THE FUND REPORTER

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SELF-INSURED FUND WINS COURT BATTLE

by Roxanne Young, *Associate Editor*

The United Optical Workers Insurance Fund has won the first and perhaps final round of a battle against New York State in federal court.

The November/December *Fund Reporter* reported the filing of *Rebaldo v. Cuomo*. The Optical Workers Fund, facing increased hospital costs of more than $100,000 each year because New York State had prohibited discount payment agreements between hospitals and self-insured, self-administered groups, sued in federal court for relief. The Fund's chairman, Sebastian Rebaldo, contended that the state law could not be applied to labor-management funds.

On March 12, the court issued a summary judgment agreeing with the Fund's argument. Self-insured welfare funds are now free to negotiate discount payment agreements with hospitals, without state interference.

The state law in question, Section 2807-a.6(b) of New York's Public Health law, is part of a complex hospital cost containment plan. It directly affected only those funds which self-insure their hospitalization benefits and negotiate discount payment rates with hospitals. This includes 60 to 70 funds covering about 750,000 people. However, the principle forming the basis of the case is of paramount concern to all welfare fund trustees and administrators.

The Employee Retirement Income Security Act of 1974 (ERISA) established the right of a welfare fund to remain independent from state regulation. Both its language and its legislative history give to the federal government the sole power to regulate employee benefit plans. With a few narrow and well-defined exceptions, ERISA preempts any and all state laws dealing directly or indirectly with such plans.

All parties to the lawsuit agreed that the state legislation dealt with employee benefit plans, and so was subject to the provisions of ERISA. The State maintained that the law regulated insurance, and was excepted from ERISA preemption.

The court granted permission to Blue Cross to enter the

(continued on page 4)

HOW TO BUY GROUP INSURANCE

by George Perla

The purpose of an employee welfare fund is to provide eligible participants with the best benefits for the dollars available. Most funds operate on an insured basis, purchasing life insurance, hospitalization, major medical, surgical and dental benefits from insurance companies. Welfare funds buy group insurance because of its economies.

It is imperative that expenditures for benefits be evaluated to assure that maximum value is being received. Plan trustees and their attorneys and accountants who are expert in their chosen fields of endeavor are not necessarily equally well equipped in the field of welfare benefits. Understanding the mechanics of purchasing benefits and of analyzing and evaluating costs can avoid premium payments that are higher than need be.

After deciding upon a package of benefits, a set of uniform specifications must be developed including plan provisions, census data and previous claims experience. This makes it possible to obtain proper competitive bids, evaluate each bidder's initial premium cost and determine which company will provide benefits at the lowest retention. Consideration should also be given to each company's experience in the welfare fund field, its administrative and claims paying facilities and its financial status. In many cases, it is also possible to negotiate rates below the initial quotation. The companies with the lowest bids should be approached, and further negotiation should take place.

In order to attract business, some insurance companies offer a "cut-rate" initial premium, at a discount so substantial that it is almost impossible to reject. The discounted rate may turn out to be the most economical, but bids should be compared on the basis of long range net cost, rather than on initial cost.

Many funds automatically buy insurance from the company with the lowest initial premium. Funds that buy on the basis of cut-rate initial premiums are frequently subjected to substantial premium increases at a later date. This is a dangerous situation, particularly for funds that owe their existence to collective bargaining agreements where contributions levels are set for an extended period of time. Such funds may find that their "locked-in" contractual contribution will not cover increased premium costs. The fund's actuary can evaluate experience and develop a cash flow analysis to estimate the long range cost of a particular bid. The insurance company can also be asked to guarantee rates for more than one year.

(continued on page 5)

SERVICES FOR ALCOHOL AND DRUG-RELATED PROBLEMS

By Gerald R. Waters, Sr.

The Central Labor Rehabilitation Council, Inc. is the social service arm of the trade union movement in the New York area. It has long had a special interest in helping to deal with alcohol and drug problems. Treatment and referral for alcohol and substance abuse, and outreach activities are the components of the Council's Alcohol and Drug Program.

