have been successful in Los Angeles in persuading the carriers with whom we deal to provide this continued care at the same monthly premium rate as charged for members, with the understanding, of course, that adverse experience for the smaller retired group will be spread over the entire group so that, in fact, the worker, prior to retirement, is building up an equity to pay for these benefits after retirement.

- (b) Cash Supplemental Pension.

Under our plan, any member who meets the retirement eligibility requirements of the Trust has continued health and welfare for life with all of its benefits for himself and dependents, plus a cash supplemental pension of \$30.00 per month.

Our eligibility rules are modest compared with most plans of our knowledge:

- 1) Age 65.
- 2) Employment in the industry in union contract houses nine months out of each 12 for 10 years preceding retirement.
- 3) Registration with the union for employment for the 10-year period preceding retirement.

(c) Eligibility for Social Security.

Under our retirement plan, members are permitted to continue to work in the industry and earn up to \$100 per month, the same as they are by federal statute for social security.

(d) Work After Retirement

We have taken this one step further and have made available by contract negotiations, special easy shifts for these workers, recognizing two points which we consider of paramount importance in planning any retirement program: one, that retirement should be voluntary and not compulsory, but should be available at a reasonable age, and two, that the member should be permitted, if he chooses after retirement, to retain the associations of his life-time by working in the industry on a limited basis, and earning money which, in most cases, is needed in addition to the union's pension and social security benefits for a decent standard of living.

In considering this type of supplemental benefit, it is of the utmost importance, prior to negotiating a retirement program, to decide the types of coverage desired and the eligibility rules, because these go to the heart of the question of how much money shall be available for each retiree under the plan.

(e) Los Angeles has elected to finance its retirement program on a pay-as-you-go basis, the same as social security is financed. According to present actuarial estimates, borne out by experience so far under the plan, we are providing benefits costing \$48 per month at an average employer cost of 1 1/4¢ per hour for an anticipated life expectancy, after retirement at age 65, of 15 years. Our experience so far has indicated that our members feel the continued health and welfare benefits to be of equal importance to the cash pension.

(f) Another supplemental benefit we deem of importance and have negotiated in Southern California is a reciprocity agreement between other local unions of our International Union in Southern California where health and welfare plans are in existence. Members may transfer from our one local to another city without loss of eligibility for basic health and welfare benefits. In all cases a minimum program of hospital and medical care for the member is put into effect immediately upon termination of eligibility in his former local union plan. Should the local into which he transfers have greater benefits than the local from which he transfers, the member must wait the usual time for eligibility for these added benefits. For example, a member transferring from Santa Monica to Los Angeles would have to wait and earn eligibility by working 60 hours per month for 3 months before he would be entitled to full dependency care, our dental program and the life insurance (and legal plan, when it goes into effect).

(g) It is also important, in our opinion, to make arrangements that when members lose eligibility by permanently terminating their employment in the industry or for any other reason, the carriers agree to provide

individual plans where the employee can pay the premium directly and have basic hospitalization and medical care needs covered without a physical examination.

(h) Our plan provides for disability eligibility credits for members who become ill or disabled due to an injury or illness. This benefit is unlimited so long as actual unemployment results which is caused by the injury or illness and is certified to by a doctor. This is of extreme importance, we feel, because of the new regulations regarding eligibility for retirement benefits. Ours is the only plan in the country, at least to our knowledge, that has unlimited benefits of this nature. The Trust Fund pays the total cost of such monthly premiums. For example, a young man becomes permanently injured or suffers an illness that incapacitates him from work for the rest of his life. He continues to be eligible, without work or pay, for all our health and welfare and retirement benefits, and upon reaching the age of 65 is entitled to retirement benefits as well.

(i) A supplemental benefit that most unions have not considered as yet is continuity of eligibility in case of serious unemployment. Our plan at present provides that individual members who fail to earn eligibility by working 60 hours or more per month in one or more union contract houses and who are not disabled, may continue their eligibility by paying the monthly premiums themselves. However, the cost of our plan has now reached the figure of \$18 per month and has become prohibitive for most workers, especially for those who may be unemployed and have no income.

I think this is one of the largest areas for planning for the future facing all unions having health and welfare plans! Obviously, it will require tremendous reserve funds to pay premiums for members during serious periods of unemployment.

(j) A further supplemental benefit provided under our plan is a staff of social service workers employed by the fund who assist members at the medical facilities and at the hospital in securing services to which they are entitled, and assisting in filling out claims for State disability, hospital and industrial accident compensation, and in expediting these applications through the hands of the doctors and hospitals and on to the appropriate State agency. I believe having this staff of social service workers has done more to insure its smooth operation and popularity with our members than any other factor.

(k) A further supplemental benefit that unions have to provide themselves outside of their plans is an adequate blood bank. Los Angeles has recently taken steps to provide emergency blood through the Red Cross by adopting an insurance program whereunder a member who donates one pint of blood a year gets a certificate of warranty guaranteeing all the blood for himself and his family for the entire year. Other methods have been attempted without much success. We hope that this plan will have more appeal than past efforts. We are also planning in the shops to provide the same certificates to all shop employees upon showing that a majority of the employees in the shop have earned individual blood donor certificates.

Our reason for the shop "blanketing in" is because we recognize that a large group, from 20 to 30 per cent of our members, cannot meet the rigid high standards set by the Red Cross for blood donors due to weak hearts, high blood pressure and other physical ailments that are common to workers in their middle years. A member who volunteers as a donor and is rejected should not, in our opinion, be left out of the program.

You will note that our scope of supplemental benefits is somewhat broad. We have interpreted "supplemental health and welfare benefits" to cover any benefits in the field of social services rendered by a union directly or through employer contributions to a fund under a plan.

(1) In this connection, there is one final service rendered by our Los Angeles Joint Board to our 22,000 members which has been deemed of great value. This is the establishment of a Credit Union in which members of each of the six unions affiliated with the Joint Board can participate. Our Credit Union has shown phenomenal growth; in less than 2 years of operation it has paid dividends in excess of 5 per cent to depositors! Total deposits exceed \$500,000 and low interest (below bank rates) loans are, of course, providing all of the income the Credit Union receives. The primary feature that appeals to our members is the low interest loans that are available which protects them from the loan sharks, and the free life insurance features which are provided without medical examination. For example, a member who has a \$1,000 savings account is insured for \$1,000 without cost. In case of his death, his estate receives \$1,000 plus the \$1,000 savings on deposit. Likewise, in case of loans the unpaid portion of a loan is automatically insured, without cost, so that if the member who borrowed \$1,000 should become permanently injured or suffer a fatality, a \$1,000 insurance is processed to pay off the obligation.

All of these supplemental benefits cost money. With the exception of the Credit Union, all of the benefits listed above are financed by the employer contributions into Trust Funds provided for by collective bargaining agreement in the amount of 8¢ per hour for all hours worked or paid for, whether the employee is eligible for benefits or not.

This method of financing is important and we discuss it here because of what we consider to be of significance in comparison with a fixed monthly rate per eligible as paid by employers under many plans.

For example, under our plan, as I have indicated, an employee working 60 hours per month or more in one or more contract houses (and this applies to any of over 1,000 contract houses in the area within the jurisdiction of the Los Angeles Joint Board), is provided with this full schedule of benefits. Yet a 60-hour employee has had contributed for him only \$4.80 for the month -- yet we pay out from the Trust Funds \$18.00 per month for each eligible person. Let's take the full-time employee who works 40 hours per week. The total contribution paid by his employer is \$13.86 per month, yet, as already indicated, we pay out \$18.00 per month premium for him! The difference between what is paid in on that employee and the \$18.00 is provided by contributions made on employees who never become eligible.

At "first glance" this might seem as though we are dis-franchising from benefits a large segment of our industry. Nothing could be further from the truth. Our eligibility rules are that employees must work 60 hours per month in covered employment for three months. Certainly this takes care of people who are legitimately earning a living at this trade and protects the Fund from abuse by sick persons joining just for benefits.

We do not permit the employer to be relieved of any obligation to make contributions for hours worked by transient employees because, in a very real sense, any fringe benefits negotiated could be won in the form of additional wage increases by the union. In all of our contracts we require the employer to pay the same wages for all employees of like classification. To do less would encourage employment of transients at the expense of regular employees.

During the past 10-year period of full employment there have been many cases where union workers are hired and work for 30 days or more before the union business agent obtains their application fee. We insist that these hours, worked as a non-union employee, be paid for the same as for all other employees.

One final word on the financial status of our overall plan. During the five years of our experience, in addition to paying premiums averaging now \$2,356,674 annually, we have still accumulated a surplus and reserve of \$763,300.43.

I believe a large reserve to be of the utmost importance in order to guarantee to the union and its members an ability to pay the cost of premiums in the event of a strike or a lock-out so that unions are not put into a position of losing health and welfare and retirement benefits for its members if they go on strike.

One of the reasons why, in our opinion, we have had such a favorable experience financially, is because of low administrative costs and because only a small portion of our plan is insured. The life insurance and alternate hospital and medical plans are the only insured portions of our plan. The rest of our program is not insured and no commissions are paid. The total commissions paid for the year 1956 were \$3,545.00 only. During the year 1956 there were in excess of 35,000 persons covered under our plans.

A PROGRAM IN PREVENTIVE MEDICAL CARE

by

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Half a century ago, garment workers spent their lives in the notorious sweat shops. They worked in filthy, vermin ridden tenement rooms which were dark and airless. Tuberculosis and other diseases were as much part of the job as long hours and short pay. When the International Ladies' Garment Workers' Union began to make headway in improving conditions for the garment workers, it found that it was just as important to bring cleanliness and sanitary surroundings to the workers as it was to gain shorter hours and higher earnings. From the very beginning, thus, there was a preoccupation with problems of health.

From this arose two important trail-blazing concepts for the entire Labor Movement. The first was the principle that the employer has a financial responsibility for the maintenance of the good health of his employees. The second was that the Union itself should establish and operate medical institutions which would look after the health of the workers. Thus in 1913, the first Union operated Health Center was opened in a single basement room in New York City. Today, the International Ladies' Garment Workers' Union has about twenty such Health Centers. The Los Angeles ILGWU Health Center was opened in 1951.

Because we started with the problem of disease coming about from the combination of hard work, inadequate diet, poor air, and bad environment, emphasis was given from the very start to preventive medical care rather than "catastrophic" costs. Our reasoning was, "We have sick people, and we must work out means of preventing this sickness from spreading and preventing people from becoming ill in the future." Thus, our Health Centers have no beds for hospitalization, and they perform no surgery. Cash benefit payments from the Health Funds help defray these serious monetary crises.

The Center cares for ambulatory patients and gives long term treatment when necessary. Its philosophy is that if you treat the minor ailments, you'll stop the major ones from getting a foothold. Through this kind of treatment, and through examination, many incipient diseases have been discovered in time to stop them. The Health Center has often caught cancer in patients early enough for local treatment to be completely effective. Heart disorders have been found in patients who had no idea they were in this danger. Diabetes has been discovered and stopped. And most important of all, the people who in the past neglected small colds and passing headaches because they couldn't spare the ten dollars for the doctor for slight discomforts, and thus waited for them to develop into something serious enough to warrant seeing a doctor about, are going to the Health Center to get their little troubles taken care of before they become big troubles.

