

GROUP INSURANCE

FOR PUBLIC EMPLOYEES

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PREFACE

The report on "Group Insurance for Public Employees" which follows was prepared at the request of the House Committee on Public Health of the First State Legislature.

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Introduction

A public employer contemplating the desirability of providing for its employees and their dependents a measure of social security may wish initially to identify its objectives both in terms of its moral obligation to its employees and in terms of the conditions of employment adequate to recruit and maintain the number and quality of personnel required to ensure a satisfactory level of public service. Such moral obligation need not be determined introspectively. A survey of the attitudes and practices of society in general and of similar employers in particular may be of value in arriving at an estimation of moral responsibility.

Disability, health and life insurance coverage, which are commonly referred to as fringe benefits, are an intrinsic element of total wages, and wages, in substantial measure, determine the attractiveness of employment. Attractiveness, however, is a relative concept. The employment offerings or opportunities of a public employer are attractive or not in relation to the offerings of competitive employers. In a competitive labor market the employer who permits the attractiveness of his employment offerings to become tarnished loses his balance of advantage. The granting of fringe benefits under such conditions cannot be held to be vouchsafement, but rather the exercise of self-interest.

This report assesses the relative need for disability, health and life insurance, and shows why, of the three, the need for health insurance is preponderant. The development of the health insurance industry and the growth of its acceptance in the United States is treated historically, and the prevalent attitude of progressive public employers with respect to the provision of medical care is summarized. In order to afford some understanding of the health insurance benefits offered by other employers, the benefits, costs, and contributory arrangements of various plans sponsored by the federal government, public employers in other jurisdictions, and private employers in Hawaii are reviewed. The extent to which state and

local employees in Hawaii are today covered by group health insurance is shown by examining the plans available to members of three public employees' unions. A brief analytical treatment of selected controversial problems relating to the administration and fundamental design of the health insurance program is given. Finally, there is an estimation of the total cost of premiums, presented in a form that will enable an estimation of the cost of possible contributions by the employer.

Historical Development of Health Insurance

Although the beginnings of what we now know as "earnings protection" are lost in antiquity, modern accident insurance gained widespread public acceptance during the last half of the nineteenth century as a hedge against the risks of railroad travel. Toward the end of the century accident insurance coverage had expanded far beyond public transportation and the demand persuaded even many of the large life insurance companies to open accident insurance departments.

Modern sickness or health insurance in the United States made an abortive beginning around the middle of the last century. Reinitiated by mutual companies in the late 1880's, insurance covering illness has continued since that time to win public acceptance. The stock companies entered this field during the 1890's. From roughly 1890 on there has been an increasing trend toward bringing accident and health insurance under one cover, until today it is unusual to disassociate the two.

The experiences of the early years were marked by either the total absence or great imprecision of morbidity tables, unsound financial structures (frequently capital stock was sold on a five per cent margin), laxity of law and supervision (unscrupulous fly-by-night companies found this to be a lucrative field for many years) and harassment by many of the state governments (by assessing exorbitant fees and requiring investment in municipals of dubious quality). As might be expected, the rate of attrition among these companies during the early years was nearly 100 per cent.

With the formation of several strong companies, a boom took place in accident and health insurance during the 1890's lasting until about 1916. This boom period was characterized by cut-throat competition and the absence of planning and sound underwriting practices. As a result of competition, this period witnessed the wholesale introduction of a bewildering variety of frills, among which double (and triple) indemnity, the accumulation clause and the identification benefit were notable. The disability provision was extended from 26 to 52 weeks and then to 104 weeks. In 1913 lifetime

disability was introduced. The non-cancellable, guaranteed renewable feature appeared in 1907 and found great favor in the years thereafter. Jumbo risks of up to \$150,000 on one life and amounts in excess of \$1,000 per month disability were underwritten. This was the period when the fine print on policies became famous. This competition devoted itself to devising new forms or frills rather than emphasizing security and service on standard, or practically standard, policies.

The boom ended rather abruptly in 1916 as a result of World War I. This saddening experience brought home the wisdom of the war exclusion clause and an appreciation of the growth of the automobile hazard. The health insurance business had by 1929 not fully recovered its momentum, when its growth was further retarded by the ensuing depression. During the 1930's sales fell, old policies lapsed and loss ratios climbed alarmingly. Losses were particularly heavy in the field of sickness coverages where there was a wide exaggeration of the extent of disability. Frequently, disability benefits were the sole or most lucrative source of income for the insured.

Health insurance companies would have suffered during the depression, regardless of the foresight they exercised, but their suffering was aggravated by: (1) improper underwriting, primarily by underwriting only physical risk and almost completely ignoring the moral hazard; (2) by the writing of increasingly large amounts of monthly indemnity, particularly in the non-cancellable, guaranteed renewable and permanent and total disability income life-policy rider; and (3) by inadequate premiums resulting from a lack of experience on which to base rates.

Throughout the commercial insurance business there was a withdrawal from the health or sickness insurance field. Where coverage remained, the waiting period was reintroduced and commissions were sharply decreased to discourage sale. Non-cancellable insurance was almost entirely abandoned, and virtually every life insurance company discontinued disability income riders.

The withdrawal of the commercial insurance companies from the field and the increasing interest in and emphasis upon social security during the 1930's gave impetus to the establishment of hospital and medical plans sponsored by the hospital associations and medical societies.

Voluntary non-profit health insurance programs, even as late as the mid-1930's, were slow in getting started primarily because of the uncertainty of their legal status. Since 1934 the several states have clarified the most bothersome question of legal status by so-called "enabling acts" which permit hospital and medical plans to qualify under the state law as "charitable and benevolent" institutions. (Section 181-4 (b)(4), Revised Laws of Hawaii 1955, exempts such plans from the provisions of the Hawaii Insurance Law.) Permitting hospital and medical plans to qualify as non-profit "charitable and benevolent" institutions has two signal advantages: they are not required to maintain the large financial reserves required of commercial carriers and they are tax-exempt.

The twin exceptions of exemption from financial reserve and tax requirements give the non-profit health insurance plans an advantage over commercial plans in being able to offer more service per premium dollar. The relative absence of cut-throat competition among the non-profit plans and the lessons learned from the experiences of the commercial carriers provided sufficient stimuli for these non-profit plans to emphasize service rather than frills. The hazardous disability insurance was omitted. Starting conservatively with separate hospital and medical coverage, there has been a trend among the voluntary non-profit plans toward the gradual consolidation of types of coverage (hospital, medical, surgical and ancillary services) and to expand this coverage.

The commercial carriers emerged from the 1930's sadder but sufficiently wise to take advantage of the increased demand for health insurance which came with the economic upswing in the early 1940's and which has continued unabated through the present day. The history of the phenomenal growth of private health insurance in the United States is a story of the past two decades.

As recently as 1940 less than ten per cent of Americans had any hospital insurance, only four per cent had some surgical coverage and slightly over two per cent any form of non-surgical medical coverage. By the end of 1957, the percentages were approximately 71, 64 and 42 respectively.¹ Between 1948 and 1956 annual premium payments, as shown in Table 1, were multiplied four-fold, from less than \$0.9 billion to over \$3.6 billion.²

Beginning in the late 1930's private health insurance plans were rapidly advanced as alternatives to proposed governmental programs.³ The simultaneous growth of organized labor and collective bargaining, the war-time wage stabilization program and its encouragement of fringe benefits, the effect of National Labor Relations Board and U. S. Supreme Court decisions in making such benefits a routine matter for collective bargaining and management's increasing concern for human relations in industry were perhaps of equal importance to the growth of private health insurance during the past two decades. These developments encouraged the practice of the employer contributing a portion of or paying in full the medical benefits for his employees and their dependents. Perhaps the greatest shot in the arm, however, came during the immediate post-war years, when the medical profession was most concerned with counteracting the possibilities of national health insurance. For information on the extent of this growth and current coverage see Table 2.

