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April 16, 1984

To: Members of the Committee on Administrative Policies

From: The Committee Secretary

Subject: Medical Benefits Plan Review - Position Paper

The attached paper by the Staff Association Committee on its position on the review of the medical benefits plan is circulated in connection with the meeting of the Committee scheduled for Thursday, April 19, 1984.

Att: (1)

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Medical Benefits Plan Review

Position Paper

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When the Executive Board Committee on Administrative Policies suggested an in-depth review of the Medical Benefits Plan in early 1982, the latest data for the Plan showed a significant financial deterioration, and this situation determined the focus of the subsequent paper (EB/CAP/83/6) of the Administration Department (ADM). In the opinion of the Staff Association Committee (SAC), the statistics used in the paper are rather selective and potentially misleading (see Appendix I). They seem to be an attempt to justify the cost containment measures which appeared to be called for when the study was initiated, even though data for 1982--and subsequently for 1983--show that the Plan's 1981 performance was not indicative of a trend. We would consider more useful a comprehensive review of the Plan in all its aspects, providing an estimate of the costs or savings to be expected from each change proposed. This paper discusses the major recommendations of the ADM paper and offers some suggestions.

1. The recommendations

Notwithstanding the paper's failure to substantiate the asserted need for overall cost curtailment changes, it does bring to light some apparent anomalies which should be corrected regardless of the financial state of the Plan.

The SAC was appalled to learn that the Fund is using the staff's contributions to the Medical Plan to defray the Fund's financial costs. In our opinion, the payment of both Fund and staff contributions into a trust fund, such as is done for the Pension Plan, is both necessary and long overdue. Moreover, we believe that equity requires the Fund to make an initial contribution to such trust account equal to the estimated interest payments foregone during the last five years, or to defray future plan losses up to that amount. Also, it seems highly inequitable to base pensioners' premia on their pension income, which may well be a small fraction of their total income and which they can reduce by electing to commute part of the pension. The recommendation to base premia on final salary deserves full support, and we see no reason to qualify this for staff with over 10 years of service.

We favor the extension of coverage to hospice facilities and home hospice care. (Several staff members have indicated to us that they would also support an extension of the medical plan to cover custodial care, for example, in connection with Alzheimer's disease. While we sympathize with the idea, we would like to have reliable estimates of the effect of such extension on premia before taking a SAC position on this issue. We would, however, recommend that this issue be studied as soon as possible.)

Other recommendations in the ADM paper do not merit the same unqualified support. The proposal to limit reimbursement to the UCR scale is a good one to the extent that doctors can be made to lower their charges to those of the scale. The purpose of the Plan should, however, remain the reimbursement of charges actually paid by staff members (subject to deductibles and maxima). The medical services market is not one of perfect information nor is the doctor-patient relationship one where price bargaining precedes the contract. Rather than placing on the staff member the uncomfortable burden of informing doctors that their fees substantially exceed UCR limits (as proposed by the Administration Department), we would suggest that compliance with UCR rates be achieved by the Plan administrators directly informing offending doctors (and the staff going to them) that their fees will not be reimbursed to the same extent in future.

The SAC cannot support the proposed change in cost-sharing for hospital expenses. We feel that such a change can be justified only if it is clear that the present practice actually results in increased hospitalization for minor surgery which could be performed on an outpatient basis. At present no such evidence is available. In any case, the proposed increase of coverage of outpatient surgery to 100 percent should eliminate the supposed current incentive to hospitalization, rendering unnecessary the proposed change in hospital cost coverage. In particular, we are concerned that this proposal might discourage single staff members from obtaining proper health care. Within this context, we fully support the proposed increase in the reimbursement for the cost of diagnostic testing done on an outpatient basis within seven days of a scheduled hospital admission and for surgery done on an outpatient basis.

A central theme of the paper is that eligibility for participation in the Plan is too broad and that this is an important source of (unspecified) "abuse" and cost. Hence, a more limited definition of "other dependents" is proposed. No evidence is provided to support the contention that the broader definition of "other dependents" (still limited to two persons) in the Fund's Plan makes for significantly higher costs than the more limited definition of other plans, and we do not support the proposed change. At very least, data should be collected for a year or two so as to make available some statistical basis for calculating the expected savings of a change in eligibility. Most Fund staff members come from countries where the family is more extended than in the United States and thus may well have responsibility for caring for more than just

parents and parents-in-law. Also, if there is evidence that dependent-switching is taking place on an appreciable scale (which evidence has not been provided in the paper), the rules permitting this could be tightened.