The Los Angeles Health Center is open the five week-days from 10:30 A.M. to 6:00 P.M. On Saturday, it is open until noon. One doctor is on hand from 1:00 until 3:00 P.M., at which time the panel of doctors begins to arrive so that for the peak period of 4:00 to 6:00, there are usually ten doctors on duty. These include internists, dermatologists, allergists, orthopedists, proctologists, ENT men, gynecologists, ophthalmologists, and the other specialties. Examination facilities also include a fully equipped lab with full time technologists on duty throughout the day, and an X-Ray department. Further, in cooperation with the Los Angeles Health Department, the Health Center promotes an annual chest X-Ray program for the entire membership. At present, we are working on a plan to obtain inoculation of all ILGWU members under the age of forty with the Salk vaccine.

Another department that is very widely used is a physio-therapy department equipped with diathermy, hydro-therapy, and weights. Also in great demand is the eye refraction clinic, where examinations are followed with the issue of free eyeglasses.

Every worker in a factory under contract with the ILGWU affiliates in the Southern California area is entitled to care at the Health Center. In the early days of operation, a point quota, set to give full care for the average patient, was used. This was felt necessary in order not to overtax the facilities of the Center and to give everybody equal opportunity to share in its use. However, during the past few years, it was found possible to remove all restrictions on the amount of use the individual patient is to receive. Today, any eligible person gets all the care medically indicated. Obviously, as a medical institution dedicated to the principles of healing, charitable cases are also accepted whether connected with the garment industry or not, a number of individuals receiving care on the basis of an indigent status.

When a patient makes a first visit, he or she sees an internist for examination and medical history. The internist orders necessary examinations, and, if required, refers the patient to the proper specialist. Future visits are scheduled as needed. The patient has the option of selecting any doctor on the panel, and as much as possible, a doctor-patient relationship is established. We are very proud that a large number of our original doctors are still on the panel.

After forty-four years of Health Centers in the ILGWU, we have the proud sense of pioneering in a field that almost every Union has adopted as a basic area of Union interest. Other Unions have in recent years built Health Centers. In some cities, a number of Unions have joined finances and facilities, and are operating joint institutions. Many Unions have other plans where the emphasis is on catastrophic care rather than preventive. Candor requires that we state frankly that no plan short of a federally directed, general participation health insurance program can fully meet the needs for medical and hospital care of working people and their families. But meanwhile, we are all coping with these problems in a manner in keeping with our traditions and our principles.

RELATIONSHIPS WITH MEDICAL AND HOSPITAL ASSOCIATIONS

By

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Motion Picture Health and Welfare Fund
Hollywood

The subject of labor's relationships with medical and hospital associations is a broad one, that within itself might well be the topic of a week-long conference such as this. The method of dealing with the Associations and their members and non-members has many facets, and today we hope to convince you of the importance of giving more and more attention to this aspect of your health and welfare fund administration.

First, however, I would like to put the question to you as union representatives as to whether or not you believe that the problem of proper relationships with the professions is a necessary concern of your union, or management personnel, or of the fund or insurance company personnel. I ask this question because many of the funds and companies make no attempt to establish any relationships with the professions and do nothing about policing of claims.

I assure you that as a fund administrator I see the need daily for establishing such proper relationships not only for the financial protection of the fund but for the health protection of your members. If you have doubts, statements of professional persons themselves should be sufficient to warn you of the need to be aware of this problem.

In 1952 Dr. Kenneth Babcock, Chairman of the Joint Committee on Hospital Accreditation reported the following, after a study at the Grace Memorial Hospital in Detroit by five independent physicians:

1. A large number of persons were sent to the hospital for diagnostic work that could have and should have been done outside of the hospital or inside the hospital for an out-patient. This was done in most cases either as a convenience to the doctor or in order to take advantage of an insurance policy.
2. There were too many hospitalizations for medical treatment that could have been given just as successfully outside of the hospital. In this category were mild cases of anemia, gastro-intestinal upset, headache, and colitis.
3. Admissions for X-ray and physio-therapy treatment that should have been done in the doctor's office or as a hospital out-patient.
4. Prolonged pre-operative care and hospitalization.

5. Unnecessary stay for ambulatory orthopedic patients. Dr. Babcock cites the case of a hospitalization of 27 days where the patient had a banjo splint on his finger.
6. Overuse of medications in hospital -- Dr. Babcock again cites a case where a patient was on an expensive penicillin and vitamin treatment for 14 days, every 4 hours. WHY? The doctor forgot to cancel the house order.
7. Unnecessary duplication of X-ray and laboratory work.
8. Faulty diagnosis -- known as slot machine diagnosis -- where the doctor drops a \$50 or \$100 benefit in an X-ray machine or test tube -- pulls the handle -- and hopes he'll find the source of trouble.

Dr. Babcock found that many of the chief abuses were caused by the hospital themselves due to red-tape, bottlenecks, delays, and poor administration. This was in his own hospital; in a few others he might add dishonesty, or for the record, at least sharp practices. He found among other faults:

1. Delay in processing lab tests -- a doctor discharges the patient subject to the result of a lab test. The delay results in an extra day of hospitalization. The hospital's inefficiency makes money for it -- costs you.
2. Delay in notification of discharge. A doctor orders the release of a patient -- the order is delayed -- you pay for an extra day.
3. Excessive drug charges because of poor house orders. Dr. Babcock suggests that a time limit be placed on all house orders. How many hospitals do this?
4. Routine House Orders -- for example, electrocardiograms, blood count, or chest X-ray ordered for every patient regardless of need.
5. Allowing expensive prescriptions to be taken home. There is no need for this. Perhaps the patient does not even need them when he leaves the hospital. In any event few of our plans furnish medicine out of the hospital. Why should we pay for them through the back door -- the hospital's back door especially?

Let me assure you that the problem has not changed and further that we have a far more critical problem in California where we have a large percentage of privately owned hospitals, run for a profit, and a smaller proportion of accredited hospitals than elsewhere in the country.

Now what about the doctor? During the past few years I have spoken at Osteopathic, M.D., Chiropractic, Optometrist, and Chiropodist meetings and let me assure you that there is no hesitancy on the part of any of these groups to admit, at least off the record, that there is a critical problem of gouging, unnecessary procedures, high charges, and even harmful treatment in order to take advantage of insurance programs.

At a recent osteopathic meeting one of the fine doctors of this group spoke about what he terms the "frightful five." It was his contention that about 5 per cent of the doctors are just plain dishonest or incompetent, but than another 5 per cent, the frightful five, are the real culprits. They are the ones that raise their charges, take a couple of unneeded extra X-rays or tack a few office visits on because of the presence of an insurance policy. This 5 per cent is frightful, said the doctor, because the nature of their offenses is harder to control, they encourage additional abuses by the dishonest 5 per cent, and in some cases force the honest 90 per cent into practices that can lead to reducing the effectiveness of our programs. He went on to suggest that the profession itself must solve the problem of the frightful five per cent if voluntary health insurance programs are to work successfully.

I agree with the doctor in his analysis but, perhaps, you say, these are osteopaths, what about the M.D.'s? Let me say in this respect that I haven't found much difference between the two groups -- maybe the D.O.'s are a little worse in regard to unnecessary visits and unnecessary X-ray and lab work, but if so they would point out that the M.D.'s are inclined more to raising charges because of an insurance program.

In regard to Doctors of Medicine, Dr. Lucius M. Johnson, M.D., following a series of medical audits of eastern hospitals, reported that 90 per cent of the doctors appeared to be competent and ethical -- 5 per cent doing work for which they were not trained and 5 per cent scalpel-happy.

Dr. Babcock's statement and Dr. Johnson's findings give some indication of problems with the M.D., but let me quote from a talk given by Rollin Waterson in 1954 at a health and welfare conference in San Francisco at which I was privileged to participate at the invitation of my fellow panelist George Johns. Mr. Waterson was then doing some research for the California Medical Association.

"Let's start with your complaints as architects and administrators of Labor's health and welfare plans:

"You negotiate the money to buy a plan. Then you buy one. Then some of your members come storming in, saying your plan is no good because it didn't cover this or that procedure and paid only part of the doctor's bill. Then you revise your schedule of indemnities upward, broaden the coverage, negotiate for more money for managements, get it, and the same thing happens all over again. The more you cover, the more utilization you get. Doctors seem to order even more X-ray and laboratory work, run up more office calls, keep patients in the hospital longer -- and you're right back where you started -- in the soup.

"This has got to stop, you say. And so does management. Emphatically.

"You've found no good solution for this problem, either. If you raise your schedule of indemnities too high you'll be paying more than the lowest medical and surgical fees; if you don't raise them, many of your members complain because the plan doesn't pay nearly enough.

"How much,' you ask the doctors, 'are your services worth? We can't prepay for doctors' services if you won't tell us how much you're going to charge. And don't make it too high, or we can't get enough to pay you-- don't price us out of the market.'

"And furthermore, doctors, we find you are abusing the plan by seeing patients oftener and ordering more X-ray, laboratory work and hospitalization every time we add to these benefits to meet the previous increases in utilization. We can't get any more from management.

"Either stop abuses,' you have told the doctors, 'and set a reasonable schedule of fees to which you will adhere, or we'll go to Permanente or set up our own closed-panel plan so we can pre-determine costs and thereby prepay them.'

"We have to do something,' you say -- and I agree."

Now, what is this "something" that Mr. Waterson feels we must do?

First, the opinions and expressions from leaders within the professional groups indicate clearly that there is need for proper policing of claims, need to be alert for unnecessary hospitalization, unnecessary laboratory and X-ray procedures, prolonged office visits, and scalpel-happy surgeons.

Second, and of even greater importance, however, is a growing need to pay more and more attention to the quality of medical care furnished as a result of our programs. We must have a greater realization that our programs were primarily established for the benefit of the worker -- your member -- the doctor's patient -- and not for the financial benefit of the doctors or hospitals -- nor even for the glory of union or management participants.

In order to achieve success toward these ends the only answer is to establish proper relationships among all groups in the medical community. I would also like to point out that while the negative approach may be more dramatic and make for more effective soap-box oratory our real need is to establish a positive program that will inevitably lead to high quality medical care. To emphasize the need for a positive approach I would like to quote from a paper written by a man who knows well both the union and professional problems, Harry Becker, formerly with the United Auto Workers -- AFL-CIO, now program consultant to Blue Cross plans.

"Too much emphasis on 'abuse' of benefits can very easily create a negative attitude if not an actual desire to be punitive, and result in more, rather than less 'abuse.' Positive attitudes toward prepayment, an understanding of the true function of the prepayment mechanism must be encouraged -- attitudes which are positive, constructive, rather than those which promote exploitation, are the only ultimate answer to more appropriate utilization. Scolding or prohibitions will not pay off in the end. This will require time and skill, and will require the help of the prepayment agency and the providers of service, but the rewards will be real and lasting.