For various reasons there has taken place during the past quarter of a century a marked change in the public's concept of accident and health insurance. Today there is a broad consensus in this country that people

¹Press Release, June 12, 1958. These percentages computed against the Census estimate of U. S. civilian population, November 1, 1957, of 170 million (excludes the armed forces), U. S. Bureau of the Census. Department of Commerce, Ser. P-25, No. 169 (1957).

²In 1956, nearly 30 per cent of total U. S. medical expenditures was financed by government--local, state and federal. Total expenditures that year for health and medical care were about \$17 billion. Consumers paid \$8.5 billion directly. Health insurance premiums accounted for \$3.6 billion. Almost \$5 billion was financed through public programs.

³The Wagner Bill, Senate Bill 1620, 76th Congress, 1st Session; The Capper Bill, Senate Bill 429, 77th Congress, 1st Session; and the Eliot Bill, House Bill 7534, 77th Congress, 2nd Session.

Table 1

PRIVATE EXPENDITURES FOR MEDICAL CARE AND VOLUNTARY HEALTH
INSURANCE BY TYPE OF PAYMENT AND TYPE OF SERVICE
UNITED STATES
1948, 1951, 1954, 1955 and 1956

	1948	1951	1954	1955	1956
	(amounts in millions)				
Type of Payment					
Direct Payments	\$6,438	\$7,055	\$ 7,735	\$ 8,059	\$ 8,467
Insurance Benefits	606	1,353	2,179	2,536	3,015
Expenses for Prepayment ^a	256	307	577	614	609
Total	\$7,300	\$8,715	\$10,491	\$11,209	\$12,091
	(expressed as per cent)				
Direct Payments	88.2	81.0	73.7	71.9	70.0
Insurance Benefits	8.3	15.5	20.8	22.6	24.9
Expenses for Prepayment	3.5	3.5	5.5	5.5	5.1
Total	100.0	100.0	100.0	100.0	100.0
Type of Service					
Hospital Services ^b					
Direct Payments	16.6	16.0	15.4	15.1	14.3
Insurance Benefits	6.2	10.3	13.8	15.0	16.7
Expenses for Prepayment	2.6	2.1	3.1	3.0	2.9
Total	25.4	28.4	32.3	33.1	33.9
Physicians' Services ^b					
Direct Payments	28.5	24.2	21.2	20.2	19.5
Insurance Benefits	2.1	5.2	7.0	7.6	8.2
Expenses for Prepayment	.9	1.4	2.4	2.5	2.2
Total	31.5	30.8	30.6	30.3	29.9
Medicines and Appliances	24.5	23.5	20.9	20.7	20.7
Dentists	11.4	10.2	9.3	9.1	8.8
All other	7.2	7.1	6.9	6.8	6.7

Source: Derived from Social Security Bull., Dec. 1957, p. 4, Table 1.
Footnotes omitted or abbreviated.

^aRepresents difference between expenditures for health insurance premiums and amounts returned to consumers as benefits.

^bCombines amounts received by providers of service (direct payments and insurance benefits) and the costs of financing prepayment.

Table 2

NUMBER OF PEOPLE WITH HEALTH INSURANCE
PROTECTION BY TYPE OF COVERAGE
UNITED STATES, 1940-1958

(numbers in thousands)^a

End of Year	Type of Coverage ^b				
	Hospital expense	Surgical expense	Regular medical expense	Major medical expense	Loss of income
1940	12,312	5,350	3,000	-	(c)
1941	16,349	6,775	3,100	-	(c)
1942	19,695	8,140	3,200	-	(c)
1943	24,160	10,069	3,411	-	(c)
1944	29,232	11,713	3,840	-	(c)
1945	32,068	12,890	4,713	-	(c)
1946	42,112	18,609	6,421	-	26,229
1947	52,584	26,247	8,898	-	30,574
1948	60,995	34,060	12,895	-	32,700
1949	66,044	41,143	16,862	-	33,626
1950	76,639	54,156	21,589	-	37,793
1951	85,348	64,892	27,723	108	38,035
1952	90,965	72,459	35,670	689	38,373
1953	97,303	80,982	42,684	1,220	39,571
1954	101,493	85,890	47,248	2,198	39,397
1955	107,662	91,927	55,506	5,241	39,513
1956	115,949	101,325	64,891	8,876	41,688
1957	121,432	108,931	71,813	13,262	42,939
1958	123,038	111,435	75,395	17,375	41,870

Source: Health Insurance Council.

^aNet total of people protected--eliminates duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage.

^bFor hospital, surgical and regular medical expense includes coverage provided by insurance companies, Blue Cross, Blue Shield, and Medical Society-approved plans, and independent plans. For major medical expense, includes insurance companies only. For loss of income includes insurance companies, formal paid sick leave plans, and coverage through employee organizations.

^cNot available.

should receive the medical care they need. In 1952 the President's Commission on the Health Needs of the Nation, after a year of study and voluminous testimony, agreed upon a set of guiding principles for approaching the nation's health problem. The first of these was: "Access to the means for the attainment and preservation of health is a basic human right." The Commission also said, "We set as a goal for this nation a situation in which adequate health personnel, facilities, and organization make comprehensive health services available for all, with a method of financing to make this care universally accessible."⁴ A 1957 study of tax-supported medical programs in Pennsylvania begins, "Democratic societies are by definition committed to a series of ethical assumptions emphasizing the value of human life and well-being. We interpret these humanitarian principles to mean that each individual has the right to command certain fundamental necessities, among them, medical care."⁵

Thus during the past century health insurance has grown from a "gimmick" to promote railroad travel to a modern industry with nearly universal acceptance throughout the United States. Increasingly, employers, public and private, are making health insurance available to their employees, and since World War II employers are contributing an ever greater portion of the premium payments up to 100 per cent.

⁴Quoted in Somers and Somers, "Private Health Insurance," California Law Review, v. 46, August, 1958, p. 382.

⁵Ibid.

Existing Health Insurance Programs

The State competes with other employers in Hawaii, governmental and non-governmental, and to some extent with governmental employers on the mainland for the services of individuals. The costs of health insurance and the benefits available under programs offered by other employers as well as the cost and types of coverage currently available to state employees need to be reviewed when considering the design of a new state program.

Non-governmental Employees

One of the forces motivating the advocates of state-sponsored and supported group health insurance for state and local employees is the amount of coverage provided employees of local private industry and their dependents. The nearly universal practice of local employers contributing in some measure to their employees' health insurance cannot be ignored by state and local government, if for no other reason than the fact that local industry is, at least in many fields, a competitive employer.

The most recent study of group health insurance plans among private employers in Hawaii is the Hawaii Employers Council Report No. 797, revised August 1, 1960, which is enclosed with this report.⁶ Portions of its earlier comprehensive study on the extent of coverage and degree of participation, dated March, 1958,⁷ are here summarized to afford a thumbnail sketch of the extent of group health insurance among local non-government employees.

Of the 308 companies participating in the survey, 277, or 90 per cent have a health insurance plan. An even higher percentage (97 per cent) of the employees in these 308 firms have group health insurance available to them. Excluding the industry-negotiated health insurance plans in the sugar, pineapple and stevedoring industries, data were compiled for 276 plans.

⁶Research Department, Hawaii Employers Council, Comparison of HMSA and Kaiser Group Health Insurance Plans in Hawaii. Research Report No. 797, revised August 1, 1960. Reproduced with the permission of the Hawaii Employers Council.

⁷Research Department, Hawaii Employers Council, Employee Benefit Plans in Hawaii. Special Publication No. 38, March, 1958, pp. 41-65.

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These data show that in 142 plans (~~13~~ per cent) the employer makes some contribution to the premiums of both the employee and his dependents; in 81 plans (29 per cent) the employer makes some contribution to the premiums of the employee only; and in 25 plans (9 per cent) the employer makes no contribution toward premiums, but does provide certain "bookkeeping" services, such as payroll deductions.

