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Advance Medical Directive (Living Will)

Introduction

The prudent plan sponsor of a self-funded medical plan should have an interest in adult plan participants having a living will (i.e., advance medical directive) for these reasons:

- To protect plan assets from *invasion* by a health care facility who gives needless medical care to those patients unable to direct their own medical care because of mental incompency.
- To provide a lifetime maximum of $1,000,000 or even more for those participants who legitimately need extraordinarily expensive care.
- To give utilization review vendors an additional tool by which medical care may be most prudently managed.

To use the presence of the advance medical directive as a condition of providing a higher lifetime maximum, or vice versa, is acceptable so long as it is supported by an certification of actuarial or underwriting parity. Typical parity is (a) high-limit lifetime maximum with a directive or (b) reduced lifetime maximum without a directive.

Employers may wish to offer their employees (and spouses) the opportunity to execute such directives as a fringe benefit similar to on-site flu shots. Many personnel vendors will view this fringe benefit as an addition to their *product/service* line.

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Plan Amendment

Effective ____________, the Individual Lifetime Maximum Benefit of the Health Care Plan of __________________, for Participants and their Covered Dependent Spouses, will be:

Group	Description	Individual Lifetime Maximum Benefit
1.	Those who have on file with the Plan Administrator a legally-valid advance medical directive (living will)	$
2.	Others	$

This Amendment does not apply to Covered Dependent Children. This Amendment will be applicable only if the Plan Administrator has on file an Actuarial Certification, of reasonable currency, which attests to the actuarial and underwriting equivalence (or parity) between the estimated (a) cost savings to the Plan and (b) reduction in benefit value, and which meets the so-called anti-subterfuge provision of the Americans with Disabilities Act § 501(c) and relative EEOC Regulations.

The purpose of this Amendment is to (a) extend lifetime maximum benefits as high as possible for those who are medically needful while (b) protecting plan assets from being imprudently used to provide unnecessary care to those who have lost mental competency to make their own medical decisions.

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Actuarial Certification

I certify that the Plan Amendment for the Health Care Plan of ____________________effective ____________________meets the anti-subterfuge provisions of Section 501(c) of the Americans with Disabilities Act and related EEOC Regulations.

That is, the economic value, as measured by acceptable actuarial and underwriting practices and standards of the following two plan benefits are equal:

1. Lifetime maximum of $__________with an advance medical directive.

2. Lifetime maximum of $__________without an advance medical directive.

This certification presumes that the subject plan uses a utilization firm for purposes of hospital certification and large case management.

My logic assumptions and methodology are described in the Attachment A hereto.

By____________________
Actuary

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ATTACHMENT A
Logic, Data And Assumptions Methodology

Logic

This subject amendment is cost neutral as to *total* plan costs. The reason is two-fold:

Actuarial

The additional plan claims resulting from raising the lifetime maximum from $150,000 to $1,000,000 are offset, to a great extent, by reduced claims because of savings from the medical directive on claims below such maximum.

Underwriting

It has been demonstrated that those with a medical directive are more prudent (or less costly) health care purchasers (at least for facility-related care) than those without such directive. In underwriting terms, the presence of a medical directive equates to a better risk and vice versa. Treated as an underwriting consideration is the fact that the utilization review function will be more cost effective where there is a medical directive than otherwise. This belief is supported by strong anecdotal evidence.

Data And Assumptions

Some of the experiential data used in the actuarial analysis are as follows:

1. The IRS-promulgated uniform one-year term premiums, probability of death of a plan participant is .003. See Tres. Reg. § 1.79-3(d)(2).
2. Of a population of patients under physician-care, with a lingering or terminal health condition, 8% will be classed as mentally incompetent and unable to direct their medical care. See Annals of Internal Medicine, Vol. 132, No. 6, 451-459.
3. Among Medicare beneficiaries, 5-6% will die in any year, and such final illness will comprise 25% of the program's cost. See **www.nap.edu/readingroom/books/approaching** (6.html).
4. Medical facility costs for those terminally-ill *with* a medical directive are approximately 30% of those *without* such directive. See Archives of Internal Medicine, Mar. 14, 1994, 541-547; JAMA, June 26, 1996, 1907-1914.

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5. Savings from presence of medical directives determined to be some 25% for over-65 patients and presumed to grade upward for those under 65. See Long Term Care Interface, July/Aug. 2000, 41 et. seq.
6. Anecdotal evidence abounds, primarily from TPAs and utilization review firms, that the presence of such directives would have been very useful in combating imprudent care in medical facilities.
7. One medically-controlled study showed that those patients with a medical directive used less medical care, at least for terminal illness, than those without such directive. See Archives of Internal Medicine, Sept. 26, 1994, 2077-2083.