"If the purchasers of prepaid protection would meet with representatives of physicians, most of the medical benefit problems could be resolved satisfactorily. In the past few years considerable work has been done quite successfully, in working toward fee allowances which will constitute full payment for services rendered persons under a given income ceiling. Much more in this direction can be done and is being done. Most medical economists and prepayment experts, and many physicians, are agreed that the 'service' medical benefits, for persons in the middle income group, are the most practical solution. This approach, however, requires agreements between the physicians, . . . and the purchaser of prepaid health benefits.

"Hundreds of prepayment agencies operating in a given community without working relationships with the providers of service and each representing only a few employer and employee groups in the community, are not, over the long-pull, going to constitute either an efficient prepayment mechanism or establish an effective working relationship with hospitals and other providers of health services. . . .

"The prepayment agency must act as a liaison agent between the buyer and the provider of services.

"When the prepayment agency does not have agreements with the providers of services on methods of payment and amount of payment and when the prepayment agency cannot work with hospitals, for example, on methods for more effective use of prepayment funds and improved hospital administrative methods, the only alternative is to modify benefit provisions as an approach to more economical use of funds. However, over the long-term, benefit restrictions designed to have a hesitation effect on utilization will not accomplish the objective intended and, meanwhile, there is danger that steps which will be effective may be postponed. Ultimately, it will not be the negative approach of prohibition which will be effective but the positive approach of appropriate use; use of facilities and personnel in the most effective and efficient manner, the concept of productivity, will pay dividends.

"Whether an employer has one hundred or one hundred thousand employees, his cost of health benefits is affected more by community factors than factors directly related to the age or sex composition of his labor force, or the benefit utilization experience of his particular employee group at any given point in time."

I have indicated to you my belief that there is a great need for establishing better professional relationships both because of abuses that reduce the effectiveness of our medical dollar and because of the need for improved medical services. I would like to discuss with you now some of the practical problems in doing so.

Most of my remarks will be concerned with the problems of open panel service plans and indemnity insurance programs -- because of their preponderance in numbers -- as against the closed panel plans such as Kaiser-Permanente or the Los Angeles Culinary Workers Dental Plan. I do

not want to leave the impression, however, that we are not interested in direct service programs. Indeed, we must concede that the amount of medical services rendered obviously will be greater under a controlled type of program, and the quality of care can be as good or better than that given by the private physician. We must also concede that without these programs problems of the insurance programs would be greater. We have noticed that our relationships improve and our problems become alleviated sharply by the operation of a closed panel plan in the area. For instance, in the Santa Monica beach area we were never able to get any cooperation from any substantial segment of the medical profession until plans were discussed for a Kaiser-Permanente plan at the Douglas Aircraft plant. This program was never consummated but some of the favorable relationships established at that time linger on.

Additionally unions that have direct service programs seem to be more aware of the need for effective cooperation between the patient, fund personnel, and medical groups. There seems to be a need for improvement in two areas, however --

1. Consumer representation. In this respect I think the unions having direct service plans should have a more effective voice in the policy making decisions of the plans. I am not talking about control by any lay group of medical practices. This should and must be left to the professions. However, in financial and administrative problems, and in program planning and expansion the consumer must speak up.

We had a rather startling experience with Kaiser-Permanente in Los Angeles in this respect recently. Some of the unions that had been among the original supporters of this program found that their coverage was changed from group to individual coverage resulting in higher costs, more restrictions, and fewer benefits without any warning or advance notice. In fact, the first some of them knew of it was when members brought their notices to the union office. Some of the labor people felt that this action was more inconsiderate and arrogant than that of the worst of the professional organizations or practitioners.

2. Better evaluation of services. More attention should be centered on the quality of services rendered and the degree of patient satisfaction. I would like to suggest that all direct service plans consider utilizing the methods that proved so successful for the Teamster's Labor Health Institute at St. Louis, and the Culinary Workers in Los Angeles.

In these instances impartial professional people were called in to study all aspects of the services rendered. Administrative methods, patient attitudes, costs, plan utilization, training of practitioners, adequacy of facilities, and detailed aspects of the quality of care being furnished were all studied. In most every aspect the plans were proven to be adequate and comparable to the best care available in the area. However, weaknesses were pointed out and questions raised which will improve the quality of care and increase patient participation and satisfaction.

Now as to the problems with the open panel and indemnity programs. My remarks will deal with Southern California problems. However, I have

attended several meetings in the northern part of the State and feel that essentially the problems are very similar. I think it might be well to recall the situation that faced us when we first negotiated money for health and welfare programs. First, we had a growing population with an expanding economy. We were over-run with defense plants operating on a cost-plus basis, with the result that both unions and management were not too concerned about the problem of how much money it would cost to maintain improperly planned health and welfare programs.

As far as trained personnel to handle health and welfare programs was concerned, we relied solely upon insurance representatives and personnel untrained and uninterested in medical or health services for advice and guidance in developing our programs.

This inevitably led to our consideration primarily of cost problems and to paying little or no attention to real health needs and quality of services. I do not want, however, to minimize the cost problem as it is important but should not be our sole interest.

Because of the continual spiralling of costs, greater utilization, and other factors, we have continually sacrificed proper planning because of the immediate necessity of fighting losing battles with doctors and hospitals over abuses and improper charges.

Second, we had a critical hospital shortage which unfortunately still exists and which led to the development of proprietary and doctor-owned hospitals. Third, we had a critical shortage of doctors in the area which has been alleviated somewhat. Finally, we had and still have the widest array of quacks of any place in the United States. This goes through the field of chiropractors, chiropodists, osteopaths, injection mills, other practitioners, and to the M.D.'s themselves. Here again, because of a lack of competition, we could not, or at least did not, consult with medical or hospital experts in setting up our programs.

It did not take the administrators who were brought into this picture long to realize that our problems were going to become greater as the years went by. Individually, we tried to deal with doctors and hospitals and found ourselves stymied. In fact, some of the smaller funds could not even get the courtesy of a reply.

It was under these conditions that the Los Angeles Central Labor Council, the Greater Los Angeles CIO Council and the Institute of Industrial Relations at U.C.L.A. formed the Health Plan Consultants Committee. While the Committee does not claim to have accomplished miracles, we do feel that it has established some beneficial relationships with doctors and hospitals. We hope that its work has put a brake on costs and we at least think that costs probably would have been higher had it not been in existence.

Now, as to our professional relationships and some discussion concerning the future. Among the hospitals we have a peculiar situation. As you may know, hospital costs in the Los Angeles area are among the highest in

the country. The cost of hospitalization under our own plan is about \$36 per day or about 25 to 30 per cent higher than in most areas of the country. Ward-room rates, for example, run as high as \$22 per day and are now being raised to a top of \$24. This is caused by several factors, including the insurance programs themselves, the shortage of hospitals, the apathy of insurance companies, higher wage rates, high cost of living, shorter length of hospital stays (approximately 5.8 days in Los Angeles, against 6.8 days in most other areas), and perhaps the failure of Blue Cross and Blue Shield to become sufficiently aware of the problem before it was too late.

We find a hospital ownership pattern that probably does not exist elsewhere in the country. Better than 25 per cent of the hospital beds in the Los Angeles Metropolitan Area are in proprietary hospitals. This 25 per cent is owned by doctors, hospital administrators, various types of promoters, real estate interests and even by medical and surgical supply companies. There is some argument as to what the impact of these hospitals has been on the over-all hospital problem in Southern California. It is my own opinion that our spiralling costs have been largely due to bad practices and a get-rich-quick attitude by a substantial number of the proprietary hospitals, plus the fact that even among the better-run groups our funds are financing their expansion programs in varying degrees through high hospital rates. However, I do not want you to rely just on my opinion but would like to quote from an article entitled -- "Want to Get Rich -- Own a Hospital," which was published in the January issue of the American Hospital Journal:

"Incredible as it may seem, there are able businessmen in Southern California who believe that ownership and operation of a general hospital in this area is a better investment risk than oil wells, even when they find oil.

"There is considerable evidence to indicate that these people are right, that the proprietary general hospital, built and operated in these parts for profit and the payment of taxes, can indeed be a lucrative investment.

"A return before federal taxes of from 25 per cent to 30 per cent per year on the capital invested is considered by shrewd investors to be minimum for the efficiently operated general hospital. In at least one instance profits during each of the first 2 years of operation of a fifty bed hospital were in excess of 50 per cent of the total investment each year.

"While oil production can give the horn of plenty an even sweeter tone, there is always the risk that oil isn't where the well is, and considerable investment is sunk. And, while hospital owners share the general reluctance of owners of small, closely held businesses to make public their profit and loss statements, diligent search and inquiry failed to disclose a single dry hole among the proprietary general hospitals of Southern California."

It should be noted that the above excerpts refer to the proprietary type hospital, which are hospitals operated on a "for profit" basis. The story goes on to say that "some non-profit administrators claim that proprietary hospitals often "load" patients' bills with unnecessary, if not downright dishonest charges, in order to increase their profits.

"These charges are indignantly denied by administrators of proprietary hospitals, but the fact remains that the profit and loss statement is the all-important document in the proprietary type hospital."

I don't think it should be necessary to document these statements from the official hospital publication, but I would like to give you two examples that point up the problem effectively:

One of the indirect gains in establishing good relationships in any field is that you make friends. Recently one of my M.D. friends made available to me a quarterly financial statement from a West-Side Los Angeles hospital, which showed:

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|--------------------|--------------|
| Total Income | \$265,300.00 |
| Costs of Operation | 140,604.00 |
| Gross Income | 124,695.00 |
| General Overhead | 50,612.00 |
| Taxes | 33,800.00 |
| Net Income | 41,115.00 |

Almost 20 per cent profit on the income -- Not a bad business.

An Osteopathic friend gave me a prospectus for a proposed hospital now under construction in the Southern part of Los Angeles. This was about a 90 bed hospital. The cost was about \$900,000.00, the total private investment to be \$300,000.00.

| | |
|-------------------------------|----------------|
| Gross Income | \$1,084,136.00 |
| Operating Expenses & Overhead | 801,436.00 |
| Gross Income | 282,700.00 |
| Taxes | 152,612.00 |
| Net Income | 130,000.00 |

In just a little over two years the investors will have all their money back. Incidentally depreciation was figured at \$62,000.00. Income from drugs exceeded cost by 100 per cent and the Administrator, who was also one of the investors, was down for a comparably high salary.

The brochure stated that the data compiled was from information obtained from a hospital of comparable size. It sure was -- it was accurate too -- right from the horse's mouth. One of the investors is the owner of the "comparable hospital."

Now what does this mean? It's obvious that it means unnecessarily high hospital costs, but it also means that the consumer, the sick, and the union health plans are not only putting hard earned dollars into the

pockets of promoters and investors of all types, but we are paying for an improper type of future hospital expansion to build them more profits.

In any event, as I have said, we found ourselves stymied in trying to deal with hospitals.