In the 142 plans in which the employer makes some contribution to the premiums of both the employee and the employee's dependents, the employer contributes in amounts shown in the following schedule.

<u>Number of Plans</u>	<u>Percentage of Plans</u>	<u>Percentage of Premiums Contributed by the Employer</u>
34	24	100
29	20	51-99
52	37	50
8	6	100 for the employee plus 50 for the dependents
3	1	Less than 50
<u>16</u>	<u>11</u>	Other formula of contribution used
Total 142	99*	

*Does not total 100 per cent because of rounding.

In the 81 plans in which the employer makes some contribution to the employee only, the employer contributes in amounts shown in the following schedule.

<u>Number of Plans</u>	<u>Percentage of Plans</u>	<u>Percentage of Premiums Contributed by the Employer</u>
51	63	100
6	7	51-99
<u>24</u>	<u>30</u>	50
Total 81	100	

It is probably reasonable to expect not only that there will be a sustained, even increased, demand for state-sponsored group health insurance

for the employees of the state and local government, but also after such program is initiated there will be continued pressure to "liberalize" it until it approximates that of the more liberal non-governmental plans in Hawaii.

State and Local Government Employees

There are a substantial number of accident and health insurance plans available today to state and local employees in Hawaii. For example, the Hawaii Medical Service Association (HMSA) offers various plans to a few individual government departments, and the Honolulu Firemen's Relief Association, the Honolulu police, the Hawaii police and the Kauai police have their own such plans. Numerically most important, however, are the major health insurance plans available to members of the United Public Workers (UPW), the Hawaii Education Association (HEA), and the Hawaiian Government Employees' Association (HGEA). The benefits and costs of these most popular plans are summarized for easy understanding and comparison with those of the five plans available to federal employees in Hawaii.

Most popular with members of the UPW are the HMSA plans, of which the basic "Plan 1" is summarized in Table 3. United Public Workers also makes available to its members another HMSA plan called "Plan 2", which is nothing more than "Plan 1" with a ward-bed rider waiving the \$10 daily limit for hospital room and board, putting it on a service basis. The HMSA monthly premium schedule for the plans are as follows:

	<u>Member Only</u>	<u>Member and 1 Dependent</u>	<u>Member and 2 Dependents</u>	<u>Member and 3 or more Dependents</u>
Plan 1	\$3.50	\$7.40	\$ 9.80	\$12.10
Plan 2	3.88	8.16	11.00	13.30

When the Hawaiian Government Employees' Association discontinued its HMSA coverage, a number of HGEA members switched to UPW in order to continue this coverage. Only those who had changed their union affiliation at that time

Table 3

HAWAII MEDICAL SERVICE ASSOCIATION PLAN 1:
HEALTH INSURANCE BENEFITS
HAWAII, 1961

Kinds of Expenses	Basic Benefits
Surgical-Medical	For doctor's care in or out of hospital. PLAN PAYS: All surgical charges for most services of most participating doctors.* Limited X-ray services. Up to \$3 and \$5 for each office and home visit, respectively, beginning with the first visit in accidental injury and the second visit in illness. Up to \$3 for each outpatient hospital visit. MEMBER PAYS: Any remaining charges.
Hospital	Up to 30 days for each contract year. PLAN PAYS: Up to \$10 per day for room and board. Up to \$37.50 for drugs and dressings. Up to \$25 for antibiotics for each separate illness. Up to \$5 for laboratory services for each admission. Ambulance service to the hospital. MEMBER PAYS: Most remaining charges.
Maternity	After the member and spouse have been enrolled for 10 months. PLAN PAYS: Doctor's charges up to \$100 normal or abnormal delivery, up to \$150 for Caesarean section or ectopic pregnancy and up to \$50 for miscarriage or abortive delivery. Hospital charges up to \$55 for normal, abnormal, miscarriage or abortive delivery and up to \$100 for Caesarean section or ectopic pregnancy. Nursery and doctor's charges for newborn infants and premature babies. Infant circumcision. MEMBER PAYS: Any remaining charges.

*More than 80 per cent of the HMSA participating physicians have agreed to accept HMSA surgical fees as payment in full.

for the purpose of continuing this coverage were permitted to enroll. Thus the number of members subscribing to what UPW calls its "Plan 3" is small and the membership is frozen.

The Hawaii Education Association offers to its membership health and life insurance plans underwritten by the Union Mutual Life Insurance Company of Portland, Maine. The benefits and costs of the accident and health insurance coverage provided by this plan are summarized in Table 4. These health and life insurance plans are being carried on a non-integrated basis. The HEA monthly premium schedule for these plans are as follows:

	<u>Member Only</u>	<u>Member and 1 Dependent</u>	<u>Member and 2 or more Dependents</u>
Hospital, surgical and medical expense	\$3.50	\$ 9.00	\$13.00
Hospital, surgical and medical plus \$1,000 life insurance on member only	4.15	9.65	13.65
Hospital, surgical and medical plus \$5,000 life insurance on member only	6.75	12.25	16.25
\$1,000 life insurance on member only	.65	.65	.65
\$5,000 life insurance on member only	3.25	3.25	3.25

The Kaiser Foundation Health Plans 1 (high option) and 2 (low option) are available to members of the HEA, UPW and the HGEA. The benefits and costs of these two plans are summarized in Table 5, and the monthly premium schedule for the plans are as follows:

	<u>Member Only</u>	<u>Member and 1 Dependent</u>	<u>Member and 2 Dependents</u>	<u>Member and 3 or more Dependents</u>
HEA Members:				
Plan 1	\$6.50	\$14.00	\$18.40	\$19.60
Plan 2	5.20	10.90	15.35	16.45
HGEA Members:				
Plan 1	\$6.10	\$13.60	\$18.00	\$19.20
Plan 2	4.80	10.50	14.95	16.05

Table 4

HAWAII EDUCATION ASSOCIATION PLAN:
HEALTH INSURANCE BENEFITS
HAWAII, 1961

Kinds of Expenses	Basic Benefits
Surgical-Medical	For doctor's care in or out of hospital. PLAN PAYS (on a reimbursement basis): Up to the amount specified in schedule for surgical operations. Up to \$3 per day for physician's services in hospital. Up to \$3 and \$5 for each office and home visit, respectively, beginning with the first treatment for accident and the second treatment for illness. MEMBER PAYS: Any remaining charges.
Hospital	Up to 31 days for each confinement. PLAN PAYS (on a reimbursement basis): Up to \$12 per day for room and board. Up to a maximum of \$240 for anesthetics, services of an anesthesiologist, use of operating room, X-ray examinations or treatment, laboratory tests, drugs, dressings, physical therapy and use of an oxygen tent. Up to \$240 for emergency outpatient treatment immediately following an accident. MEMBER PAYS: Any remaining charges.
Polio-myelitis	Up to \$5000 in lieu of any other benefits.

Table 5

KAISER FOUNDATION HEALTH PLANS 1 AND 2:
HEALTH INSURANCE BENEFITS
HAWAII, 1961

Kinds of Expenses	Benefits	
	Basic Plan 1 (high option)	Plan 2 (low option)
Out-of-Hospital Care	PLAN PAYS: Laboratory tests, diagnostic X-ray and X-ray therapy, casts and dressings and physical therapy. MEMBER PAYS: Drugs, injections and allergy tests. Per visit--\$1 office; \$5 home.	Casts and dressings. Per visit--\$1 office; \$5 home. Drugs, injections and allergy tests. "Health Plan rates"* for laboratory tests, diagnostic X-ray and X-ray and physical therapy.
In-Hospital Care	Up to 130 days for each illness each year. PLAN PAYS: All medical and surgical care and hospital services. MEMBER PAYS: Any remaining charges at reduced rates.	Up to 70 days for each illness each year. All medical and surgical care and hospital services except diagnostic X-ray, laboratory tests and X-ray and physical therapy. "Health Plan rates"* for X-ray, laboratory tests and X-ray and physical therapy. Any remaining charges at reduced rates.
Maternity Care	PLAN PAYS: Any charges not paid by the member. MEMBER PAYS: \$60 if confinement due after 10 months membership; \$140 if before 10 months. Unspecified "reasonable charge" for interrupted pregnancy.	Any charges not paid by the member. \$80 if confinement due after 10 months membership; \$160 if before 10 months. Unspecified "reasonable charge" for interrupted pregnancy.