In a typical year, the Council provides assistance for alcohol and drug problems to persons from more than 60 different unions. The Council's experienced counselors assist in whatever way is necessary. If detoxification or other hospitalization is required, the counselor will arrange for it. If outpatient counseling is the treatment of choice, it will be provided at the Council or by referral. Every case is followed up and total confidentiality is assured.

The Council serves union members or members of their families. The relative of a union member, as a teenage drug abuse or a senior citizen with a prescription drug problem, may come for assistance. If the client's drug problems affect other members of his or her family, they are also encouraged to come. Most alcohol and drug abuse clients seen at the Council are able to abandon their "habit" and resume effective social life and work activities after their treatment.

The Rehabilitation Council staff will make every effort to protect the job and seniority of a worker who enters into treatment. If he or she has to be absent from work for purposes of detoxification or hospitalization, the absence will be arranged in such a way that the worker's job status is maintained. Staff counselors know how to use available health benefits for maximum impact and utility, so that even clients with minimal benefits and income are assisted.

For most persons with a severe alcohol problem, detoxification and follow-up counseling are needed. The metropolitan New York area has an unusually broad range of facilities for the treatment of alcoholism. Assisted by a grant from the New York State Division of Alcoholism and Alcohol Abuse, the Council maintains the Employee's Counseling Service for employees of the City of New York and their families who are experiencing alcohol related problems. This referral, information and treatment service has restored a substantial number of persons to healthy functioning. Now in its third year, the service has made a special effort to reach employees of smaller municipal agencies which do not have their own Employee Assistance staff.

The Council's program in substance abuse is supported by the New York State Division of Substance Abuse Services.

The Council has probably trained more people in problems of alcohol and drug abuse than any other agency in the metropolitan New York area. Its two 12-session courses, Basic and Advanced Occupational Substance Abuse, are free for union members. The instruction is given by specialists from selected treatment and prevention facilities, and is supervised and coordinated by an experienced staff. Field visits to selected treatment facilities are arranged, and all books and other materials are supplied by the Council. Classes meet Tuesday and Thursday evenings from 6:00 to 8:00 p.m. for six weeks.

People take the courses to broaden their base of knowledge in these areas, to function as union peer counselors and resource persons at the worksite, in contemplation of a career change involving counseling duties or as part of their ongoing college studies. Each course carries three college credits, awarded by the State Education Department and accepted by practically all colleges. A student may, of course, choose not to take a course for credit. A certificate is awarded upon completion of each course, with completion of the Basic course a prerequisite for the Advanced course.

Special courses on alcohol and drug abuse are available for union officers, pastoral counselors such as ministers and priests, and for union members with special problems and needs. The Council has also developed special courses for apprentices of some unions.

Two staff members of the Rehabilitation Council regularly engage in outreach visits to unions. These visits are designed to brief union leaders on drug abuse matters, report on treatment developments and leave educational materials. The outreach staff can also assist in the development of policies for dealing with alcohol and drug problems, and supply information on a labor approach to employee assistance programs.

There is no fee or payment of any kind for any of the services, treatment, referral, courses or other assistance provided by the Central Labor Rehabilitation Council. It is located at 386 Park Avenue South (corner 27th Street), New York, NY 10016. The telephone number is 212-532-7575.

Gerald R. Waters, Sr. is Administrator of Services for the Central Labor Rehabilitation Council.

The Fund Reporter is a publication of the Consumer Commission on the Accreditation of Health Services.

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ANESTHESIA EXPLAINED—Part I

by Arthur A. Levin, M.P.H.

Until the mid-19th century, relief from the pain of surgery took the form of restraints to prevent the patient from thrashing about, or enough alcohol to render the patient unconscious. In 1844 nitrous oxide was experimented with for dental extraction, and ether began to be used on a wide scale after its efficacy was successfully demonstrated in 1846 at Massachusetts General Hospital. The early anesthetics were mostly used as single agents and kept the patient unconscious and pain free. Today, combinations of drugs are used to accomplish the same pain-free conditions but with "lighter" levels of anesthesia.

Most people are well aware that surgery carries with it potential risks as well as benefits, and that some part of the risk is the result of anesthesia. Today more and more surgical procedures are done on an ambulatory basis so that the patient goes home several hours after the surgery. Greater use of local and spinal anesthesia, as well as the development of even "lighter" forms of general anesthesia may reduce some of the risks associated with surgery.