However, once the Health Plan Consultants Committee became effective we had meetings with the Hospital Council and secured some measure of cooperation. If we have done nothing else, we have been able to deal effectively with people who do have control in determining hospital costs. While we have not accomplished all we would like to accomplish, we have had cooperation in handling of complaints and in helping solve some administrative problems.

Just recently, at our request, the Hospital Council of Southern California has agreed to create a grievance committee which will not only work with us in the matter of curbing abuses and handling complaints, but will also work with us on cost, administrative and policy problems. Perhaps Mr. Ludlam will comment further on this.

I would like to suggest that in regard to this that all the funds and unions that have complaints in Southern California process them as you would a contract grievance. Don't just sit back and complain about over-charges and abuses. Document your charges, and then if you don't get satisfaction you have a right to complain by any methods you choose.

Incidentally, all of the medical professions with which I have dealt complain that we participate in a lot of public protestations about abuses by their members but comparative few complaints are filed. There is some merit to this position. If we are ever to stop the abuses about which we protest, we must utilize these grievance or fee committees more extensively.

Our success with hospitals has been limited. We found, for example, that in dealing with them that we could never really consummate problems with some hospitals, because of lack of uniformity or accounting methods. Each hospital includes different items as part of the board and room rate, or as part of their operating room rate. This meant that every problem had to be settled individually and we have been unable as yet to establish any yardstick which we might use in all situations. We hope that this new Hospital Council Committee can help here. It also meant that many complaints were ignored.

One complaint just adjusted is fairly typical. In our office we spot-check claims. Thus, when a bill for \$195.00 for a sub-mucous resection came in, it was immediately scrutinized. There were several questionable items including \$25 for a chest X-ray. The first answer to our complaint was that this was the hospital charge for two films -- period. We then had Blue Cross check and they were told that there were 3 views, including a stereo. We tried again and were told that there was one picture only. At this point we advised Blue Cross that we wanted to see the films and until we did we would notify our members to insist on going to other

hospitals. This brought quick action from the Administrator who offered to show us the films. The fact was that there were only two films, 11 x 17, no stereo, and that their usual charge was \$15. A quick adjustment was made. I am sure that it cost us several times the saving made just in the time involved. All of this could have been avoided had the hospital had modern accounting methods and had it not taken an attitude that is all too frequent in some of our hospitals of -- the customer is always wrong!

A clipping from a Los Angeles newspaper highlights this situation --
"On the advice of her doctor, a woman we shall call Mary went to a small private hospital where he is on the staff, for surgery.

"The fee for the tiny room which she shared with another patient was \$17.50 per day. She was hospitalized for 10 days.

"As she left, she was presented with a bill for nearly \$700. It was a hard blow.

"Her employer called the hospital and asked for an itemized account for Mary's bill. She made it plain she considered it exorbitant.

"At first the hospital people were reluctant, then they furnished the information.

"Mrs. H(Mary's employer) still didn't understand how the bill should be so high and requested further information. The hospital girl looked around some more, then said, 'And then there's \$37.10 for surgical supplies.' Wasn't that included in the operating room total? 'Oh, no'.

"Mrs. H. asked for a rundown on the \$37.10 and the girl read the items -- \$10.80 for sutures, 80¢ for special silk thread, \$16 for tape and gauze --

"Mrs. H. interrupted, 'You mean \$16 worth of tape and gauze was used on one patient?' The hospital girl did, then went on -- '\$2. for a glass tube leading from the glucose drip, which cost \$5.60.' Mrs. H. interrupted again. 'Why should she have to pay for the glass tube?' 'It might break,' was the curious reply. 'Well then,' said Mrs. H., 'she should have been given the tube to take home' 'What would she have done with it?' was the irrelevant reply.

"Then the cruncher. 'And \$2.40 for two pairs of doctor's rubber gloves.' 'You mean,' said Mrs. H., 'the patient has to pay for the doctor's rubber gloves?' It seemed she did.

"Mrs. H. pursued. 'Don't you think the bill was awfully high?' 'Not at all,' was the reply, 'we're not endowed like the big hospitals -- we have to show a profit.'"

Our relationships with doctors have been somewhat better. We have established a working relationship with our medical associations. We had many meetings with one of their committees trying to establish a fee

schedule which could at least be used as a yardstick. Actually we did not accomplish what we had hoped to. We did, however, stir up enough interest in the County Medical Society that its fee committee did work out a fee schedule which was not too bad from our standpoint. It was submitted to the membership of the County Medical Society and, unfortunately while it received a majority of votes, it did not receive enough to carry by the required two-thirds of the membership. However, this fee schedule did tend to establish a yardstick for doctors to use in setting fees.

Out of these meetings and various conferences which have been held, we managed to establish some fine relationships with a large number of doctors which resulted in several beneficial programs for our members. First, the HPCC has established a panel of doctors who have agreed to accept our surgical fee schedules as full payment and who cooperate fairly well insofar as our medical schedules are concerned. Incidentally, there has been no problem of getting sufficient doctors of high quality on this panel. The problem, strangely enough, has been one of getting union member participation.

While we have not had the utilization we would like with this panel, it has served well many workers. Take the case of Mr. W. His condition was diagnosed as brain tumor. He was told that the surgery would cost \$1,800 for the surgeon. Assistants' costs were not quoted. This could mean loss of his home to him. Through this panel he went to a Beverly Hills specialist who is arranging to have the surgery done by one of the best-known neurological surgeons in the country at only slightly more than our fee schedule.

Then there's Mr. S. as reported by one of the unions:

"Mr. S. age 42 -- was treated at a small non-accredited hospital for an abdominal mass. He was operated on and it was found that he had a perforated diverticulum. A colostomy was performed. When his benefits ran out he was told to go to the County Hospital. He stayed there for a few days and went home. He appealed to the Health and Welfare Fund of the Machinists Union and was referred to an accredited surgeon, who is a diplomate of the American Board of Surgery and who has given care and advice concerning the excoriation of the skin around the colostomy. It is planned when his condition permits to take him to an accredited hospital and complete his surgical cure in 2 stages. The surgery will be performed for the fee schedule so he will have no further financial problem. His Health and Welfare Fund is now in the process of trying to adjust his previous large and extensive surgical and hospital charges with the hospital and the osteopathic association."

In relation to this panel, we should watch for doctors who go along with the schedule insofar as unit charges are concerned but who abuse it insofar as length of treatment and improper treatments are concerned. We found that there were doctors who wanted to get on our panel, but upon closer investigation we found that we would be hurt financially and that our members would receive a type of service that was of a low quality. We

found doctors who would dispense with the first call charge, which is excluded under our plan, for example. Fortunately, we were able to get valuable advice from a group of competent medical men regarding the treatment in these cases and additionally we knew that if they were to give away their most expensive office procedure, they would have to make it up later at somebody's expense, probably ours. As a result, we found very quickly that we had to screen the doctors who indicated a willingness to abide by our fee schedules, and for this purpose we have a committee of four administrators and two doctors which passes on every application.

Second, we worked out a standard claim form in cooperation with the medical society that is in wide use throughout most of the State. Administratively this has been of some value. Additionally, it has helped establish good relations with doctors who had a legitimate complaint against the wide variation of forms and amount of claims work that they were forced to do.

I might add that this form is now up for revision and we will have a voice in getting the proper type form for future use. It seems to me that there is no reason that all funds should not utilize this standard form as a gesture on our part to indicate good faith in our dealings with the professions.

Third, we worked with a smaller group of doctors, top men in diagnosis, and developed several different programs for the purpose of making early diagnosis available under an insurance program at a reasonable cost to the member. This has not been as widely used as we would like, but we have uncovered many serious cases of heart disease, cancer, and tuberculosis that otherwise would have gone undetected for a longer period of time, and we have helped develop an awareness on the part of the members, administrators, and doctors of the value of preventive measures in connection with our plans. Through the help of this group of doctors, we have been able to supplement our programs and give some measure of preventive medicine that is so glaringly missing from all our programs.

Here is a brief report from one of the doctors concerning this program:

"During the past 18 months since the conference on Preventive Medicine was held, 9 cases of early malignancy of the uterus and breast were seen as a result of preventive health programs. These patients were either members or dependents from the Teamsters Security Fund, the Sheet Metal Workers Welfare Fund, the Upholsterers Union and the Rubber Workers. All cases have been treated in Grade A accredited hospitals, their records are available. These cases have been followed by the Tumor Board and their outlook is excellent. One patient is 28 years of age, the mother of 4 children. She had one of the earliest forms of cancer of the cervix (Upholsterers Union). Another woman, 41 years of age, the mother of 3 children aged 7, 5, 3, had an early malignancy of the cervix and her prognosis is excellent (Teamsters Union). Another patient, age 53, who had no complaints but who had a family history of cancer was found to have an early cancer of the body of the uterus following a routine smear test which was picked up as positive. Her outlook also is excellent. There was another patient who was recently operated upon as a result of a periodic

health examination and found to have tuberculosis of her reproductive organs. Another patient was treated by vitamin therapy for 6 months for a painful breast. She heard about the preventive medical program and was seen by a competent diagnostician, who is a Diplomate of the American Board of Internal Medicine. The diagnosis of cancer of the breast was made. This was confirmed by frozen section. The breast was removed. There was no spread to the glands and her outlook is moderately good.

Fourth, we have received invaluable advice from a large number of competent medical people who helped us work out our program, helped us solve medical problems and who have given their time or have helped secure the services of doctors where we had difficult cases which we could not possibly handle under our insurance program.

I think we might also think more about establishing proper relations with the so-called minor professions -- the Osteopaths, Chiropodists, Physical Therapists, Optometrists, Dentists and yes -- even the Chiropractors. The HPCC has some working relationships -- formal and informal -- with all of these groups, and I might say we have had some very good cooperation, especially in the handling of grievances.

You may not realize that about 20 per cent of our dollar for medical services goes to the osteopath, 5 per cent to the chiropractor -- certainly a minority but we should not overlook this portion of the healing professions, but instead we concentrate only on medical doctors. I can assure you that all of these so-called minor professions are willing and anxious to work with us. They have proven it many times -- well, maybe this isn't true of the dental association.

Incidentally we have a plan under which we pay chiropractors. Some will say we are wrong -- and maybe we are -- but nevertheless we pay them.

I must confess that I just had my first meeting with their association after paying their claims for about five years. I found here that there are among Chiropractors men who are willing to work with us. I think we have too long overlooked trying to establish working relationships with the men of good faith in this growing profession.

We have received some good help in one instance already. The Association also has indicated that it would set up a grievance committee to help us. I don't know if it will be effective, but this action certainly indicated a desire to be cooperative.

Before leaving the area of relationships with doctors and hospitals, I would like to stress the importance of establishing proper relations with nurses and assistants in the doctors' offices. We have found that in many cases our real problems were not with the doctor, but with his office staff. As a result, several of our administrators have met from time to time with groups or associations of nurses. The results have been very favorable both from our standpoint and theirs. One problem which may not exist widely but which we found was causing us some of our real problems was that in some offices nurses, in addition to their salary, are given a bonus,

which amounts to a percentage of collections. Thus, we found that in some cases we were being charged more than the doctor intended because of the desire of the nurse to get a few extra dollars for herself. We also found that our meetings resulted in getting some very good cooperation administratively and in some cases establishing good relationships with doctors with whom we had had bad relations.