*"Health Plan rates" are posted at the Kaiser Foundation Medical Center and maintained at approximately one-half the private rates prevailing in the Honolulu area.

Premiums are forty cents less across the board for HGEA members because HGEA passes on to its members in the form of reduced premiums the refund from the Kaiser Foundation Health Plan given the union for performing a portion of the work in connection with administering the plan. The HEA, on the other hand, places this refund in its own treasury.

In addition to the Kaiser Foundation Health Plans, members of the HGEA have available to them an indemnity-type health and life insurance plan underwritten by the Hawaiian Life Insurance Company, Ltd. These indemnity-type health and life insurance plans are being carried on an integrated basis. The benefits of the health insurance portion of the integrated plan are summarized in Table 6.

Insurance is today an important function in each of these unions. Group health insurance is apparently the motivation in many instances for state and local employees joining a public employees' union. A variety of plans or options are available to this membership and there is little indication that the membership of these three unions desires health insurance coverage other than that which is presently offered.

Federal Employees

The Federal Employees Health Benefits Act of 1959, which went into effect July 1, 1960, established the first government-sponsored health insurance program for federal employees. In establishing this program Congress recognized that "a wide gap exists between the Government, in its capacity of employer, and employers in private enterprise, with respect to health benefits for employees."⁸ The statement of purpose continues, "This bill is designed to close the gap which now exists and bring the Government abreast of most private employers."⁹

While following in many respects traditional patterns set by other large employers, in some respects the plans made available under the Federal

⁸U.S.C. 1959, 86th Congress, 1st Session, Vol. II, p. 2914.

⁹Ibid.

Table 6

HAWAIIAN GOVERNMENT EMPLOYEES' ASSOCIATION PLAN:
HEALTH INSURANCE BENEFITS
HAWAII, 1961

Kinds of Expenses	B a s i c B e n e f i t s
Surgical- Medical	For doctor's care in or out of hospital. PLAN PAYS (reimbursement basis optional): Up to the amount specified in schedule for surgical operations. Up to \$3 for hospital and office calls and up to \$5 for house calls beginning with the first hospital call and the second house or office call with a maximum of thirty calls during any period of disability for non-recurrent medical conditions, or during any 12 consecutive months for recurrent medical conditions. MEMBER PAYS: Any remaining charges.
Hospital	Up to 30 days. PLAN PAYS (on a reimbursement basis): Up to \$14.50 per day or the hospital's standard ward-room charge, whichever is less. Up to a maximum of \$200 for medical care and treatment provided by the hospital.
Maternity	After member and spouse have been enrolled for nine months. PLAN PAYS (hospital expenses on a reimbursement basis): Hospital room, board and services up to \$125. Up to \$62.50 for normal delivery. Up to \$125 for Caesarean section or ectopic pregnancy. Up to \$31.25 for miscarriage. MEMBER PAYS: Any remaining charges.

Employees Health Benefits Act of 1959 set precedent. Major features which are not generally found in the plans of large employers, but which are provided for federal employees, include:

- (1) each employee has a free choice among a variety of plans and options;
- (2) the cost to employees is guaranteed through the initial contract period of 16 months, even though hospital and medical costs continue to rise;
- (3) employees who retire on immediate annuity may retain coverage for themselves and their dependents with no reduction in benefits and at the same cost to them as for active employees;
- (4) coverage of dependents, again at the same rate, may continue after the death of an enrolled employee or annuitant;
- (5) no waiting period is required for maternity benefits and no exclusion from coverage on the basis of pre-existing physical or mental condition or age is permitted;
- (6) employees in a non-pay status are covered up to 365 days without contribution by the Government or the employee;
- (7) in cases where an employee leaves the federal service for reasons other than retirement, a 31-day extension of coverage is provided at no cost to the employee or the Government in order to give the employee, or his surviving enrolled dependents, an opportunity to convert from group coverage to an individual contract without medical examination; and
- (8) a person confined in a hospital on the 31st day of continuance of coverage is entitled to benefits for up to 60 days more.

There are five health insurance plans authorized under the provisions of the Federal Employees Health Benefits Act of 1959 available to federal employees in Hawaii. The benefits and premium costs are summarized in Tables 7, 8, 9, 10 and 11.

Other Jurisdictions

Many cities and several of the states in varying extent provide their employees with a measure of accident and health protection. Of the 1,009 cities reported in The Municipal Year Book 1960, 549 (54.4 per cent) offer their employees both hospital and surgical insurance, while 215 (21.3 per cent) have hospital, surgical and major medical insurance. Another 72 cities have only hospital coverage, 18 offer some hospital and major medical, and 11 indicated other types of coverage.

Table 7

BENEFITS AND COSTS OF THE KAISER FOUNDATION HEALTH PLAN
FOR FEDERAL EMPLOYEES
HAWAII, 1961

<u>Kinds of Expenses</u>	<u>B a s i c</u>	<u>B e n e f i t s</u>
Out-of-Hospital Doctors' Care	PLAN PROVIDES:	All care in doctor's office and in your home. EMPLOYEE PAYS: \$1 for each office visit. Nothing for laboratory tests and X-rays. \$5 for each home call.
In-Hospital Doctors' Care	PLAN PROVIDES:	All medical and surgical care. EMPLOYEE PAYS: Nothing.
Hospital Care	For each illness or injury	PLAN PROVIDES: All services, up to 150 days each year. EMPLOYEE PAYS: Nothing during the first 150 days. Reduced rates for the next 215 days.
Maternity Care	PLAN PROVIDES:	All doctors' and hospital care. EMPLOYEE PAYS: \$60 for complete care <u>or</u> up to \$40 for miscarriage.

	<u>M o n t h l y</u>	<u>R a t e s</u>		
		<u>Government</u>	<u>Employee</u>	<u>Total</u>
Member Only		\$2.82	\$ 2.99	\$ 5.81
Member and Family		6.76	10.36	17.12
Member and Family--Female with non-dependent husband		3.94	13.18	17.12

Table 8

BENEFITS AND COSTS OF THE AMERICAN FEDERATION
OF GOVERNMENT EMPLOYEES HEALTH INSURANCE
PLAN FOR FEDERAL EMPLOYEES*
HAWAII, 1961

Kinds of Expenses	B a s i c		B e n e f i t s
	high option		low option
Hospital Room and Board	PLAN PAYS:	First \$2,500 each calendar year. 80% of any charge over that amount.	Up to \$12 per day, for up to 60 days for each confinement.
	EMPLOYEE PAYS:	20% of any charge over \$2,500.	Any remainder.
Other Hospital, Surgical, and Medical	PLAN PAYS:	80% of hospital charges over first \$50. 80% of out-of-hospital charges over \$75.	First \$150 <u>plus</u> 75% of additional hospital charges, for up to 60 days for each confinement. Up to \$250 for surgery.
	EMPLOYEE PAYS:	A \$50 or \$75 "Deductible" (Maximum "Deductible" is \$75 per year). 20% of remainder.	25% of hospital charges over \$150, for up to first 60 days each confinement. Any remaining hospital charges. Any remaining surgical charges.
Maternity	(Maternity Benefits are the same under both Options)		
	PLAN PAYS:	Normal delivery, up to \$150 Caesarean delivery or extra-uterine pregnancy, up to . . . 300 Miscarriage 75	
	EMPLOYEE PAYS:	Any remainder	
Maximum Benefit	\$20,000		Each hospital confinement--benefits for 60 days. Each surgical procedure--benefits per fee schedule.