2. Suggestions

(a) Reduction of cross-subsidization

The Fund's Plan includes many types of subsidization. Of course, the essence of any insurance plan is to spread risk, but the nature and degree of subsidization are open to modification. The possibility of relating premia to the number of people covered and to the mean expected cost of covering each person deserves further study.

(b) Psychological Counseling

Considering the problems of cultural adjustment and a high-pressure work environment that face staff members and their families, the coverage of outpatient counseling should be improved as to its percentage (80 percent instead of 70 percent), hourly rate ceiling (more than the current $40), and lifetime limit (more than the current $30,000).

(c) Investigation of alternative plans

A more comprehensive review of the Plan should have included details of alternative plans, especially since very many staff members feel that the total cost of medical coverage (premia, deductibles, exclusions, etc.) is inordinately high. It might prove instructive, for example, to calculate the premium costs of a plan which, with the present level of Fund financial support, covered only major medical expenses exceeding, say, $2,000 in a year. The savings in administrative costs (and paper-pushing bother to the staff member) might well make this an attractive low-cost alternative.

If, on the other hand, it is deemed preferable to keep the Plan in more or less its present form during the coming years of expected escalation of medical costs, the Fund would do well to investigate the cost of following the lead of major New York commercial banks in providing for 80 percent of the cost of their staff's medical care. Given that medical care is so much more costly in the U.S. than in the home countries of most staff, the SAC considers that the Fund should be at least as generous in its medical care assistance as major employers in the duty station country.

Consideration also should be given to broadening the scope of the Plan's coverage. For example, coverage should be extended to medically-prescribed nutritional supplements, as well as eyeglasses and hearing aids for dependents. Also, the current limit for eyeglasses ($15) is much too low.

A more active program of informing staff about health matters, focussing on the prevention of health problems, would benefit the staff and reduce medical care costs. Expansion of psychological counseling and informational services for stress, alcohol and drug-related problems also should be investigated.

3. Conclusions

In summary, the ADM paper fails to make a case for the need to reduce coverage to Fund staff, as proposed, and provides a review of the Plan which is far less comprehensive than would have been appropriate. It is the SAC's conviction that acceptance of some of the proposals made in EB/CAP/83/6 would not be in the best interests of Fund staff and is, in any case, not warranted under present conditions. We urge the Committee on Administrative Policies to request a more comprehensive review and, as always, we stand ready to cooperate with the Administration Department in the execution of this task.

The statistics

The statistics of the Plan's income (premia) and expenditure (claims) show very erratic annual movements (Annex I to the ADM paper), implying that data from different time periods can lead to very different conclusions. The statistics presented in the text of the review paper show costs outpacing revenues and increasing more rapidly than those of all comparators. However, the statistics overstate the case; less pessimistic conclusions result if different time periods are chosen. Also, comparisons between trends in the Fund's Plan and other plans show very different results if the same time periods are used for both sets of data, instead of the different time periods used in the ADM paper. If 1976-1981 data are used both for the Fund's Plan and for comparators, the Fund's Plan shows slower growth of medical expenses than comparators, rather than the faster growth suggested in Table 2 of the ADM paper. Table 3 shows that the Medical Plan's premia rose on average by 13.9 percent per annum during 1977-82 while claims grew by 18.3 percent. Again, the period chosen leads to an unnecesarily pessimistic conclusion. The same calculation for the period 1976-82 shows exactly the opposite--that premium growth (19.4 percent average) outpaced claim growth (16.5 percent). This does not mean that medical costs are not a cause for concern; what it does mean is that the statistical support for the contentions made in the ADM paper is somewhat insubstantial and that the adoption of all cost-cutting proposals is of less than the immediate urgency suggested in the ADM paper. In fact, 1982 operations showed a surplus of over $200,000, even if reserves had been kept at the desired 30 percent level--not the $52,738 shown at the bottom of page 1 of the ADM paper--and 1983 operations showed an operating surplus which we estimate at over $1,200,000. We would, therefore, suggest that attention be given to collecting more adequate data before proceeding with apparently arbitrary reductions in medical coverage presently available to the staff.