So far we have dealt with abuses by doctors and hospitals and discussed some of the activities in this and related fields by the HPCC. It is time now, though, that we start doing some positive thinking and planning that Mr. Becker believes will result in improved medical care and better prepayment plans for your members.

I would like to present a few ideas to which I believe we should give serious consideration. In the hospital field it is my feeling that we must do several things:

1. Unions or funds, or perhaps both, must get into the hospital picture. There are so many hospitals in our area where Administrators tell us that over 50 per cent of all their hospital patients come from union or management health and welfare funds, but to my knowledge there is not a single hospital that is owned or operated or financed or influenced effectively in any way by labor, management or their joint funds. I know of only one hospital that has a labor representative on its board of trustees. This situation can be blamed to some degree on labor union leaders themselves, who have been invited to participate and have not done so. It would seem that any labor leader who is invited to sit on the Board of Trustees should take advantage of this offer.

We have been working towards this end and I am happy to report that one hospital which will open soon has informed us that they will allow the HPCC to appoint one union representative to its Board of Directors. We hope that this will materialize.

Since everybody else is running the hospital business except the people who are paying the bills, it would seem obvious that it is time that the purchasers of services have some say in the mathematical aspects of running a hospital. If we hope to do anything about the rising hospital costs, we must have some say in their administration. Also the quality of hospital services will be improved and abuses alleviated if we have persons on the Board of Directors of hospitals whose interest is in the health of the member and not solely in the health of the financial statement.

2. We must find a different method of paying hospitals. The uncontrolled practices that exist today can never be properly controlled under present conditions. If we are to know what hospitalization is going to cost us, we must do two things:

- a) Expand the Blue Cross theory of contracting with certain hospitals more effectively. In other words, make more rigid requirements for a hospital to be eligible for welfare fund payments. Perhaps certain standards can be developed or perhaps we should recognize only accredited hospitals.

Incidentally, we might direct more attention towards trying to direct our members to the accredited hospitals in our areas. This would eventually lead to better hospital care and better protection for our members, as the accreditation program is primarily concerned with better hospital care for the patients.

Did you know that Southern California probably has a smaller proportion of accredited hospitals than any other comparable area in the country, and that in the San Fernando Valley there is one one accredited M.D. hospital in an area with a population of over 700,000 people?

What is the importance of the Accreditation Program to you? Primarily it was adopted to raise the quality of hospital care and furnish protection to the patient. The following organizations participate in the Joint Commission on Accreditation of Hospitals:

American College of Physicians
American College of Surgeons
American Hospital Association
American Medical Association
Canadian Medical Association

The Commission has set standards for hospitals in order to qualify as an accredited hospital. A few of these follow:

The Buildings of the hospital must be solidly constructed with adequate space and safeguards for each patient. There must be:

Sanitary environment to avoid sources of transmission of infections; Facilities for isolation of patients with communicable diseases; Emergency lighting in operating, delivery and emergency rooms; and Adequate diagnostic and therapeutic facilities.

The governing body of the hospital is legally and morally responsible for its conduct. In the discharge of its duties, it places the responsibility for the medical care of the patient in the hospital primarily upon the medical staff.

Each hospital shall maintain a medical record on every patient admitted for care in the hospital.

(Recently we inspected the chart of one of our members at a small non-accredited hospital. There was no notation of any kind on his chart for the last 31 hours of his alleged hospitalization. Either the hospital was lying about his hospitalization to collect additional benefits or it was grossly negligent in keeping of records and protecting the health of its patient.)

Most important though is the responsibility of the Medical Staff to see that the medical record contains sufficient information to justify the diagnosis and warrant the treatment and end results, and that all tissues removed at operations should be sent for examination. The extent of the

examination should be determined by the pathology department. It shall also see that there is a constant analysis and review of the clinical work done in the hospital.

This is the key to accreditation in my opinion. The "scalpel-happy" surgeon that Dr. Johnson refers to has no restraint in the non-accredited hospital and as a result the large percentage of hysterectomies done in some of these so-called hospitals would amaze you.

Finally, except in emergency, consultation with another qualified physician shall be required in all first Caesarean sections and in all procedures by which a known or suspected pregnancy may be interrupted. The same requirement shall apply to operations performed for the sole purpose of sterilization on both male and female patients. In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure, or when there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate.

It is also time to begin to analyze the hospital expansion program, especially in the Los Angeles area, to determine whether or not we are getting the proper type of hospital. The trend appears to be toward small hospitals. You might ask what's wrong with the small hospital.

Aside from the fact that small hospitals often are privately owned for profit, they are often operated inefficiently, only partially or poorly equipped, do not meet many standards of accreditation, are subservient to the staff, and in some cases unsanitary -- two such hospitals in Los Angeles were recently closed by the Health Department. No matter how well intentioned, no small hospital can have all the supplies and modern equipment necessary for the full protection of the patient. Quality of care is bound to suffer and the safety of the patient will be endangered. Perhaps you should give some thought as labor officials to working with other community groups in securing for our communities the completely equipped community hospitals that furnish all the modern medicines and methods that will fully protect the patient.

We might also encourage the building of hospitals or adding of hospital wings for the care of the chronically ill patient. Presently we are paying charges geared to acute hospitalization for chronic cases. In an aging population thought must be given to separating the chronic case from the acute. Since the profit in hospitalization is in the acute case with high initial costs and quick turn-over, experiments in this direction will be rare but they can prove valuable. In Arkansas City, Kansas for example, a separate wing for chronic conditions was utilized at the Arkansas City Memorial Hospital. The total charge there is \$4.50 per day as against \$18.80 in the main hospital. I am told that all the service and medical protection the patient needs are furnished at this price. Perhaps, we cannot expect this much of a gain but certainly there is no need to continue to pay \$35 per day in our area for a chronic heart or TB case when we receive little more than needed bed-rest.

We might consider revising our method of payment from itemized hospital bills to a flat amount per day or per case. There have been some

experiments in this field. For example, one hospital found it very profitable to charge a flat rate for certain routine procedures, tonsillectomies, deliveries, appendectomies, etc. We believe that this theory might be expanded. There are hospital administrators who have indicated a willingness to contract at a flat amount per day with a fund for all hospitalizations. This would enable us to determine our cost obligation as well as reduce hospital administrative costs. One recent itemized statement we received contained over 10 pages for hospital extras! Without mentioning the cost to us think of the bookkeeping costs involved when there are 18 separate charges for wipes (tissues) at 15¢ each -- 31 for mineral oil at 25¢ each, and numerous similar charges for pills, aspirin, etc.

In regard to doctor relationships I think it is time that we turn to the medical field for more advice concerning our insurance programs and time that we realize that our programs are not realistic. For example, our surgical fee schedules in many cases are ridiculous. They were devised by antiquated insurance doctors who in some cases have not practiced medicine for many, many years! The relationship between payments for various operations often has no real relationship to charges and inevitably leads to friction between the doctor, the patient, and the fund office. In most cases, the schedules have not been revised for many years although medical practice is constantly under revision.

In California we are fortunate in having had the State Medical Association adopt a so-called Relative Value Schedule. This is a new schedule. I feel that our funds should adopt it in principal in revising future schedules. At least we will know that the payment for an appendectomy is in line with a payment for a craniotomy. It may be that because of finances we may have to underpay on both, but at least there will be some proper relationship between various surgical or medical payments.

The California Medical Association has worked hard and spent lots of money to make this schedule possible. I am sure that the C.M.A. personnel, such as Bob Thomas here, had their trials and tribulations. I am sure that the reactionaries in the C.M.A., and they are powerful politically, have hoped that this program would become ineffective. Why? -- because it takes the mystery out of relative medical costs and makes it possible for a lay administrator to determine, within reason, whether or not a charge by a doctor for an unusual operation is out of line or not. In this respect we can establish good relationships and at the same time improve our fee schedules.

We must also recognize that regardless of how much money is available, when purchasing an insurance program, there must be limitations of some type. I think that it is time we consulted with medical people concerning these limitations and tried to determine in relation to health needs which limitations should apply to particular groups. We cannot continue to rely on insurance carriers who have no knowledge of our medical problems. For example, in our own plan our method of payment for serious heart conditions, which is one of the big problems in our industry, is very poor. In fact, it is so bad, that I have commented on previous occasions, perhaps somewhat facetiously, that a claimant is apt to have a second

heart attack when he sees our payment in relation to his bill. On the other hand, we are overly-generous in payments for some minor medical treatments, especially in the case of minor accidents where we are wide open for abuses of every type.

Two cases demonstrating this come to mind. The first concerned one of our members who suffered a serious heart attack and as a result was out of work several weeks. His initial medical bills, excluding hospitalization, amounted to over \$400, and included night calls, several hospital calls per day for over two weeks, a consultant, etc. We paid for 18 hospital calls at \$4 each or \$72. The second concerned a member who received numerous head cuts in a fight. He had them cleansed and sutured in about an hour -- had a few routine visits, then the stitches removed, lost no time from work. His bill was \$120. We paid it all.

I am sure that union leaders generally want to meet all the necessary medical expenses. However, since very few are able to do so it seems that the available money should be redistributed, after medical consultation and evaluation of the needs of the group, so that its full value is realized.

Recently representatives of the C.M.A. met with representatives of the Construction funds in Northern California in an effort to try and develop a working relationship. The C.M.A. last week sent a communication to the Construction Funds in which they offered to assist funds in trying to develop the proper types of medical services for their members. I don't know just what this means but, perhaps, Bob Thomas will comment on these meetings and on the willingness of the C.M.A. to cooperate with the various funds.

Finally, in relation to the problem with doctors, I think that we must recognize that no insurance program can, in advance, develop a fee schedule that will equitably cover every possible situation. This was recognized in our Additional Accident benefits, even though it was developed in an unsatisfactory manner. It seems to me that if we are to face our problems realistically that we must have some provision for securing competent medical advice or some type of medical review to determine proper payment for unusual cases.

Some C.M.A. representatives have long felt that insurance companies should set aside a small portion of its premium income for a fund to take care of these unusual cases. I am sure that they feel this same principle should apply to health and welfare funds. It seems to me that this is the only way we can ever hope to take care of this type of case. Surely the insurance company major medical approach has not supplied us with the answer. Here again I wonder if the C.M.A. might cooperate in setting up medical review committees to advise the funds in this respect.

The principle of special payments for unusual cases is recognized in the Relative Value Schedule which I mentioned earlier. In this instance a few items are not scheduled because of their rare nature and the complexity of problems arising in the treatment of certain conditions. These are determined by special report and, for example, in Stockton where this

schedule has been widely adopted a medical committee reviews all such claims and determines whether or not the doctor's charge is proper.