	M o n t h l y			R a t e s		
	Government	Employee	Total	Government	Employee	Total
Member Only	\$2.82	\$ 4.57	\$ 7.39	\$1.78	\$1.78	\$ 3.56
Member and Family	6.76	12.59	19.35	5.53	5.53	11.06
Member and Family--Female with non-dependent husband	3.94	15.41	19.35	3.32	7.74	11.06

* Available only to members of the American Federation of Government Employees.

Table 9

BENEFITS AND COSTS OF GOVERNMENT-WIDE COMMERCIAL CARRIER
HEALTH INSURANCE PLAN FOR FEDERAL EMPLOYEES*
HAWAII, 1961

Kinds of Expenses	B a s i c		B e n e f i t s	
		high option		low option
Hospital Room and Board	PLAN PAYS:	First \$1,000 each calendar year. 80% of any charge over that amount.	First \$250 each calendar year. 75% of any charge over that amount.	
	EMPLOYEE PAYS:	20% of any charge over \$1,000.	25% of any charge over \$250.	
Other Hospital, Surgical, and Medical	PLAN PAYS:	80% of charges over first \$50.	75% of charges over first \$50.	
	EMPLOYEE PAYS:	First \$50 each calendar year (the Deductible). 20% of remainder.	First \$50 each calendar year (the Deductible). 25% of remainder.	
Maternity	PLAN PAYS:	Hospital--up to \$15 a day for 10 days. Obstetrician--up to \$90 for normal delivery, \$150 for Caesarean, \$60 for miscarriage. Anesthetist--up to \$18 for normal delivery, \$30 for Caesarean, \$12 for miscarriage.	Hospital--up to \$10 a day for 10 days. Obstetrician--up to \$60 for normal delivery, \$100 for Caesarean, \$40 for miscarriage. Anesthetist--up to \$12 for normal delivery, \$20 for Caesarean, \$8 for miscarriage.	
	EMPLOYEE PAYS:	The remainder	The remainder.	
Maximum Benefit		\$30,000	\$10,000	

	M o n t h l y			R a t e s		
	Government	Employee	Total	Government	Employee	Total
Member Only	\$2.82	\$ 3.94	\$ 6.76	\$2.82	\$2.82	\$ 5.64
Member and Family	6.76	10.70	17.46	6.76	6.76	13.52
Member and Family--Female with non-dependent husband	3.94	13.52	17.46	3.94	9.58	13.52

*This government-wide plan is administered by the Aetna Life Insurance Company of Hartford, Connecticut as prime carrier.

Table 10

BENEFITS AND COSTS OF HAWAII MEDICAL SERVICE ASSOCIATION
HEALTH INSURANCE PLAN FOR FEDERAL EMPLOYEES
HAWAII, 1961

Kinds of Expenses	B a s i c (No Deductible)	B e n e f i t s (Major Medical Benefits (\$150 Deductible))
Surgical- Medical	For doctor's care in or out of a hospital PLAN PAYS: All charges for most services of participating doctors. Fee schedule allowances for services of non-participating doctors. 50% of charges for laboratory and X-ray services of <u>all</u> doctors. EMPLOYEE PAYS: Any remaining charges.	After the employee pays \$150 (the Deductible) then PLAN PAYS
Hospital	Up to 120 days for each separate illness or injury PLAN PAYS: All charges for room and board. 50% of charges for laboratory tests, X-rays and X-ray therapy. All other charges. EMPLOYEE PAYS: Nothing for room and board. 50% of laboratory, X-ray, and X-ray therapy charges. Any remaining charges not paid by this plan.	80% of additional allowable expenses up to \$7,500 or two year medical service, whichever
Maternity	PLAN PAYS: \$100 toward doctor's charges for normal delivery, \$150 for Caesarean or ectopic, \$50 for miscarriage. \$100 toward hospital charges. EMPLOYEE PAYS: Any remaining charges not paid by this plan.	comes first, for each separate illness or injury.

M o n t h l y R a t e s

	<u>Government</u>	<u>Employee</u>	<u>Total</u>
Member Only	\$2.82	\$ 5.98	\$ 8.80
Member and Family	6.76	14.65	21.41
Member and Family--Female with non-dependent husband	3.94	17.47	21.41

Table 11

BENEFITS AND COSTS OF BLUE CROSS-BLUE SHIELD HEALTH
INSURANCE PLAN FOR FEDERAL EMPLOYEES*
HAWAII, 1961

Kinds of Expenses	Benefits High Option		Supplemental (\$100 Deductible)	Benefits Low Option		Supplemental (\$200 Deductible)
	Basic (No Deductible)			Basic (No Deductible)		
Hospital Room and Board	Up to 120 days per admission in Member <u>Hospital</u> Nonmember <u>Hospital</u> PLAN PAYS: In full \$12 a day EMPLOYEE PAYS: Nothing Remainder		After the employee pays \$100 (the Deductible)	Same as for High Option but up to 30 days per admission.		After the employee pays \$200 (the Deductible)
Other Hospital Services	PLAN PAYS: In full 90% of actual EMPLOYEE charges. PAYS: Nothing Remainder		then PLAN PAYS 80% of	Same as for High Option but up to 30 days per admission.		then PLAN PAYS 75% of
Surgical- Medical	PLAN PAYS: Amount set by fee EMPLOYEE schedule. PAYS: Any remainder.		additional allowable expenses up	Amount set by fee schedule. The remainder.		additional allowable expenses up
Maternity	PLAN PAYS: Up to \$100 hospital expenses <u>plus</u> amounts set by fee schedule for obste- trician and anes- thesiologist. EMPLOYEE PAYS: The remainder.		to \$20,000 maximum supplemental benefit.	\$10 a day hospital expenses up to 10 days <u>plus</u> amounts set by fee schedule for obstetrician and anesthesiologist. The remainder.		to \$5,000 maximum supplemental benefit.

M o n e y R a t e s

	Government	Employee	Total		Government	Employee	Total
Member Only	\$2.82	\$ 4.57	\$ 7.39		\$2.82	\$ 2.82	\$ 5.64
Member and Family	6.76	12.61	19.37		6.76	7.45	14.21
Member and Family--Female with non-dependent husband	3.94	15.43	19.37		3.94	10.27	14.21

*This government-wide plan is administered by Blue Cross and Blue Shield through the Hawaii Medical Service Association.

A total of 793 cities with some form of group accident and health insurance indicated the percentage of the total premium for employees paid by the city. Of these, 361 (45.5 per cent) do not share in the cost; 44 (5.5 per cent) pay less than 50 per cent; 141 (17.8 per cent) pay 50 per cent; 34 (4.3 per cent) pay between 51 and 99 per cent; and 213 (26.9 per cent) pay the full premium.

The types of health insurance and portions of premiums paid by cities in the 500,000 to 1,000,000 population range (roughly comparable to the State of Hawaii) are shown in Table 12. Group accident and health insurance plans in the several states are summarized in Tables 13 and 14, which were prepared by the South Dakota Legislative Research Council.

Table 12

TYPES OF HEALTH INSURANCE OFFERED AND PORTIONS
OF PREMIUMS PAID BY UNITED STATES CITIES
OF 500,000 TO 1,000,000 POPULATION
1960

City	Type of Insurance	Per cent of Premiums Paid by the City
Baltimore	Hospital and Surgical	0
Boston	None	-
Buffalo	Hospital, Surgical, & Major Medical	100
Cincinnati	Hospital and Surgical	58
Cleveland	Hospital and Surgical	0
Houston	None	-
Milwaukee	Hospital and Surgical	100
Minneapolis	Hospital and Surgical	0
New Orleans	Hospital and Surgical	0
Pittsburgh	None	-
St. Louis	Hospital and Surgical	0
San Francisco	Hospital, Surgical, & Major Medical	50

Source: Orin F. Nolting and David S. Arnold, (editors), The Municipal Yearbook 1960. Chicago: International City Managers' Association, 1960, p. 171.

