CONFIDENTIAL

COMMITTEE ON ADMINISTRATIVE POLICIES

Meeting 84/1
3:00 p.m., April 19, 1984

W. B. Dale, Acting Chairman

Executive Directors	Alternate Executive Directors
	M. K. Bush
	T. Yamashita
	J. E. Suraisry
	C. P. Caranicas
	H.-S. Lee, Temporary
	A. A. Agah, Temporary
	E. I. M. Mtei
	A. Lindø

A. Wright, Secretary
R. S. Franklin, Assistant

Also Present

R. K. Joyce

G. Grosche

Administration Department: R. Tenconi, Director; H. J. O. Struckmeyer, Deputy Director; S. L. Dove, J. D. Huddleston, J. G. Keyes. Legal Department: J. G. Evans, Jr., Deputy General Counsel. Secretary's Department: B. R. Hughes. Treasurer's Department: R. Noe. Advisors to Executive Directors: S. R. Abiad, I. R. Panday. Assistants to Executive Directors: H. Kobayashi, G. W. K. Pickering, Shao Z, A. Yasseri.

1. MEDICAL BENEFITS PLAN - REVIEW

Committee members considered a staff paper on a review of the Medical Benefits Plan (EB/CAP/83/6, 8/19/83; and Sup. 1, 4/17/84). They also had before them a position paper on the same subject prepared by the Staff Association Committee (EB/CAP/84/1, 4/16/84).

Mr. Lindø, noting that one purpose of the review was to consider ways in which to contain the growth in the cost of the medical insurance scheme, suggested that the brochure describing coverages and costs to participants might usefully be updated and rewritten in a way that encouraged

those protected under the Plan to save money. Also, the review should be conducted from an even broader perspective than that suggested by the staff. For example, it might be worth studying the usefulness of offering free medical checkups for everybody irrespective of age on an annual basis and of staffing health rooms in both the Fund and the World Bank buildings. More generally, the costs and benefits to the Fund of "preventive medicine" activities should be explored.

Mr. Mtei asked whether it was the policy of the Fund or the World Bank to require annual medical checkups. As he understood it, the prevailing view was that people below age 35-40 did not need a medical checkup every year.

The Director of the Administration Department observed that it was currently the policy of the World Bank to require annual medical checkups for staff, although some thought was being given to modifying the policy. Medical checkups had never been mandatory in the Fund except for new staff members or for those assigned overseas; however, within certain cost limitations, the Medical Benefits Plan (MBP) did reimburse staff members for an annual checkup if they desired to have one. When the checkup was performed in the Fund/Bank Health Room, there was no charge.

Mr. Suraisry considered that it was of course important to contain the costs of the Medical Benefits Plan; it was equally important, however, that cost-control measures not adversely affect the general health of the staff or the objective of attracting the best staff to the Fund. In that regard, he had been attracted by the proposal of the Staff Association Committee to extend coverage under the Medical Benefits Plan to include custodial care in addition to hospice care.

The Director of the Administration Department observed that, in proposing that the Plan cover hospice care for terminally ill persons, the drafters of the staff paper were following a general trend in health insurance. Coverage of hospice care as well as home care for the terminally ill served a dual purpose: it filled a need for participants, and, in the long run, it should help to reduce Plan costs by diverting usage from higher-cost medical care to less expensive forms of care.

Coverage of custodial care for sufferers from, for example, Alzheimer's disease, was another matter, however, the Director continued. Alzheimer's disease had only recently been recognized as an illness, and there was little statistical information about it. While it clearly affected a certain number of people--perhaps 4-6 percent of the population above 65--it was difficult if not impossible to diagnose, particularly in its earlier stages. Moreover, the insurance company that managed the Fund's Medical Benefits Plan had offered the legal opinion that it would not be possible to cover custodial care for Alzheimer's disease without expanding coverage to all other diseases requiring such care; the costs of such expansion could be very large. The lack of statistical information made estimates difficult, but he would venture to say that custodial care costs in the Washington area at present were equivalent to about $30,000 per person per

year; coverage for such amounts could add significantly to the cost of the Medical Benefits Plan. Any decision to reimburse the cost of custodial care before firmer estimates were made of the cost of such a decision and before more was known about the sorts of diseases that might be covered under such care would be premature. The Administration Department was thus continuing to study the matter.