So much for doctors and hospitals. From the union side we can take certain actions that should better relationships, put our programs on a sound financial basis, and improve the quality of service:

1. We can make a real concerted effort to establish sound relationships with the associations by working with their various committees when the opportunity arises. At the same time we can create good feelings with the decent doctors and hospitals by working closely with them in an effort to simplify their office procedures. For example, if we could get all the funds to adopt standard claim forms and fairly uniform fee schedules, if we could all give members identification cards that would help doctors and hospitals in filing claims, I am sure that we would receive much cooperation in return. In other words I believe we can recognize many of the doctor's problems without surrendering our right to continue to oppose abuses, excessive charges, and unnecessary treatment.

2. We can encourage experimentation and competition in the hospital and medical fields by cooperating with services willing to lead the way. In Stockton, California, for example, the Medical Association has sponsored a pre-paid plan with strong safe-guards for both quality and cost of medical care. They deserve the full cooperation of unions in the area.

This cooperation will pay dividends. In Stockton many members of the medical profession have worked tirelessly to protect the interest of the members and the funds. Their plans are proving financially sound because of this and they are now beginning to expand benefits, I am told. In Long Beach the doctors have also set up a plan of their own and have done much to stabilize costs while improving both the quantity and quality of medical care. In San Pedro and Redondo Beach similar efforts are being made and a little encouragement would help the doctors who are community-conscious in these areas.

3. We should consider in each community a centralized office or committee to work as a coordinating body between the funds, the professional groups, and the members of the unions. In the larger communities there is need for a full time person to do this job. Better relationships could be established between the various groups by a person whose full-time is given to this problem.

In Los Angeles we have the Health Plan Consultants Committee and the Association of Health Plan Administrators doing some work in this field. Staff shortage makes effective work limited, however. The East Bay Welfare Council is working toward the same end in Alameda County, and in San Diego consideration is being given to expanding labor activities in the Health and Welfare field.

4. We should encourage educational projects from both sides; surely labor needs to understand better the professional groups and I can think of no group that needs to know better the problems of working people and

their desires and needs than the average doctor. It is also necessary to educate members as to the proper use of the programs. We have found that they are responsible for many abuses of the programs and have, in some instances, been responsible for causing bad relations between doctors and the welfare program.

At the beginning of this talk I posed the question whether or not we should try to establish sound relationships with the various professional groups. I have stressed the abuses as a reason for pursuing this program and only touched lightly on the positive gains. I did this, however, in order to make the answer to my question obvious to all.

I don't believe that sound labor leaders should negotiate a contract with management and then sit back and relax. It is well recognized that labor-management contracts can be largely nullified by the failure of the union to effectively police contract abuses and to fail to establish sound working relationships with management at all levels.

Your health and welfare programs are part of your negotiated contracts, but instead of dealing with management to make them effective you must deal with the individual practitioners, the individual hospitals, and all of the various associations.

While you have every right to ask for the full cooperation of all of these groups, you must be realistic in your dealings just as you are in your dealings with management. For instance, while you cannot expect to have doctors go along with a fee schedule that provides payment far below the going rate in the area, you must oppose vigorously the tendency for many doctors to raise their fees to higher levels because of the impact of insurance programs.

You must recognize that while you must deal with the Associations, you cannot rely on them to solve all your problems. While they can help in shaping policy and in extreme cases, most of your effective dealings must be with your community medical groups and the practitioners and hospitals in each community.

Finally, I think we must adopt a more positive attitude towards the professional groups. We have spent too much time publicly berating doctors and hospitals -- perhaps this has been necessary in order to create a public awareness to the problem. I think it is now time that we try to seek the help and cooperation of the many fine professional people and groups in each community. Their interest is primarily the same as ours -- namely protection of the health of their patients -- your members. If we can work effectively with them we cannot only secure better health protection for our members, but we can make some substantial strides toward getting rising medical costs under control.

HEALTH PLANS AND THE C.M.A.

By

Robert L. Thomas
Assistant Executive Secretary
California Medical Association

I appreciate this opportunity to discuss with you the relationships between health and welfare plans and the Medical Association.

This meeting reminds me of one held here in Santa Barbara in June of 1954 under the auspices of the Tri-county AF of L, CIO, the Health Plan Consultants Committee of Los Angeles, and the Institute of Industrial Relations at UCLA. Those of us who participated in that meeting were somewhat doubtful of each other, perhaps uncertain of the relationship which existed, but, most importantly, uninformed on our respective principles and organizational programs.

The CMA benefited greatly from that meeting, and I hope the labor representatives did also. We found that it was possible to develop good relations with people in the labor movement. My being here today is evidence of our willingness to explore areas of mutual interest.

But what of the relationships between medical organizations and health and welfare plans?

For example, there is a need for better cooperation and closer liaison. There is room for improvement in the relationships. If real progress is to be made, not only in developing better relationships but also in the field of medical care insurance -- there must be an understanding of mutual problems and a sincere desire to work together within the framework of our organizational limitations, general policies and fundamental principles.

In some particulars, organized labor and the medical profession have very similar objectives; namely, better service to the membership and the provision of the best possible medical care to all patients.

On the other side of the coin, health and welfare plans represent, in a large degree, the buyers of medical care and medical organizations represent sellers of that care; each with differing philosophies, attitudes and methods of operation.

Keeping these points in mind, the question arises, "Why have better relationships failed to develop?" No one can, in all honesty, point an accusing finger at either labor or the medical profession. By the same token, no one can rightfully say that the failure to establish better relations is largely the responsibility of any single group.

Today we are all caught up in a period of changing times, the development of new concepts in social thinking and an ever changing economy. Even though differing ideologies and philosophies exist, and will probably continue to exist, progress is being made. The blending of time and the mellowing of interpretation through knowledge and understanding are certainly heavy contributors to this progress.

But this alone is not enough. The position of the Medical Association has never been clearly defined and, before further developments can be achieved, it is necessary to have a clear understanding of the California Medical Association -- What is it? -- What are its principles? -- What can it do? -- What can it not do?

The CMA is a voluntary membership association of doctors of medicine in California. Membership in the CMA is not a prerequisite to the right to practice medicine in this state. Let me explain this important point. In California today, there are over 20,000 doctors of medicine of whom approximately 15,000 hold membership in the CMA. Another 10,000 physicians hold California licenses but are not in active practice within the State. The State Board of Medical Examiners currently issues licenses to some 2,000 physicians each year. Naturally, not all of these men are entering practice in the State immediately; nevertheless, enough of them do begin practice that they constitute a large group of individuals who are not familiar with affairs in this State, and who may not be acquainted with the progressive programs of California physicians. Neither the CMA nor its forty component county medical societies has an opportunity to acquaint these new physicians with the profession's objectives until these men individually see fit to apply for membership in a county medical society.

The Council of the CMA, our day to day governing body, has recently expressed in definite terms some basic principles which have been arrived at over CMA's many years of continued efforts to protect and safeguard the welfare of all patients. Effective cooperation between the Medical Association and organized labor hinges upon an understanding of these principles and a willingness to jointly seek solutions to problems, bearing in mind that the patient's welfare must be considered the foremost factor at all times.

First a resume of the basic principles of the CMA:

1. The CMA believes in the fundamental principle of free choice of physician. By way of explanation: The Association believes that the best medical care is provided to the patient who, through personal selection, can choose the physician in whom he has the greatest confidence -- a physician with whom he can discuss each problem in confidence, and who, because of his particular skill and training, the patient feels can render the best care for him as an individual.

Furthermore, the Association is of the opinion that the best quality of medicine is provided to the patient if he is free to change physicians in the event he becomes dissatisfied with the professional services rendered in his behalf. In this same vein, and for these same reasons,

physicians must be free to accept patients of their choice and to terminate care if the intangible elements of the doctor-patient relationship should cease to exist. In a competitive market, physicians strive to provide the best care within their means. Patients, naturally, are seeking personal physicians who give them the most satisfaction and the best care.

2. The CMA recognizes the right of any individual or any group of individuals to select the type of medical care insurance program desired. Everyone is entitled to a free choice of medical care plan. In California there are no legal barriers against the establishment of groups, cooperatives, or other types of medical care programs. People certainly must have the individual right to select, on their own volition, the type of program which best suits their needs....the California Medical Association has, on numerous occasions in the past, encouraged experimentation in the development of new types of pre-paid medical care insurance and follows each new innovation with a great deal of interest. To further emphasize this point, I should like to quote from the report of the Commission on Medical Services of the Association to its House of Delegates in 1954, ". . . to proceed upon the assumption that only the medical profession knows what is good for people and should therefore attempt to legislate or by any other means dictate what kind of health plan should be made available to people is to be naive. . . ."

3. The CMA stands, and has always stood, unalterably in favor of provision by physicians of a high quality of medical care to patients -- both individual patients, and those who are members of plans.

4. The CMA is completely in accord with the principle that fees for services performed by physicians must be reasonable and related to the service performed and not to the amount or type of insurance available to the patient. The CMA recognizes variations in fees because of geographic differences; varying degrees of training, skill and experience of physicians; and different conditions encountered in treating different patients -- the usual versus the unusual cases.

For the past five years, the CMA has urged that each county medical society within the State make known the facilities of its public service committee. The function of these committees is to provide the public, insurance companies, health and welfare plans, and other interested people with a method by which they may receive an unbiased professional opinion regarding medical care and related fees.

The four principles which I have just outlined are ones which have stood the test of time and have been adopted by the medical profession as being necessary to the safeguarding of the welfare of all patients.

The limitations of authority of the CMA over individual members and its general policies should be known and acknowledged.

The CMA, guided by its democratically conceived structure and its basic concept as a voluntary organization, cannot command its individual members to provide professional services in any set or mandatory manner. It should be understood that:

1. The Association has no authority whatsoever to dictate to its members what fees they must accept for any particular service, whether it be service provided for an individual, a group, a trust fund or even for California Physicians' Service. Likewise, CMA cannot direct, nor does it desire to force, its members to perform any services under fixed or arbitrary schedules of compensation.

2. The CMA cannot make an agreement with any party, private or governmental to the effect that its members will accept a pre-determined schedule of fees as complete payment for services rendered. CMA can recommend. CMA cannot enforce. For example, the contract between the Department of Army and CMA implementing the provisions of Public Law 569 (MEDICARE) states that ". . . The Medical Association shall encourage physicians in the State of California to provide medical service for dependents of service personnel. . . a physician shall have the right to decline to participate under this program or to refuse any individual case without stating a reason therefor. . ."

* * * * *

The CMA can, and willingly, offers those services which are within its proper functions as a voluntary medical organization.

1. CMA offers for the serious consideration of labor unions and trust funds its widely accepted Relative Value Studies which were developed after several years of careful analysis of medical services and surgical procedures. On the basis of your own experiences and statistical studies, it is CMA's sincere belief that the application of these medical and surgical related values will help you to arrive at and establish a realistically integrated medical care program.

2. CMA offers its professional assistance in reviewing the payment schedules of your health and welfare plans in accordance with relative values.

3. CMA will continue to expand and emphasize its program of urging physicians and patients to discuss in advance the prospective costs of surgical or other procedures. CMA will cooperate with health and welfare plans to educate your beneficiaries on this important point.