Table 13

ELIGIBILITY PROVISIONS, PREMIUM PAYMENT ARRANGEMENTS
AND INSURANCE CARRIERS OF GROUP HEALTH
INSURANCE PLANS FOR STATE EMPLOYEES
VARIOUS STATES
1960

State*	Classes Eligible	Dependents Eligible	Percentage of Premium Employee pays for		Carrier
			Member	Dependents	
Alabama			50	50	Blue Cross & Blue Shield
Alaska	All	Yes			
California	None	None			
Colorado	No State plan, but private plan of Colorado hospitals.		100	100	Blue Cross & Blue Shield
Connecticut	All	Yes	100	100	Blue Cross & Blue Shield
Hawaii	None	None			
Illinois	All	Yes	100	100	Blue Cross & Blue Shield
Indiana	All	Yes	100	100	Blue Cross & Blue Shield
Kansas	All	Yes	100	100	Blue Cross & Blue Shield
Kentucky	All	Yes	100	100	Blue Cross & Blue Shield
Louisiana	All	Yes	50	50	Commercial
Maine	None	None			
Maryland	All	No	100	—	Blue Cross & Blue Shield
Massachusetts	All	Yes	50	50	Blue Cross & Blue Shield
Michigan	All	Yes			
Minnesota	All under 65 years.	Yes	100	100	Blue Cross & Blue Shield
Missouri	None	None			
Montana	None	None			
Nebraska	All	Yes	100	100	Blue Cross & Blue Shield
Nevada	All	Yes	100	100	Commercial
New York	All	Yes	50	35	Blue Cross & Blue Shield
North Carolina	Each agency has separate plan which is optional for employees.		100	100	Blue Cross & Blue Shield
Oklahoma	None	None			
Oregon	No State participation, employees make own arrangements.				
Pennsylvania	All permanent	Yes	100	100	Blue Cross & Blue Shield
South Dakota	None	None			
Tennessee	Full time employees.	Yes	50	50	Commercial
Virginia	Variable	Yes	100	100	Blue Cross & Blue Shield
Washington	All	Yes	100	100	Blue Cross & Blue Shield
Wisconsin	Departments arrange a plans. (Total coverage pending in legislative bills).				
Wyoming	None	None			

Source: South Dakota Legislative Research Council, Staff Report No. 18,
1960 Series, April 12, 1960, pp. 19-20, 25-26.

*States which did not report data are not listed.

Table 14

PROVISIONS OF GROUP HEALTH INSURANCE
PLANS FOR STATE EMPLOYEES
VARIOUS STATES
1960

State*	Hospital	Surgery	Out Patient	In Hospital	X-ray Lab	Polio	Add'l Accident	Dental Care	Med. Catas.
California	None								
Colorado	.....	No	State plan, but private plan of Colorado	hospital.	.....	.....	.....	.....	.....
Connecticut	\$15/day 120	\$300-\$1800/ yr.	\$1800/ yr. max.	\$550 max.	\$100/yr.	Yes	\$10/visit	Part	80%-\$100
Hawaii	None	None	None	None					
Illinois	Unlimited for 120 days	\$200 for 90 day period	Unlimited for 24 hrs.	\$220 for 90 day period	Unlimited	Unlimited	None	If M.D. performs.	\$220 max.
Indiana	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
Kansas	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
Kentucky	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
Louisiana	Variable					Variable	Variable	Variable	Variable
Maine	Legislation pending.								
Maryland	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
Massachusetts	Massachusetts hospital service.	.....	.....	.....	Blue	Cross	and	Blue	Shield
Minnesota	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No
Missouri	None								
Montana	None								
Nebraska	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
New York	Three plans involving companies. They are very com-	.....	.....	.....	Blue	Cross	and	Blue	Shield
North Carolina	.....	.....	Each agency has a separate plan which is optional for employees.	.....	.....	.....	.....	.....	.....
Oklahoma	None	None	None	None	None	None	None	None	None
Oregon	.....	No	State participation, employees make their own arrangements.	.....	.....	.....	.....	.....	.....
Pennsylvania	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
South Dakota	None	None	None	None	None				
Tennessee	\$10/day for 70 days.	\$300 max.	None	\$200 & 3/4 of \$1000.	Included with hospital.	\$500 max.	None	None	None
Virginia	.....	.....	Blue	Cross	and	Blue	Shield	coverage	.....
Washington	Yes, detailed.	Yes, detailed.	Yes, detailed.	Yes	Yes	Yes	No	No	No
Wisconsin	.....	.....	Total	coverage	pending	in	legislative	bill.	.....
Wyoming	None	None	None	None	None	None	None	None	None

Source: South Dakota Legislative Research Council, Staff Report No. 18, 1960 Series, April 12, 1960, pp. 21-24.

*States which did not report data are not listed.

Policy and Cost Considerations

The design of a health insurance program may assume a number of forms. As a means of affording maximal security or protection against the financial hardships associated with the illness and death of his employees and their dependents, an employer may wish to incorporate some measure of disability, health and life insurance into one comprehensive program. The form selected may be a function of the designer's philosophy or, at the other extreme, may simply reflect immediate exigencies.

Advisability of Providing Disability Coverage

Disability insurance is "earnings protection" against income loss resulting from non-occupation-connected accidents and illnesses. It is thus distinct from workmen's compensation, which latter is confined to on-the-job accidents and work-connected illnesses. Disability insurance is further distinct from health insurance, the latter coverage being confined to expenses associated with hospital, surgical, medical and ancillary services, while the former covers the income loss resulting from accident or illness. Four states--Rhode Island, New Jersey, California and New York--have made disability insurance compulsory. However, the movement toward compulsory disability insurance has appeared moribund for more than a decade. In Hawaii, to a greater extent than in any other state, sick leave, rather than disability insurance, is relied upon to provide this type of protection. Disability insurance is treated by the Legislative Reference Bureau in a separate paper.

Separating or Combining Health and Life Insurance

With few exceptions the life insurance provided by employers for their employees are standard term-type policies, usually in amounts not exceeding \$5,000 face. The type of protection for which such life insurance is designed is to a considerable extent presently available to members of the employees retirement system under the provisions of sections 6-51 and 6-52, Revised Laws of Hawaii 1955, as amended.¹⁰

¹⁰Ordinary and accidental death benefits, respectively, administered by the employees retirement system.

It is possible to institute a life insurance program without health insurance or a health insurance program without life insurance. Choosing between these two alternatives is a problem of evaluating relative need. The need for health insurance clearly outstrips that for life insurance because (1) health insurance costs in the preponderant number of cases far exceed the cost of life insurance, and (2) in the absence of health insurance coverage, hospital, surgical and medical expenses are unpredictable, immediate and frequently not within the ability of the employee to pay.

It is also possible to combine health and life insurance into a single package or program. Such combination, if exclusive with respect to carrier, would of course limit the underwriting to commercial carriers since the so-called voluntary non-profit health plans do not underwrite life insurance. The combination of health and life insurance in one program need not, however, be exclusive with respect to the carrier. It is quite possible to administer jointly a life insurance program and a health insurance program with any number of carriers participating, but it is economically advantageous to restrict the number of carriers to the maximum extent consistent with the mutual interest of the employer and employees. Extraneous qualitative considerations may also influence the number of carriers authorized to participate. Thus, although it is possible to allow the participation of carriers which do not underwrite both health and life insurance, if life insurance is to be included in the program, the services of a commercial carrier must be secured for this coverage. If such commercial carrier is permitted to underwrite simultaneously both health and life insurance, the question of whether such underwriting should be on an integrated or non-integrated basis will arise. The following paragraph attempts to distinguish between the integrated and non-integrated programs.