Mr. Yamashita stated that, like Mr. Suraisry, he had no major difficulties with the recommendations in the staff paper. In present circumstances, the preservation of the financial balance of the Medical Benefits Plan could not be satisfactorily achieved by revenue measures alone; accordingly, he endorsed the suggestion to limit Plan participation for "other dependents" and to employ eligibility criteria similar to those used by the World Bank. He could also accept the suggestion that a three-year waiting period should be instituted before the Plan covered treatment arising from illnesses or conditions existing at the time of the "other dependent's" enrollment. However, depending upon the outcome of the current discussion, he would have no strong objection to waiting for a more detailed study on the subject of coverage for other dependents if that were the wish of the majority of the Committee.

He could also support the recommendation for cost sharing for hospital expenses, which should serve to discourage short-term hospital confinements, Mr. Yamashita continued. And he could go along with the recommendation that coverage for hospice facilities and home hospice care be added to the Plan, as it appeared that such an extension would more appropriately serve the changing needs of staff members. In that regard, he noted from the supplementary paper that the hospice care benefit would apply only to those persons with a life expectancy of less than six months. He would appreciate some explanation from the staff on the addition of that requirement. On a related matter, before taking a position on custodial care for Alzheimer's disease, he wished to see the results of further studies.

Remarking on proposals for revenue enhancement, Mr. Yamashita endorsed the suggestion that Plan reserves and cash balances should earn an imputed interest at the rate of remuneration. Although it might be true that investing such balances would require the Fund to pay more remuneration to the United States--to the extent that two thirds of the balances were attributable to the Fund's contribution to the Plan--it would be difficult to argue against the charge that the Fund was using money earmarked for the Medical Benefits Plan to offset the cost of operations. In that regard, he wondered whether the entire amount of the imputed interest would be credited to the Plan or only one third of that amount.

The suggested approach for changing the premium structure for pensioners was acceptable, Mr. Yamashita said, and he could support the staff's intention to ask the Plan's administrator to review all claims against the "usual, customary, and reasonable" standard and to report periodically on the Plan's experience to see whether there was any concrete use of such criteria. Finally, the staff's suggestion for a flexible management of reserves, given wide fluctuations in claim payments, seemed appropriate.

Mr. Caranicas, commenting on specific recommendations in the staff paper, pointed first to the tightening of eligibility criteria for Plan participation by "other dependents." The Staff Association Committee had argued against the more limited definition of "other dependents" proposed in the paper and had called for further study. However, as mentioned on page 5 of the report, enrollees in the category "other dependents" had accounted during 1981 for 10 percent of Plan medical expenses and 19 percent of dental expenses while providing only 2 percent of premium contributions. Whether or not there had been abuses was irrelevant; it was obvious that other dependents made up the most heavily subsidized group per capita of any in the Plan and, on balance, he could support the proposal to limit the number of other dependents that would be eligible for coverage.

On pages 3 and 4 of its position paper, the Staff Association Committee had suggested a number of areas where, depending upon the outcome of further studies, an expansion of coverage might be warranted. He had no objection to further studies on the value of, say, psychological counseling, eyeglasses, and hearing aids for dependents, coverage of "medically prescribed nutritional supplements," and so on; however, it would be premature to extend coverage in those areas simply because they had been identified as a cost to the Plan participants. Finally, he could fully support the proposal for cost sharing of hospital expenses. Requiring enrollees to meet 20 percent of the first $1,000 in hospital charges might make Plan participants more aware of hospital costs and discourage them from accepting unnecessary short-term confinements.

Mr. Mtei proposed taking up the recommended measures one at a time in order to get a clearer view of the Committee's reaction to each.

Mr. Agah stated that he could of course go along with Mr. Mtei's proposed approach. However, he was troubled by the charge of the Staff Association Committee that "the statistics used in the paper are rather selective and potentially misleading." Before taking up each of the recommended changes in turn, the Committee might benefit from an explanation of that charge.

The Director of the Administration Department replied that, in the long run, the only statistical point of any validity was that premia had to be sufficient to meet the claims and the administrative costs under the Plan. The Staff Association Committee was correct in noting that, when statistics covering the Plan's income and expenditure showed erratic annual movements, the implication was that data from different time periods could lead to very different conclusions. However, whatever statistics and time period were chosen, it was obvious that premia had been increased over the years to keep pace with increases in claims. In the past five years, for example, the deductible for individuals had been increased from $60 to $110, and the ceiling on which premia were based had been increased from $26,000 to $47,000, but those increases had served only to cover the rising trend in claims.