4. CMA can, and will, urge its county medical societies to make their public service committees available to all trust fund administrators for the review of fees which appear to the administrators to be questionable. Such reviews, from our past experience, will result in the satisfactory adjustment of fees in relation to the services performed, or give assurance to the trust fund administrator that, based upon impartial professional analysis, the fees are justifiable.

The CMA offers you cooperation in the sincere belief that it will bring about a better understanding of mutual problems and provide a basis whereby joint efforts can be combined with the objective of providing the best possible medical care.

LABOR-MEDICAL RELATIONSHIPS IN SAN FRANCISCO

by

George Johns
Secretary
San Francisco Labor Council

It has been estimated that some 50 cents of each premium dollar is diverted into channels other than actual "health value" for members.

This results from a number of causes some of which have already been discussed in this conference. Of interest to this panel are the charges of wasteful expenditures resulting from abuses of fee schedules, provision of unnecessary hospital, surgical and other services and excessive claims rates for hospital and surgical services resulting from the exclusion of benefits for preventive, diagnostic and early medical treatment in the home and office.

In San Francisco, our Labor Council has attempted to remedy some of these problems.

In the matter of the hospitals we have not made a direct approach. Instead, we have participated in community efforts, notably in cooperation with our Community Chest, in trying to survey and find answers to the many problems. We have had most indifferent results, despite many efforts in this direction. Although we have been able to establish happy relations with many administrators, the fact remains that the ultimate decision usually rests with the various hospital boards.

Of one thing we are certain. The often made claim that wages are the cause of ever-increasing hospital rates can be very simple and quickly disproved by an examination of the wage scales and working agreement of the Hospital and Institutional Workers Union.

In looking at present, private hospital administration a substantial question arises in my opinion as to whether or not the private hospital as we know it will every survive another depression or serious recession. This indicates a nasty word, Socialization.

In the case of the Medical Society we have had a direct relationship. Since 1951 many meetings, official and unofficial have taken place.

We have not tried to decide doctor's fees, but we have requested a reasonable fee schedule that a reasonable number of doctors would accept.

In 1953 the County Society effectively ended a long series of meetings by official and unilaterally approving a fee schedule which was prefaced by the following statement of principles:

- "1. The schedule prepared by the Society is intended solely as a guide in the preparation of any prepaid health insurance plan for a \$5,000 (or less) a year family income group."
- "2. All fee schedules submitted as a guide would be subject to review and revision if necessary with a reasonable period of time (two years) by a committee of representatives of the medical profession."
- "3. We recommend that the fee schedule apply in toto to all such prepaid health insurance plans. However, we realize that complete inclusion of the whole schedule may not be practicable at this time. If this is not done, the schedule may not be referred to as that prepared by the San Francisco Medical Society unless all exceptions such as omissions, changes, etc., be prominently described in the fee schedule and other literature."
- "4. Fees should be arranged prior to rendering of service whenever possible, and it should be clearly understood that the patient is obligated solely to the doctor for services received; the insurance payment should be an indemnification to the patient to assist in the payment of the bill. No member of the Society is obligated or compelled to work by this schedule."
- "5. The principle of co-insurance should be invoked in this fee schedule whenever possible."

This statement was obviously unacceptable and from that time until now, formal discussions have been discontinued.

At the request of the Society we did submit 12 test cases for review by their Ethical Practices Committee. This we were reluctant to do as we had no desire to see the Labor Movement become, in effect, the District Attorney of the Medical Profession. The results of this action on our part exceeded our anticipations as in one of the 12 cases we heard that they did criticize the doctor involved.

You will note I have not used the word negotiations in referring to the above mentioned meetings with the Society. Negotiations indicates a possibility of compromise. This was never evident.

Recently, by registered, return receipt mail, we sent a communication to all doctors in San Francisco.

(This communication included a letter and a fee schedule, copies of which have been already sent to all affiliated unions).

This created quite an impact in San Francisco. You would be fascinated by some of the replies I received.

Although the response in terms of signed fee schedules was not impressive, we received a great number of communications from doctors which were most heartening and demonstrated that many individual doctors were becoming increasingly aware of the problems involved.

As a direct result of this action, our Labor Council committee has been invited to meet with a committee of the County Medical Society on August 8th. We will proceed from there. Our committee consists of Brothers Phillips, Goldberger and Johns.

In conclusion I should like to suggest the following:

1. It seems to me that standardization of forms, particularly claims forms covering services of doctors, hospitals, x-rays, lab, anesthesia and ambulances would be of great value.
2. It also seems to me that standardization of the list of procedures contained in fee schedules would be of great value in clearing up much of the existing confusion.
3. In my opinion, the answer to almost all the problems that plague us has been clearly placed before us by almost every qualified speaker. This answer lies in a militant, courageous approach on the part of labor leaders to establish competition between the various plans. If the individual member had a completely free choice of type of plan whereby he could compare the various offerings, the inherent competition should help alleviate our present worries.

I subscribe to the eventual necessity of recognizing these problems are local problems, not national, as it is in the local area that medical service is tendered and where abuses exist.

And I believe the choice of plan should include insurance plans; self insurance programs; fee for service plans; use of industrial medical facilities; hospital plans; group practice plans; consumer operated health centers; Labor's own health center; Health and Welfare plans that should be established by State and Federal Government and any other conceivable type of plan that would broaden the choice of our members and establish the type of competition necessary to keep some people within the bounds of reason.

The word Utopia has been used here....This is not Utopia.... This is Necessity.

RELATIONSHIPS BETWEEN WELFARE FUNDS
AND HOSPITAL ASSOCIATIONS

by

James E. Ludlam
Legal Counsel
California Hospital Association
and
Secretary
Hospital Council of Southern California

Hospitals may be members of a number of different associations, ranging from a national level to the local level. An individual hospital may be a member of one or more of these associations as membership in any one is not a condition to membership in any other one. Although none of these associations has any control over the activities of any of its members, all of the associations have an impact upon the availability and quality of the hospital care furnished in any area. The more important of these associations are:

1. American Hospital Association. This association is the spokesman for hospitals on all nationwide problems and also in Congress. It is a prime mover in the field of education of hospital personnel through institutes and manuals. It is a joint sponsor of the joint commission on accreditation and is active through the Blue Cross Commission in approving the various Blue Cross Plans. The A.H.A. has been of great importance in improving the standards of hospital management, cost control, and quality of care.

Each welfare plan should have a real concern for the quality of care its members are receiving. It can best assure this through seeing that its members are hospitalized at an accredited hospital or one that is genuinely striving for accreditation.

2. Association of Western Hospitals. This is a regional association of hospitals in the thirteen western states. Its most important function is a large well organized convention held each year, at which the suppliers display the latest equipment and new ideas, and problems are discussed. This association is also directly responsible for an extensive educational program through local institutes.
3. At the state level we have the California Hospital Association, made up of about 450 out of the some 600 hospitals in

the state. Although not all hospitals are members, the leadership in the hospital field centers in this association.

Logically, this association is primarily concerned with the status of hospitals and the quality of care in this state. The association acts as the spokesman for hospitals in Sacramento, as well as to all statewide matters. It has established a nationwide reputation for its aggressive promotion of better and safer hospital care. Any new problem that develops is reviewed by it for solution. The association is now actively supporting a program for uniform accounting on a statewide basis.

4. At the local level we have the councils or conferences. There are now ten of these throughout the state. They are either on a countywide or multiple county basis. With the exception of the San Francisco Conference and the Hospital Council of Southern California, these groups do not have a paid staff and must rely entirely on volunteers or elected officers to perform their administrative functions. These groups are concerned with the same problems that concern the welfare funds, such as relationships with third party contractors, abuse of insurance, abuses by insurance carriers, and the like. It is at this level that the welfare fund directors should make their contacts for working out mutual problems.

It should be pointed out that by and large these groups do not know about the problems discussed at this meeting. They have heard a lot of generalized statements from insurance executives or welfare fund directors, but to date they have been given little, if any, specific information about alleged abuses by hospitals. They would be willing to work out mutual problems over the table but they are sick and tired of being blasted in the newspapers by a lot of general statements that blanket the good operators in with the bad. Unless they are given the specific information as to what the abuses are and who is guilty they can be of little, if any, help. Furthermore, this is a give and take proposition. If the fund managers and the insurance carriers are seeking cooperation they must be prepared to clean up their own practices. Obviously this is an area where there is much misunderstanding and some bad will, which can only be cleared up when mutual confidence has been developed. It is a two-way street.

Much has been said about labor representation on hospital boards. There is considerable merit in the idea, but actual experience has not been entirely satisfactory. The Blue Cross Board in Southern California has had two spots for labor representatives for many years. Until very recently these representatives took no interest and very rarely even attended any of the board meetings. Recently Jim Murray of the C.W.A. has been a member and he has not only been most effective in presenting the viewpoint of organized labor but he has been most constructive

in helping solve the many problems of this rapidly growing organization. If labor is to seek representation on boards of community institutions such as hospitals, it must also share in the responsibility that flows from such representation.

Many proprietary hospitals present a problem. However, not all should be condemned for the abuses of a few operators. Actually the proprietary hospitals fulfill a real need in our communities. In a rapidly growing area there is not sufficient community support to build the necessary nonprofit hospitals. The proprietary hospital is the only alternative to no hospitalization. It is extremely difficult to obtain financing of these projects and by and large they are financed by the personal guarantees of the participating doctors. They expect a large return for taking this risk. Unfortunately in some cases the emphasis has been on the financial return instead of quality care at a reasonable cost.

In conclusion, I can assure you that the leadership in the hospital field is more than willing to cooperate on mutual problems. It must be recognized that both sides are trying to solve difficulties that at the moment appear to be almost insurmountable. However, the progress in the field of prepaid hospital and medical care indicates that nothing is impossible when approached by people of good will.

SUMMARY OF REMARKS ON LEGAL ASPECTS OF HEALTH AND WELFARE FUNDS

by

Charles P. Scully
Counsel for the California State
Federation of Labor

(1) With respect to negotiations, he discussed the distinctions and ramifications resulting from negotiating health and welfare benefits as distinct from the money amounts.

(2) With respect to trust agreements, he discussed the necessity of the immediate completion of a trust instrument tailored to meet the needs of the particular plan and complying completely with both federal and state laws. In this regard, he stressed the necessity of prompt application for ruling from the respective state and federal agencies, particularly with respect to the tax incidences and in this respect pointed out the tax hazards that resulted from the insistence of certain groups including both employers and employees under the plan.

(3) With respect to ownership of property by the fund, he mentioned the present uncertainty as to whether or not certain trusts could take clear title to property without some holding agreement and stressed the necessity of immediate clearance of such problems with responsible attorneys before the funds should enter into such purchases.

(4) With respect to group practice through trust controlled clinics, etc., he also stressed there were substantial legal problems that should be cleared in advance of the establishment of any such programs.

(5) With respect to policies, he stressed the importance of a complete and thorough review of the policy by competent consultants and counsel to insure that the policy provided what the trustees thought they had purchased.