The principal distinction to be made between the integrated and non-integrated health and life insurance programs is one of accounting. In the non-integrated program the accounting and reporting for each, health insurance and life insurance, is separate, whereas, in the integrated program for these

purposes the health and life insurance contracts are treated as one. Thus, the integrated program permits the "losses" of one, for example the health insurance, to be offset by the "profits" of the other, in this example the life insurance. This formal device, allowing for some absorption of possible losses, lends an element of stability to the premium structure, which latter is subject annually to review and possible adjustment. On the other hand, the integrated plan, treating as it does both health and life insurance as one, by its integrated accounting procedure masks the costs so that it is impossible to assess or analyze either the health or life insurance programs individually. The most common experience is for the life insurance program to show a profit, that is, to have a favorable experience record for the previous contract year, and the health insurance program to show a loss, that is, to have an unfavorable experience record for the previous contract year. Because the costs of many of the health insurance benefits are rising, almost always unevenly and frequently precipitously, it is desirable to analyze from time to time both the benefit and premium structures of any health or life insurance plan and to compare such structures to alternative plans. Only in this way can a determination be made as to the self-sufficiency of a plan. A health insurance plan which is being subsidized by the life insurance plan is unfair to the employee who desires only life insurance coverage. The integrated accounting procedure deprives the master contract holder, the employer or union, of a portion or all of the retrospective premium refunds¹¹ which would otherwise accrue to him.

Distinct from the general policy considerations discussed above, certain specific problems of program design remain. The following sections attempt to identify and define the more controversial of these, among which are the problems of compulsory coverage, retired employees, temporary employees and the selection of an agency to administer the insurance program.

¹¹Retrospective premium refunds are calculated in the following manner: (1) For the contract period, usually one year, gross claims are deducted from gross premiums; (2) From this balance the amount of retention is deducted, the retention rate being specified in the contract and represents the "profit" to the carrier; (3) From this balance any conversion charges are deducted, such charges being the cost of enrolling annuitants who have ceased membership in the plan as a result of leaving active employment, either for retirement or for other reasons, in another plan, usually on a non-group basis; (4) The residuum or balance is referred to as retrospective premium refunds and normally accrue to the master contract holder.

Making Health Insurance Coverage Compulsory

The question of whether government employees should be required to participate in the health insurance program is apt to arise. Proponents of compulsory participation, in addition to advocating compulsion as something which is in the employee's own interest, will probably also stress that such compulsion is in the government's own interest, as well. Four reasons are advanced in substantiation of this latter point:

- (1) employee morale will be enhanced with the knowledge that the employer "cares" and that the employee has attained an additional measure of security;
- (2) the health of the government employees, on the whole, will improve since all will have access to better and more timely medical attention;
- (3) public welfare costs will be reduced because these "compulsory savings" will ensure the improvident this kind of protection; and
- (4) the cost of benefits per individual will be reduced with a greater number participating, or greater benefits will be possible for equal cost.

Opponents of compulsory participation will in all likelihood stress the following points:

- (1) the very idea of compulsory participation is distasteful to many since it presumes that the employer is capable of wiser personal budgeting for this type of expense than is the employee;
- (2) some, as for example Christian Scientists, will seek exemption on religious grounds;
- (3) the employee's family may already be receiving either wholly or partially paid health insurance coverage as a result of a member of the family being:
 - (a) eligible for coverage under the provisions of the Federal Employees Health Benefits Act of 1959,
 - (b) eligible for coverage under one of the plans offered by private industry, or
 - (c) a retired veteran of the armed services; and
- (4) some employees, now being covered by a commercial carrier, may not wish to change carriers or change from the present commercial carrier to a non-carrier-type plan.

Providing Health Insurance Coverage for Annuitants

Inevitably, when the establishment of a health insurance program is being considered, the question of whether coverage ought be extended to

include retired employees will be considered. Of all questions this perhaps the most difficult to resolve. Although, broadly, there are three ways of addressing this question, there is no general consensus with respect to the appropriateness of any one approach.

Retired government employees could, as one alternative, be included in the plan. To require this group to pay the same share of the premiums as the employed members would result in some financial hardship for the retired employee because of his reduced income. Further, because of the higher utilization rate of the retired, suffering primarily from the degenerative diseases of old age, and because of the inherently higher cost of geriatric treatment, allowing this group the same comprehensive medical coverage as the employed members, at the same cost, would, in effect, require the employed to subsidize the retired.

A second alternative is to exclude the retired employees, limiting participation in the health insurance program to those on the payroll. The rationale for this approach is that a health insurance program for government employees is by definition limited to those employees and their dependents. Coverage for those outside this group, however pressing the need may be, is not properly a function of such a health insurance program. The impeccability of this logic is not seriously vulnerable to challenge, but it does beg the question of health insurance coverage after retirement. The seriousness of begging this question is diminished as the federal government broadens its social security program to encompass medical care, as it did in Title VI, Public Law 778 of the 86th Congress.

The third alternative is the establishment of a separate health insurance program either limited to retired government employees and their dependents or including others, as for example, the unmarried dependents of government employees over 18 years of age or temporary employees who would not normally be eligible for health insurance coverage within a group plan designed for the protection of government employees. This alternative frequently receives serious consideration, and when employed usually offers reduced benefits at a reduced cost in order that it be within the ability of the participants to pay. Such a program, restricted in the comprehensive-

ness of its coverage and admittedly a compromise solution is frequently inadequate to meet the needs of retired individuals. Commercial carriers offer such plans, as does the Hawaii Medical Service Association.

Insuring Temporary Employees

When considering the establishment of a health insurance program for government employees, the question of covering temporary employees usually receives consideration. Generally, the various employee unions favor extending coverage to include temporary employees, while the carriers oppose such coverage. Six alternative methods of resolving this question suggest themselves.

- (1) Exclude all temporary employees, that is, those filling positions described in section 3-20 (c), Revised Laws of Hawaii 1955, as amended by Act 156, Session Laws of Hawaii 1957.

This alternative would eliminate the additional paperwork required in frequently enrolling and striking from the rolls temporary employees. The temporary employee upon termination of employment loses his status as a government employee and thus for purposes of group health insurance, his membership in the group. There is a serious question of whether a group health insurance program can be designed to extend coverage to sizeable numbers of a casual labor force without significantly increasing the cost of coverage to the members filling permanent positions. In addition to the increased paperwork, the inclusion of temporary employees facilitates abuse not only of insurance, but with respect to personnel practice as well. Because some positions are on occasion filled for a considerable period of time on a temporary basis, the exclusion of persons filling such positions is inequitable. Any line which may be drawn in order to define temporary employment, in light of the substantial range in the length of such employment from casual labor on a per diem basis on one hand to a temporary position extending several months or more than one year on the other, is necessarily arbitrary.

- (2) Exclude no government employee for reason of filling a part-time or temporary position.

The facilitation of abuse and the increased administrative cost, mentioned in (1) above, are the principal reasons considerable circumspection may be advisable when considering this alternative. The patent liberality and apparent equity of this alternative are its most attractive features.

- (3) Exclude no government employee, but require all employees to pay a substantially greater proportion of the first month's premium.

This alternative, of course, assumes the State will contribute a large portion of the premium payments. Because it discriminates against those employed but for a few days, it offers the hope of decreasing the additional administrative expenditure resulting from the inclusion of temporary employees in the group health insurance program. On the other hand, this alternative is

completely ineffective as a deterrent to abuse. The time-honored insurance maxim, "the level of premiums determines the level of use," is pertinent here. The increased initial expense of enrolling will in no way discourage the individual seeking employment in order to secure medical care.

- (4) Exclude any employee filling a temporary position until such employee has been employed 90 consecutive days.

This alternative is a compromise between alternatives (1) and (2), above. It would eliminate a major portion of the increased cost incurred by the inclusion of temporary employees in the group health insurance program, by excluding most casual labor. At the same time providing coverage after 90 days to those who do in fact fill temporary positions for periods longer than 90 days would alleviate the inequity.

- (5) Exclude any employee filling a temporary position until such employee has been employed 90 consecutive days, with the proviso that the employer reimburse the employee for any medical, hospital or surgical expenses incurred during the first 90 days.