The Staff Association Committee had also suggested that the problem was not as serious as had been presented in EB/CAP/83/6, as evidenced by the surplus in 1983, the Director continued. To a great extent, the positive results in 1983 had been based on earlier premium and deductible increases. Moreover, according to the manager of the Plan, the insurance industry was forecasting strong increases in medical expenses in 1984 and beyond, which seemed to call for some further cost-control efforts.

Mr. Agah said that he remained troubled by the Staff Association Committee's charges, which had not been fully answered and which would remain on record.

The staff representative from the Administration Department commented that the matter in question had been discussed with the Staff Association Committee; he had thought that understandings had been reached. Given some of the statistical complexities, particularly in the more recent period, there could be genuine grounds for disagreement on the statistical base. However, there was one thing about which no one could disagree: the total family premium contribution had grown from approximately 3.6 percent of salary in 1972 to 7.5 percent of salary in 1983. The repercussions on enrollees' out-of-pocket expenditures was checked somewhat only because of a change in the cost-sharing formula from 50 percent to 33 percent in the staff members' favor. If the trend of growing medical insurance payments continued into the future at the same pace that it had in the past, medical expenses in 1995--whether financed by the organization or by the staff member--would be equivalent to 15 percent of salaries. In his view, an effort should be made to avoid such a development, and one way of doing so was to stop increasing premia and to make greater efforts to contain costs.

Ms. Bush said that, as she understood it, there was some graduation of premia in the Medical Benefits Plan. She wondered whether the Administration Department was satisfied that the graduation employed was in line with other plans.

The Director of the Administration Department noted that there were two types of graduation of premia in the Fund Plan. First, premia were based on salary, so that coverage for those at lower salary ranges was subsidized by those earning higher salaries; and that was different from the approach taken in some other plans, such as that offered by the U.S. Government. The Fund Plan also had two sets of premia--one for single and one for family coverage--that led to another type of graduation subsidy. Based on claims data, a husband and wife with no children or other dependents were probably subsidizing families with more than one child or dependent. To a lesser extent, those paying for single coverage were also subsidizing families with several dependents.

Ms. Bush noted that among the recommendations were a number of items that would probably reduce costs; however, a benefit in the form of extended coverage for the terminally ill was also being proposed. She wondered whether it was possible to estimate the effect of all those measures, taken together, on the cost of the Medical Benefits Plan.

The staff representative from the Administration Department observed that, while the extension of coverage to hospice care was an additional benefit, it would also--according to industry analysts--be a cost-saving device in the long run because some of those using hospice facilities might otherwise be staying in a hospital where the costs were much higher. The cost-saving effect of all the recommendations could not be estimated with any degree of accuracy in an organization the size of the Fund where, as noted by the Staff Association Committee, erratic movements in the Plan's income and expenditure occurred on an annual basis. Still, certain comparisons were telling. For example, claimants under the Fund's Medical Benefits Plan spent one third more days in hospital than the national average, despite the fact that surgical procedures had been used in substantially fewer cases than had been used nationwide. Under the Fund Plan, the incentive was to have all surgical procedures, even minor ones, done in hospital rather than on an outpatient basis, and some of the recommendations in the paper were designed to tilt the balance of incentives and disincentives with a view to producing more satisfactory financial results.

Mr. Lindå remarked that the arguments put forward by the staff representative from the Administration Department served only to strengthen his view that the booklet explaining the Medical Benefits Plan should be updated and written in a way that sought the cooperation of all participants in reducing costs as a way of preventing further increases in premia.

Mr. Suraisry commented that, while it was of course important to contain costs as much as possible, several other factors should be taken into consideration in making recommendations for change in the Medical Benefits Plan. For example, it was important to recall that G-IV visa holders were not entitled to participate in Medicare programs. It should also be remembered that the Fund was attempting to recruit qualified staff worldwide, which made it necessary to look at practices outside the United States for meaningful comparisons. It was with some of those factors in mind that he had earlier asked for further information on custodial care and its likely cost to the Plan. In the long run, such care might be very important for the Fund staff.