People facing surgery rarely have the opportunity to discuss anesthesia with their physicians. The first opportunity to see the anesthesiologist is usually several hours prior to the surgery, when a brief visit consisting mainly of a short history-taking occurs. In most hospitals, there is a team of anesthesiologists who have contracted to provide their services for that institution. As a result people do not have any opportunity to choose who will deliver the anesthesia; that decision is left to the operating surgeon or the operating room administration.

The visit by the anesthesiologist prior to surgery should consist of a review of medical records and a physical examination. The history should include previous experiences with surgery and anesthesia, any history of drug allergies, hay fever, bronchial asthma, diabetes, high blood pressure, chronic lung disease, heart disease and blood problems. Equally important is the determination of what, if any, medications are currently being used which interact with anesthetics. The following are of particular concern:

- Corticosteroids; can cause problems with the adrenal cortex.
- Reserpine group of drugs; can cause problems with the cardiovascular system.
- Antibiotics; some of these drugs cause respiratory insufficiency.
- Levodopa; can cause heart problems.
- Monoamine oxidase (MAO) inhibitors; can cause cardiovascular problems.
- Propranolol (Inderal); is a myocardial (heart muscle) depressant.
- Cigarettes; smoking 1 or 2 packs daily is regarded as an indication of chronic bronchitis. Smoking should be decreased or stopped several weeks prior to surgery.

Another pre-anesthesia concern is pulmonary function. The following are problems that need at least to be taken into account in the administration of anesthesia, and may be contraindications to the surgery:

- Acute respiratory infection; patients should be recovered at least one week before surgery is scheduled.
- Respiratory insufficiency; extreme cases are recognizable upon examination, but borderline cases may not be. Obesity, spinal arthritis, obstructive lung disease or neuromuscular disorder may result in borderline respiratory insufficiency.
- Those described above should have pulmonary function testing to determine whether they are at risk for anesthesia. Others who should be tested are:
  - Smokers (one pack or more a day)
  - Persons with chronic cough
  - Those with bronchial asthma, bronchitis or emphysema
  - People having thoracic or abdominal surgery

People with severe anemia, bleeding disorders or low blood volumes may not be good candidates for elective surgery. Lastly, people who have eaten within six hours of the time of surgery are not considered "acceptable" for elective surgery because of the dangers of pulmonary aspiration which can cause severe disability and death.

In our next issue we will discuss the different types of anesthesia and what factors are used in their selection. This column has focused on the importance of a good history and exam by the anesthesiologist prior to elective surgery. It is important that the person about to undergo surgery provide the practitioner with as much information as possible to help reduce the risk connected with anesthesia. It is also useful in judging the quality of care you are receiving to remember that the visit by the anesthesiologist should cover the areas mentioned above, and that you should express any concerns or questions you have during that visit.

Arthur A. Levin is director of The Center for Medical Consumers and Health Care Information, Inc.

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Self-Insured Funds
(continued from page 1)

case as a friend of the court. Blue Cross argued that exempting ERISA funds would wreck the entire cost containment plan.

The Fund's attorneys, Sipser, Weinstock, Harper and Dorn based their arguments not only on ERISA preemption but also on impairment of contracts, denial of equal protection of the law and violation of anti-trust laws.

The court, declaring that ERISA preemption was the overriding issue, rejected the arguments of Blue Cross and the State and ruled that "Section 2807-a.6(b) of New York's Public Health Law is preempted insofar as it relates to ERISA funds, and enforcement against such funds is hereby enjoined."

Both state and federal government are encouraging companies, unions and government health administrators outside of New York to lower health care costs through competition and direct negotiations with providers. The concern with rising health and hospital costs has even led to proposals to tax employee health benefit contributions above certain dollar levels as a way to promote cost consciousness.

The ERISA funds in New York have been cost conscious for many years. They have not sought regulatory relief, but have competed in the health marketplace to attain their goals. Their successful experience in hospital rate negotiations has resulted in a national movement toward negotiating rates and the development of physician panels. The much-discussed "preferred provider organizations" or PPOs are simply negotiated payment systems with health care providers rendering care at an all-inclusive, discount rate.