The advantage of this alternative is the elimination of the administrative expenses associated with the enrollment of casual labor. On the obverse side of the coin, temporary employees would be required to meet out-of-pocket the medical expenses of their first 90 days, which type of payment most insurance programs are designed to eliminate. Further, it facilitates two types of abuse:

- (a) the employer would be obligated to pay medical bills over which it had no or at best inadequate control; and
 - (b) the employer may show reluctance to terminate the employment of the incapacitated employee when the financial hardship of such termination is dramatic and readily apparent.
- (6) Permit temporary employees to enroll in a separate plan which would also extend coverage to retired employees and their dependents.

Because of the relatively youthful age of the temporary employee, this alternative would have the advantage of extending to him some coverage, while simultaneously lessening the burden to be carried by the retired group. This advantage of a younger age group with its lower rate of utilization might, however, be offset by the increased utilization which studies have shown to be associated with temporary employment.

Comprehensiveness of Health Insurance Benefits

The final question of generic importance in this continuum of considerations with respect to coverage is the comprehensiveness of the benefits. There is a general consensus that any health insurance plan should cover hospital, medical and surgical expenses. The extent to which these three categories of expenses and the extent to which ancillary services are

provided will be determined in part by the state officials designing the health insurance program and by the considerations of competition among potential carriers.

Recommendations that the State of Hawaii pattern her health insurance program after one or another of the various plans available to members of the public employees' unions or employees of local private industry, other state and local jurisdictions and the federal government will be forthcoming. In particular, suggestions urging the use of the Federal Employees Health Benefits Act of 1959 as a model may be expected.

The principal attraction of using this act as a blueprint is the marked liberality and/or comprehensiveness of its benefits. It should be recognized, however, that several of the most attractive features or provisions of the Federal Employees Health Benefits Act of 1959 are new or experimental. In the field of health insurance experimentation and research are constantly being undertaken. With respect to the experimental areas of insurance, it is perhaps most important to realize that the costing of such features is not susceptible to forecasting within reasonable limits of confidence. It is quite possible for the costs of any of the experimental features to skyrocket quite out of proportion to the initial prediction. Once a feature has been included within the structure of benefits, a public employer finds it annoyingly difficult to adjust or eliminate such a feature for it is readily apparent that such adjustment or elimination is a reduction of benefits. This is especially pertinent when the employer is contributing a major portion of the premium payments. Rather than adopting in toto or in substantial measure any one prototype, however attractive and liberal it might be, it would probably be more prudent to make a conservative beginning, incorporating into the health insurance plan only those features which have been demonstrated to be actuarially sound. From such a foundation liberalization of the benefit structure of the plan may take place over time in such a way that the State of Hawaii is not forced to underwrite the unpredictable costs of experimentation.

The Cost of a Health Insurance Program

In the absence of a prototype plan, accurate forecasting of costs is tantamount to impossible, because the benefit and rate structures remain unknown. Further, recent experience data in Hawaii are not readily available. One may only guess at the number of employees who will choose to enroll in the various plans offered by the potential carriers. Such guesswork is less sure if participation is not compulsory.

In addition to the problems outlined above with respect to estimating the initial cost of health insurance, long-run forecasting must also take into account the uneven but inexorable rise in the various component costs of health insurance.

In order that some meaningful estimation be made, the current costs of an extant comprehensive health insurance plan have been used, together with a recent official estimate of the number of state and local employees, including teachers. By taking a sample of nearly 1,100 members of the Hawaiian Government Employees' Association, an estimation of the number of government employees in each of four "categories," individual, individual and one dependent, individual and two dependents and individual with three or more dependents, was determined. It was then calculated, as shown in Table 15, that the total annual cost would be approximately \$3.2 million.

The figure of \$3.2 million represents an estimation of the total annual cost if all state and local employees, including teachers, participate. This cost will be reduced if some employees choose not to participate. Because the per unit cost of health insurance will be higher for other plans, the \$3.2 million estimate is too low, if the benefit structure of these other plans is identical with that of the Kaiser Foundation Health Plan 1 used in Table 15. In all probability, however, the benefits and rate structure of these will not be identical. Competition will probably assure that the cost of premiums of the other plans will not vary greatly from those of the Kaiser Foundation Health Plan used in Table 15. If this is so, the \$3.2 million estimate is reasonably reliable.

Table 15

ESTIMATION OF THE TOTAL ANNUAL COST OF HEALTH INSURANCE
FOR STATE AND LOCAL GOVERNMENT EMPLOYEES
STATE OF HAWAII
1961

Categories Of Coverage	Number of Participants In Sample (a)	Percentage of Participants In Sample	Number of Government Employees	Monthly Premiums (d)	Monthly Pre- miums for all State and Local Employees (e)
Member	383	35.1	7,027	\$ 6.10	\$ 42,864.70
Member and one dependent	224	20.5	4,104	13.60	55,814.40
Member and two dependents	114	10.4	2,082	18.00	37,476.00
Member and three or more dependents	370	33.9	6,787	19.20	130,310.40
TOTAL	1,091	99.9(b)	20,000(c)	-	\$ 266,465.50

Total Annual Cost - \$266,465.50 X 12 = \$ 3,197.586.00

(a) Data supplied by the Hawaiian Government Employees' Association, January 13, 1961.

(b) Percentages do not total 100 per cent because of rounding.

(c) Bureau of Employment Security, Department of Labor and Industrial Relations, The Hawaii Labor Market. No. 181, November, 1960, p. 4 gives 20,020 state and local employees, including teachers.

(d) The amount of monthly premiums paid by members of the Hawaiian Government Employees' Association for Kaiser Foundation Health Plan No. 1. Data supplied by HGEA, January 13, 1961.

(e) Number of government employees multiplied by the dollar amount of the monthly premiums.

The Administration of the Health Insurance Program

The administration of a health insurance plan for government employees may be divided into two related functions. The first of these is mechanical, that is, processing the individual applications for or notices of change of carrier and change of coverage, performing the payroll deductions and paying the carriers. The processing of such applications and notices might well be undertaken on the department level, with each department notifying the governmental unit responsible for payroll deductions. The department of accounting and general services, now performing payroll deductions for the State, is perhaps best equipped to undertake this function for the purposes of the health insurance program.

The second function is evaluative and contractual. The agency responsible for administering this function will periodically review and analyze the health insurance program together with the benefit and premium structures of the various plans, select an insurance plan from among the tenders offered by commercial carriers and represent the State in negotiating health insurance contracts.

The determination of which government agency should be entrusted to administer the evaluative and contractual function may well hinge on whether such function is viewed as a normal executive function or as a function of employee trust. Those who hold the administration of the health insurance program to be a normal executive function may stress the desirability of executive responsibility and thus wish to place this function in such a way as to facilitate gubernatorial control. Assuming the plans to be contributory, retrospective premium refunds would then be held to be the money of the State. The rationale for this point of view is that any retrospective premium refunds which might accrue could never be expected to approach the amount of the State's contributions. In contrast, those who would ^{view} the administration of the health insurance program as a function of employee trust would probably wish to insulate such program from executive control by having it administered by a board representative of employee interest.

Retrospective premium refunds might be viewed as belonging to the employees, in which case the representative board would be responsible for this additional fiduciary obligation.

If the administration of the evaluative and contractual is held to be a normal executive function, such administration might be placed in the department of accounting and general services, which will probably perform the mechanical function and is presently administering the State's self-insurance programs. Alternatively, this function might be placed with the department of personnel services, especially if health insurance is viewed as a fringe benefit similar to vacation and sick leave now being administered by this department. Finally, a new unit of government could be created for administering this function.

On the other hand, if the administration of the evaluative and contractual is held to be a function of employee trust, the logical place for such administration is the employees retirement system in the department of budget and review. The board of trustees of the employees retirement system is, as presently composed, representative of the membership of the system, is relatively insulated from control by the governor and being plural in character is probably less susceptible to pressure than an individual executive. As an alternative, a new representative board could be created in order to administer this function.

Wherever the administration of the health insurance program may be placed, provision will want to be made for expert consultative service either within or without the administering agency.