Mr. Caranicas observed from page 11 of EB/CAP/83/6 that the Administration Department had originally recommended that the Fund should "treat the MBP reserve and cash balances in a manner similar to that of the Staff Retirement Plan, i.e., to pay both Fund and staff contributions into an employee benefits trust that would serve as an earning asset of the Plan." He wondered whether Recommendation 7 on page 2 of EB/CAP/83/6, Supplement 1--which was the distilled version of the earlier proposal but no longer made mention of an "employee benefits trust"--would produce similar financial results.

The Acting Chairman replied that, if Recommendation 7 were implemented, there would be no "trust" in the legal sense of the term, although most of the practical benefits of a trust would still be produced.

Ms. Bush, also referring to Recommendation 7, wondered why the imputed rate was to be based on the rate of remuneration instead of, say, the SDR interest rate. At what rate did the World Bank or other institutions invest their reserves?

The Director of the Administration Department replied that, at one time, the Fund had purchased health insurance, an approach that the World Bank continued to take. With the purchase of insurance, the implicit or actual rate of interest on balances was most likely a U.S. market rate. In shifting to a self-insured plan, the Fund had saved a significant amount of money, however, and it might be argued that any loss on the interest side was compensated by that saving. Once the Fund had moved to a self-insured plan, it had become important to isolate the amount of money belonging to the Plan from the rest of the money on the Fund's books; for simplicity's sake, the rate of remuneration had been adopted as the rate for computing interest on those amounts.

Mr. Yamashita reiterated an earlier question concerning the proportion of imputed interest accruing to the Medical Benefits Plan.

The Director of the Administration Department remarked that, once the interest was computed, it was counted as income to the Plan and would either increase the dividend to be paid out to the staff and to the Fund--in the same proportion as contributions--or reduce the amount of additional premia required to keep the Plan in balance.

The Acting Chairman said that it might be useful to continue the discussion by taking up Mr. Mtei's proposal to look at the seven recommendations in the order in which they had been presented on page 2 of EB/CAP/83/6, Supplement 1. If accepted by the Committee, the recommendations could be presented to the Executive Board for approval on a lapse-of-time basis. An indication might also be given to the Board that the staff would, when feasible, make an effort to update the Medical Benefits Plan brochure along the lines recommended by Mr. Linda and would look more closely at the possibility of coverage for custodial care in relation to Alzheimer's disease and other similar medical conditions.

- Recommendation 1

Mr. Mtei remarked that, while he could accept the limitation on the number of "other dependents" residing in a staff member's household, he was concerned about the proposal for a three-year waiting period "for coverage for treatments arising from illness or conditions existing at the time of their enrollment in the Plan." If an individual recruited to work in the Fund had been supporting a parent who happened to be sick (perhaps with assistance from a medical benefits plan sponsored by the previous employer), the new employer--and the new Plan--should continue that coverage or aid in that support. He understood that there were those who might, in the absence of the recommended provision, abuse the benefit; however, he saw no reason why those who were not attempting to take special advantage of the Plan should be penalized.

The Director of the Administration Department replied that the provision had been directed at those who had been participants in the Plan for some time and who decided to pay for additional coverage for "other dependents" only when it became clear that the medical expense of those dependents was going to be significant. There had been no intention to impose special limitations on newly recruited staff members' requesting coverage for other dependents at the outset. The recommendation would therefore be redrafted to meet Mr. Mtei's concerns.

Recommendation 2

Mr. Lindø stated that, while he was in favor of cost-saving measures, he wondered about the extent to which participants in the Plan had abused the benefit that paid for 100 percent of hospitalization charges. Also, by his own calculations, he saw very little savings engendered by the change in Recommendation 2.

The staff representative from the Administration Department observed that, in 1983, there had been 360 cases of hospitalization paid for by the Plan. If all those cases had been for more than two days, if all had been absolutely necessary, and if the recommended provision had been in effect, the savings would have been $200 x 360, or $72,000. There would be another form of saving, however, if the provision served to deter participants from checking into the hospital for relatively minor treatment. Hospital costs were approximately $500 per day, so that, even under the recommended provision, the cost to the Plan would be $400 per day. If some patients could be persuaded to get treatment on an outpatient basis, the Plan, although paying out 100 percent of the cost, should benefit nevertheless as the overall bill would be much smaller.