The decision in *Rebaldo v. Cuomo* can be appealed by the State. However, the progress of the case has been carefully observed by many welfare fund trustees and administrators and union officials. A number of them have offered support to the Optical Fund.

If the State chooses not to appeal, the issue is settled. An appeal could go as far as the Supreme Court for final decision. If that happens, self-insured funds are still protected against the loss of negotiated hospital discounts while the case is winding its way through the courts. Dr. David Axelrod, Commissioner of the New York State Health Department, has indicated in writing to a number of funds that, "...pending the resolution of this legal question, we have no plans to initiate any enforcement action in this area."

The initial cost of health and welfare benefits is the total of monthly premiums paid to the insurance company during the plan's first year of operations. The initial cost is determined by a number of factors including the scope of benefits, occupations of participants, sex of participants, ages of participants, size of the group, and the number of participants with dependents. Not all insurance companies charge the same premiums for a given plan of benefits, because they use varying assumptions in formulating initial premium rates.

The net cost of benefits is determined at the end of the first and subsequent years. It consists of premiums paid to the insurance company, less any refunds from the company because of favorable claims experience.

Claims experience is defined as the relationship between premiums and claims. When premiums paid to the insurance company exceed claims paid out by the company, plus the company's retention, experience is considered to be favorable. If claims payments plus retention exceed premiums paid to the company, then experience is considered unfavorable.

The premium cost may be segmented into two components: Incurred claims and retention by the insurance company.

Incurred claims include all claims arising during the year, i.e. those that were paid, or at the end of the year were unreported, still in the course of payment, or reported but pending. Since utilization of benefits will be the same regardless of which insurance company is selected, incurred claims will not change from company to company.

Retention is that portion of the premium kept by the insurance company to cover its own expenses. This includes such items as commissions paid to agents and brokers, administration costs, claims handling and investigation expenses, premium taxes, contingency reserves, risk charges and profit. The higher the retention, the greater the net cost to the fund.

There are a number of reasons for different retention charges for the same business by different companies. One company may have lower administrative costs because of more efficient operations, or it may pay lower commissions. Another may keep a larger share of the premium for profit. Still another may have had poor claims experience in the organization as a whole, and may try to recoup its losses by charging higher retentions to new customers.

Insurance companies must detail the various items of retention on Schedule A, Form 5500 which must be provided to their client funds annually for filing with the Internal Revenue Service. Review the Schedule A items with the following suggestions in mind; it may result in lower costs for the fund:

1) Include as large a group as possible in order to take advantage of the economies of mass merchandising and shared experience.
2) Keep commissions to a minimum. The National Association of Insurance Commissioners has promulgated a "Code of Ethical Practices With Respect to the Insuring of the Benefits of Union or Union-Management Funds." The code contains a decremental commission scale ranging from 4.1% for an annual premium volume of $20,000 to 1/10 of 1% for a $5,000,000 annual premium. The code scale can be used as a guideline by all welfare funds.

   Insurance companies can also be asked, as a part of the uniform specifications, to submit their bids on a net basis, minus commissions. If bids are requested through an actuarial consulting firm, and the insurance company will not bid on a net basis, the commission is usually deducted from the consulting firm's fees.
3) Eliminate unnecessary fees by making certain that administrative services charged for are actually performed. The insurance company should not duplicate services performed by the fund.
4) Consider using a self-accounting system, thereby saving the insurance company's expenses for preparing and processing premium statements.
5) Consider using a "draft book" system of paying claims, thereby saving the insurance company's expenses for processing and paying claims.

Trustees and their professional advisors play important roles in the selection of an insurance company through the drawing up of schedules, statistics and ratios pertaining to experience, and through reviewing bids submitted by the insurer. Familiarity with the language of the insurance business, the technique of insurance buying, costing practices and other complexities will enable them to perform more effectively and to obtain the most benefits at the lowest cost.

George Perla is the former associate insurance examiner in charge of welfare and pension funds for the New York State Insurance Department. He is a certified public accountant and a chartered life underwriter.

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