(6) With respect to regulation, he reviewed the existing and proposed regulation at both the federal and state levels and reviewed in detail the provisions of the application of the so-called Rees-Doyle bill which will become effective in California September 11, 1957.

(7) With respect to Labor Commissioner proceedings, he reviewed in detail the application and operation of Section 227 of the Labor Code dealing with the collection of unpaid contributions and noted

the decision of the Los Angeles Municipal Court in the case of Manuel Alves, No. 64496, which held the section unconstitutional. He recommended serious consideration by interested trust funds and perhaps filing of a brief amicus curiae on the appeal of this case before the Appellate Department of the Los Angeles Superior Court.

(8) With respect to bonds, he reviewed in detail the protection afforded to the funds by bonds, both public and private, and discussed fully the implications of the decision by the United States Supreme Court in the so-called Carter Case involving the Miller Act.

(9) With respect to bankruptcies, he reviewed in detail the conflicting decisions with respect to priority of health and welfare contributions as wage claims under the federal Bankruptcy Act and indicated that undoubtedly the United States Supreme Court would have a final decision on this matter in the near future.

(10) Self-Insurance. He reviewed in detail the uncertainty of the law with respect to self-insurance by health and welfare funds. He stated his opinion that such was permitted under Section 669 of the Insurance Code but understood that the Insurance Commissioner had some reservations in this regard. He noted the desirability of obtaining a specific ruling from the Attorney General in this regard and advised that such application would be made in the immediate future.

He also reviewed the possibility of regulation by other authorities, such as the Corporation Commissioner or the Attorney General's office, depending upon whether the operations might constitute sales of securities or a charitable trust.

(11) Reserves. He discussed the possibility of application of the rule against unreasonable accumulation and the rule against perpetuities as far as this type of trust fund is concerned.

(12) Recent Legislation. In addition to the Rees-Doyle bill, he reviewed other recent legislation such as that permitting the state to contribute like all other local bodies to negotiated joint trustee health and welfare programs.

CONCLUDING REMARKS AND SUMMARY

by

C. J. Haggerty
Secretary-Treasurer
California State Federation of Labor

I believe you share with me the feeling that this has been a highly educational and worthwhile conference. What we have learned should be helpful in the development and improvement of health and welfare programs on the most beneficial basis possible.

It became clear, during this week, that there is no single way of resolving the problems in health and welfare programs. Aside from that, it is also clear that many of the problems will require solutions which may take some time and diligent and informed effort to work out.

The proceedings of this conference, which will be distributed at a later date, will furnish to each of you and to the unions throughout the State a fine reference source which can be referred to time and again, in the future, as a place where you will find provocative, stimulating, and realistic information.

I will not attempt to summarize in detail each of the papers which were presented at the conference or the details of the panel discussions. Your attentive interest throughout the conference would make this kind of "repeat performance" unnecessary. However, I will review with you briefly the highlights of the papers which were presented, and the panel discussions, as I appraise them simply as part of this overall summary of the constructive work done this week.

On Monday morning, Professor Pfeffer spoke of the shortcomings in both negotiated and non-negotiated plans. He reviewed some already well publicized abuses. He made the point that there would undoubtedly be a continuous growth in the negotiated type of plan.

Mr. Hughes of Crown Zellerbach gave an interesting management point of view when he said that even in the so-called employer-administered programs it is possible to involve the employees and the unions in the development of the benefit package. He also said that a well-organized educational program can keep the employees fully informed on all pertinent aspects of the program.

At this panel discussion, Ronald Weakley, Secretary of IBEW, Local 1245 commented on the experiences of his organization.

Monday afternoon there was a spirited discussion about service versus indemnity plans. Lane Kirkland, who gave the principal talk on this subject, made what I think was a most pertinent observation when he said that the words "Service" and "Indemnity" do not mean nearly as much as what the actual content of the plan is -- regardless of its name. He stressed the shortcomings of many plans which do not provide comprehensive prepaid medical care. He expressed the view that while it was true plans could be abused and therefore cost more money, this was more desirable than no use or under-utilization which might cost lives, rather than money.

Lane also expressed considerable opposition to experience rating and said that it was the responsibility of all health and welfare plans to consider the community's needs along with the needs of each individual group.

He also discussed the advantages of group practice pre-payment medical plans and said that while this was not the only good way for providing medical care, it was a way that should be explored further and helped to grow.

In the panel discussion which followed Lane Kirkland's presentation, Daniel O'Sullivan of Union Labor Life, Arthur Weissman, Chief of Statistics of the Kaiser Health Foundation and George Lucia, Assistant Director for the Blue Cross Hospital Service of California pointed to the respective merits of indemnity and service plans. Mr. O'Sullivan indicated that in his opinion the Blue Cross was not doing as good a job as the indemnity plans offered by insurance companies. Mr. Weissman described how both indemnity and service plans have been influenced by the development of health and welfare plans -- suggesting that as a result of competition there is an increased blurring of the differences between indemnity and service plans, with each type of plan frequently taking on the more favorable, as well as the occasional more unfavorable, aspects of the other. He pointed out that the Kaiser plan represents a totally different approach -- complete medical service on a group practice basis. He expressed the view that the ultimate developments in this field will be affected by the needs and experience of workers now under many different kinds of plans.

On Tuesday morning Martin Segal, pension and welfare consultant, gave an analytical paper on self insured versus insured programs. It must have been a fair statement of the advantages and disadvantages of self insurance versus insurance, and the considerations which could be taken into account when this question is before trustees, because the panel members who commented on Mr. Segal's paper had no disagreement with him on the essential facts he presented despite the fact that each of the panel members has a background and point of view which would lead each of them to take a rather hard position, on different sides of the question, under ordinary circumstances.

I think too, that Mr. Segal pointed up the fact that the question of self insurance versus insurance was not one on which there could be

glittering generalizations. It is evident that in each situation there must be an objective analysis of the facts to determine what kind of an arrangement is best for the particular fund involved.

We appreciate the participation of the panel in the Tuesday morning session on self insurance versus insurance, and we extend our thanks to Clarence Tookey, George Elner, and Irving Pfeffer.

On Tuesday afternoon Carroll Lynch delivered a paper on the technical questions involved in how to increase values and reduce costs in health and welfare plans. There were some very valuable suggestions as to procedure in accomplishing these objectives in Carroll's presentation. John Thomas, Bernard Berkov, and Charles Cross, the panel, added some worthwhile observations in the discussion on this subject.

I know that many of you were interested in Charles Cross's observation about the possibility of an association of administrators of health and welfare plans in California. While such an association might be worthwhile, as a means of exchanging pertinent information among the administrators of health and welfare plans in this state, I am sure that the administrators would not attempt to get into functions of a policy making nature, which are essentially the duties and responsibilities of the trustees.

I do not know how the trustees of health and welfare funds would look upon an association of administrators if such an association were ever formed. However, I think that one administrator who spoke on Wednesday's panel stated what is probably the viewpoint of most trustees when he said that the administrator's function is basically that of carrying out the policy of his particular health and welfare fund. Further, I think it would be well for all of us to keep in mind the fact that different problems in different health and welfare funds, unions, and industries, call for different solutions and policy approaches.

On Wednesday morning we heard a discussion on effective administrative procedures. Dan Johnston, in his paper, presented some very provocative points. The panel discussion which followed as well as the floor discussions and questions indicated that virtually everyone recognized the importance of the problem of delinquent employers. I think, too, that practically everyone believed that the essential responsibility for solving the problem of delinquency rests with the local union.

On this important problem of delinquency, on the part of some employers in making their contributions to health and welfare funds, the aid of the State Industrial Commissioner's office was commented on very favorably. We are grateful to Ed Parks, State Industrial Commissioner for the time he took in addressing us on how his office works on this problem. I am sure that you will all bear in mind his suggestions which would make the work of the Commissioner's office even more effective. To Bliss Baker, administrator of the Cement Mason's Fund; Bill Clark, administrator of the Seamen's Security Fund and

Bruce Sutherland, administrator of the Carpenter's Health and Welfare Fund, we extend our deep thanks for the valuable and constructive observations they made with respect to effective administrative procedures.

The discussion yesterday morning on supplemental benefits in health care underscored the observation I made that, insofar as the benefits are concerned in health and welfare programs, we were just scratching the surface. It is quite clear already, I think, that there are many new kinds of benefits which need to be explored and which will be included over a course of future years in many health and welfare programs.

Helen Nelson, Assistant Chief of the State Division of Labor Statistics gave a resume of the many different kinds of health and welfare benefits being provided through various means. The discussion which followed her able paper indicated how some unions were exploring new types of coverage like dental care, psychiatric care and other supplementary benefits. We also heard how there are social service aspects of health and welfare programs which are getting increased attention from trustees and unions.

Yesterday afternoon, Ted Ellsworth, Administrator of the Motion Picture Health and Welfare Fund presented an excellent paper concerning the relationships of labor with medical and hospital associations. Ted indicated that relations between health and welfare funds and medical and hospital associations more seriously effect costs than other factors like the group's age distribution, sex distribution and basic insurance cost. He discussed the advisability of developing more realistic fee schedules and working arrangements with doctors which would eliminate the fee-gouging which is going on in some areas. Ted also pointed out the advisability of dealing only with an accredited hospital. From the experiences which he related, it should be quite clear to all of us, that negotiations and a sound working relationship with medical and hospital associations, doctors and hospital administrators, can be very worthwhile in securing quality care at a reasonable cost. Robert L. Thomas, Assistant Executive Secretary of the California Medical Association, stated that the CMA wants to improve its relationship with health and welfare funds. He also stated that the CMA believes that health and welfare funds should have a free choice of plans; and he offered the professional assistance of the CMA and its committees in problems relating to fee schedules or abuses of health plans.

George Johns, another panel member yesterday afternoon, spoke on what the San Francisco Labor Council was doing to make possible better hospital and medical care at an affordable cost.

James Ludlam, Legal Counsel for the California Hospital Association and Secretary to the Hospital Council of Southern California, pointed to the attempts of the American Hospital Association to have uniform accounting in hospitals. He stressed the value of the accreditation program and the fact that quality care is not cheap care. He

explained the hierarchy of hospital affiliations with all kinds of associations and indicated that the most effective level to work out problems with hospitals was the local hospital council level. He said that the members of the hospital councils were almost invariably from the best-run hospitals and for this reason the members of the councils frequently knew little of the kind of problems discussed at this conference. He suggested that administrators and trustees of programs would be wise to acquaint hospital council members with these problems and enlist their aid in resolving them.

This morning Charles P. Scully, Counsel for the State Federation, made his usual pertinent comments when he discussed the legal aspects of health and welfare programs.

At the opening of this conference this past Sunday evening, I said that we would face our problems and resolve them. Certainly the discussions that took place this week indicate the value of education and cooperation with all parties involved in one way or another with health and welfare programs. With information, a realistic appraisal of what we can and should do, unselfish devotion and integrity, I believe that health and welfare programs negotiated by unions and employers in this State will continue to move forward towards the goals of better benefits, better health, security, and the preservation of our democratic freedoms, in the interests of all of our people and the community as a whole.