Mr. Caranicas considered that the amount of saving should not be the primary or only criterion used to decide whether or not to accept a particular provision.

Recommendation 3

The Acting Chairman remarked that the important element to be noted in Recommendations 2 and 3, taken together, was a reversal of incentives designed to discourage unnecessary hospitalization for medical treatment while encouraging appropriate outpatient testing and treatment.

Mr. Yamashita recalled from the Staff Association Committee's paper the argument that increasing reimbursement for surgery done on an outpatient basis from 80 percent to 100 percent would seem sufficient to prevent unnecessary short-term hospitalization, so that there was no reason to require enrollees to meet 20 percent of the first $1,000 of hospital charges.

The Director of the Administration Department commented that, even if the cost to the enrollee of hospitalization were the same as the cost of treatment done on an outpatient basis, many people might still prefer to

go to the hospital. The intention was to create a small disincentive to hospital care while establishing an incentive for surgery on an outpatient basis.

Mr. Mtei observed that it was being recommended that enrollees be reimbursed for the cost of diagnostic testing done on an outpatient basis only if the testing were done within seven days of the scheduled hospital admission. The seven-day provision was troubling because there might be unforeseen reasons why the hospital admission might not be scheduled within that period. Perhaps it would be better to suggest that the cost of the testing would be reimbursed if, as a result of the testing, the doctor recommended admission to the hospital, whether in seven, ten, or twenty days.

The staff representative from the Administration Department noted that it had not been the intention to cover all diagnostic testing. Some doctors had a tendency to admit patients to hospital in order to do diagnostic tests, and those were the tests that would be fully covered under the recommended provision if they were to be done on an outpatient basis. He understood Mr. Mtei's concern; however, experience showed that, if the tests were done more than a week before admission to the hospital, they would almost certainly have to be repeated.

Recommendation 4

Mr. Yamashita reiterated an earlier request for an explanation of the requirement that a terminally ill person to be eligible for hospice care should have a medical prognosis of a life expectancy of less than six months.

The Director of the Administration Department responded that the prognosis was a standard requirement of hospice facilities; it did not seem unreasonable, therefore, to mention it in the recommended provision.

Mr. Caranicas wondered what would happen if the terminally ill individual lived beyond six months.

The Director of the Administration Department replied that hospice facilities would not refuse to care for a patient who lived beyond the six-month period; nor would insurance schemes stop covering the costs unless of course the prognosis were changed and the patient were no longer considered terminally ill. It should however be noted that, under industry-wide standards, there were cash limits on the total amount that would be reimbursed for such care. The $7,500 made available by John Hancock, for example, was unlikely to cover hospice care for more than six months.

Mr. Suraisry stated that, as he understood it, the majority of those with a life expectancy of six months or less died before the six-month limit. Unfortunately, there seemed to be no flexibility for dealing with those who, for whatever reason, lived beyond six months but remained terribly sick. The matter was a serious one and should be dealt with.

Mr. Lindå agreed with Mr. Suraisry that there should be some procedure under which "borderline" cases could continue to receive care. It did not seem appropriate, in drawing up provisions for the Fund's Plan, to rely on the practices of insurance companies, which were thinking mainly in actuarial terms. The Fund should adopt for its Medical Benefits Plan a procedure that took account of the needs of those who lived beyond six months.

The Director of the Administration Department remarked that, so long as the patient continued to be diagnosed as terminally ill and the life expectancy continued to be six months or less, the cost of hospice care would be reimbursed under the Plan.

The Acting Chairman noted that the concept of hospice care was relatively new and was no doubt still evolving. It might be useful for the Fund from time to time to review the practices of hospice facilities and insurance company standards with an eye to determining the appropriateness of benefits under the Fund's Plan.

Recommendations 5 and 6

The Director of the Administration Department explained that, at present, there were two anomalies in the system of contributions by pensioners to the Medical Benefits Plan. First, because retirees' contributions were based on their pensions--regardless of the number of years of service--those with relatively few years of service were paying very small amounts; indeed, at present, close to one third of all pensioners were paying less than $20 per month for full coverage. To correct possible inequities, it was being recommended that, for those retiring after May 1, 1984 with less than ten years of service, contributions should be based on Fund salary on their last day of active service.

Another anomaly was related to the opportunity given staff members upon retirement to commute up to one third of their pension, which could be received in a lump sum payment, the Director continued. Depending upon whether or not or to what extent that option was employed, staff members with the same number of years of service and the same salary level might receive very different pensions; and it seemed unfair to base contributions to the Medical Benefits Plan on pensions without taking those differences into account. Hence, it was being recommended that the monthly contribution rate to the Medical Benefits Plan would be linked to gross annual pensions as determined before any commutation took place.

The Staff Association Committee had argued that the anomalies could be removed by asking all retirees, whatever their years of service, to pay contributions to the Medical Benefits Plan on the basis of their Fund salary for the last pay period during which they were in active service, the Director commented. As far as he could tell, the difference in cost to the retiree between the approach recommended by the Administration Department and that recommended by the Staff Association Committee was that most staff members retiring with ten or more years of service would

pay somewhat more under the approach recommended by the Staff Association Committee; only in those rare cases where a person's gross pension exceeded his final working salary but was below the contribution ceiling would the retiree pay less.

Recommendation 7

Members of the Committee accepted Recommendation 7 without comment.

Mr. Mtei, remarking on another matter, asked what role the John Hancock Insurance Company played in the Fund's Medical Benefits Plan.

The Director of the Administration Department replied that the insurance company acted as administrator of the Plan, keeping records, processing all claims, and preparing payments.

Mr. Lindå wondered whether there was any procedure by which the Fund could overrule the administrator in cases where strict adherence to the limits left a Plan participant in dire straits.

The Acting Chairman observed that there was no Fund person or office with the authority to change the rules; if serious problems arose for Fund staff members, whether due to illness or some other reason, ways could be found to deal compassionately with those difficulties. However, as a matter of principle, it would be inappropriate to establish a mechanism for breaking rules. As a practical matter, if such a mechanism were to exist, it was likely to be made use of far more often than was considered desirable.

Mr. Yamashita observed that some of the possible approaches described in the section on administrative measures in EB/CAP/83/6 had not been incorporated among the recommendations in the supplementary paper. He wondered whether those would be a subject for further study.

The Director of the Administration Department replied that the matters referred to by Mr. Yamashita did not require a decision by the Executive Board. For example, there was already a provision in the agreement with the insurance company administering the Plan that "usual, customary, and reasonable" (UCR) criteria would be used. In the past, because of the nature of the Fund staff, those criteria had been enforced with great flexibility. What was being proposed was that the insurance company should keep the Administration Department informed about the extent to which usual, customary, and reasonable costs were exceeded to see whether the enforcement needed to be tightened.

Mr. Yamashita observed that the Staff Association Committee apparently preferred that the responsibility of complying with the UCR criteria should not rest with Plan enrollees but rather with the administrator.

The Director of the Administration Department considered that it would be impractical as well as costly to ask the insurance company to intervene between patient and doctor and to indicate when a doctor's fees were considered unreasonable by industry standards. The insurance company did, however, inform the enrollee if and when a doctor's fees exceeded a reasonable level by more than 10 percent.

In response to a question by Mr. Suraisry, the Director noted that, in 1983, John Hancock had been paid $187,412 for administering the Plan. That amount represented somewhat less than 4 percent of premiums and about 5 percent of claims. Bids had been solicited a few years previously for the task of managing the Plan, and costs were checked periodically to ensure that they were not out of line with what others in the industry might charge.

Mr. Lindo wondered whether the Fund could save money by administering the Plan itself.

The Director of the Administration Department said, first, that it was doubtful that the Fund could perform the same service at less cost. Second, the use of an outside administrator helped to maintain the confidentiality of claims. Finally, external administration avoided a situation in which every claim might become a matter of negotiation.

Mr. Caranicas considered that the Fund should not necessarily involve itself in taking on a specialized task just because it might save money by doing so. There was a great deal to be said for relying on the expertise of those who were trained in specialized fields.

The Committee then concluded its discussion and agreed that the recommendations on page 2 of EB/CAP/83/6, Supplement 1 (4/17/84), modified somewhat in light of the discussion, would be incorporated in a report and submitted to the Executive Board for approval on a lapse-of-time basis.

APPROVED: September 28, 1984