Group Medical Expense Provisions and the AIDS Crisis

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The bulk of AIDS patients in the U.S. are working age adults. Therefore, the coverage afforded by group medical expense plans provides critical funding for the treatment of a large portion of AIDS patients. This article explores nine specific provisions of group medical expense plans that play a significant role in determining coverage for AIDS patients, the research that indicates these provisions are particularly important and the terms and prevalence of such provisions among U.S. group medical plans. The laws governing applicability of Social Security and Medicare to AIDS patients are explored, along with the status of public policy debates to amend those rules.

At least 16,000 Americans have AIDS. The Centers for Disease Control of the U.S. Public Health Service estimate that as many as 1.5 million Americans may be infected with the human immunodeficiency virus (HIV). Almost all persons afflicted with the HIV are between the ages of 20 and 59—the age cohorts that form the bulk of the U.S. workforce. Those few who are not in these age groups are children who may be covered as dependents under an adult's group medical plan.

Coverage afforded AIDS does not at this time differ substantially from that provided for other medical problems. Only three of 294 (1%) insurance companies responding to a survey conducted in 1986 jointly by the Health Insurance Association of America and the American Council of Life Insurance indicated that "any of [their] individual or group policies provide coverage for diseases related to AIDS or ARC that differs from coverage provided for most diseases."[1] These results do not answer questions about (1) whether the differing treatment, while still rare, is a new occurrence rather than a dwindling one; and (2) whether or not it is occurring among group insureds.

This article explores the specific provisions of group medical expense plans that play the most significant role in determining coverage for AIDS patients, the research that indicates these provisions are important and the terms and prevalence of such provisions among U.S. group medical plans.

Number of AIDS Cases

Studies by actuaries Cowell and Hoskins offer some insight into the number of AIDS claims that can be expected by group insurers and medical plan sponsors. The works of Cowell[2] and Hoskins,[3] although centered on mortality estimates for the life insurance industry, provide important projections for health care costs of AIDS cases for two reasons: (1) the extremely high mortality rate of AIDS means the number of health claims projected is virtually the same as the number of death claims expected; and (2) life insurance is most likely to be owned by individuals with middle and upper class lifestyles—the same demographic group that can be expected to have an employer-sponsored medical plan. Their preliminary analysis of both life and health claims indicates that the prevalence of HIV infection among persons with insurance (whether or not symptoms are present) is about half the rate in the general population. This lower incidence rate is due primarily to the rarity of intravenous drug users within the insured population. Among group insureds, the rate of infection is estimated to be somewhat higher than the average for all insureds. Cowell's study is based on AIDS cases reported by

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both life and health insurers. No separate incidence rates are developed, however, for these two lines in his study.

Cowell's study indicates that from the time AIDS is diagnosed, life expectancy is about 2.1 years. Only 4.7% of diagnosed AIDS patients survive eight years following a diagnosis of AIDS. Panjer builds upon the Cowell and Hoskins studies to estimate distribution of patients' progression from the at-risk classification through the five stages of HIV infection known as the Walter Reed Staging Method[4] to AIDS.[5] These probabilities are of particular value in studying issues of health costs for AIDS patients.

Funding for AIDS Treatment

One major public policy problem surrounding AIDS is funding the cost of treatment. This problem was characterized in a national television broadcast by the two word sentence, "I'm indigent."[6] The cost of treating U.S. AIDS patients, particularly in locations where the problem is tied strongly to intravenous drug use, is falling heavily on public and charitable agencies. For the remainder of the population, a major funding source of treatment funds is certain to be the diverse medical expense plans provided by employers. The actual coverage provided to an AIDS patient under such a plan for diagnostics, hospitalization, blood transfusions, outpatient treatments, prescription drugs and all the other elements of care depends upon the details of the group medical plan document. The following provisions are crucial to measuring the extent of coverage provided:

1. Maximum limitations on lifetime expenditures
2. Hospice care
3. Home health care
4. Experimental treatments
5. Prescription drug coverage
6. Mental health benefits
7. Continuation benefits
8. Leaves of absence
9. Preexisting condition clauses.

Lifetime Limits

The lifetime treatment costs of AIDS patients at present seldom reach the lifetime limits of an employer-sponsored medical plan. In 1986 the first major study on the costs of AIDS was published. It estimated the resources used directly for hospital care but did not review individual hospital charge records. These initial estimates were based upon total number of hospital days and average charges per hospital day. Using the preliminary information available at the time, it was estimated that expenditures for each patient with AIDS would reach $147,000.[7]

Most subsequent studies have focused on cost in a particular geographical area and have produced average lifetime costs lower than this 1986 study. One early California study provided information on the AIDS population covered by that state's MediCal system.[8] A San Francisco study reviewed hospital charge data for about one-half of all San Francisco patients with AIDS.[9] Both inpatient and outpatient costs of Boston patients were studied.[10] Overall, these studies and others led the Rand Corporation report to estimate the price of care for each AIDS patient at between $67,500 and $100,000.[11]

The results of these cost studies and others are analyzed, and the methodologies and sample populations are compared in a comprehensive article that appeared in the summer of 1987.[12] At this writing, two additional cost studies have appeared. One is a study of hospital charges for Richmond, Virginia patients.[13] The other, the *1987 Community Data Report,* details costs for hospitalized AIDS patients covered by Blue Cross of Greater Philadelphia.[14]

Despite the data problems in these studies, the lifetime cost of treating an average AIDS patient appears to be less than the $147,000 originally estimated. The Rand Corporation estimates of $67,500 to $100,000 are reasonable averages based upon today's information and today's treatments. The limits of 59% of group medical plans equal or exceed $250,000, and an additional 20% have unlimited lifetime maximum benefits. Fewer than 5% of full-time participants in plans with major medical coverage have lifetime coverage of $50,000 or less.[15] Thus, lifetime limits only occasionally play a significant role in determining how much AIDS treatment cost is transferred to the patient and/or public sector. Sadly, the lifetime maximums of group medical expense plans are, at the present time, largely immaterial to AIDS patients. Until treatments develop to prolong the life expectancy of AIDS patients beyond their present 2.1 years, few patients will survive long enough to reach existing plan limits. The lifetime costs of treating end-stage renal disease, many forms of cancer and heart disease easily can foreshadow the lifetime treatment costs of AIDS.

Despite these data indicating that the lifetime limits of an average plan pose no significant limita-

tion to an average patient, problems may exist for the patient unfortunate (or fortunate) enough to incur medical costs higher (live longer) than average. The HIAA study revealed that 41 claimants, or 6.2% of the 657 identified, had incurred insured medical costs in excess of $100,000; five claimants (0.76%) had insured costs in excess of $200,000.[16] This study does not provide complete cost information on patients whose medical insurance limits were exceeded.

One element within the many studies of AIDS treatment costs that remains inconclusive (and which this author continues to study) is the role of insurance coverage in treatment costs. The Boston study estimates that costs for patients with Blue Cross/Blue Shield coverage were more than double the costs for patients with no insurance.[17] The Virginia study shows no statistical difference in charges or lengths of stay among the five payer groups examined.[18] The *1987 Community Data Report* is the only study identified to date that examines the detailed costs records for a group of insured patients. Comparison of these results with the other studies will yield some additional information on costs to researchers and benefits planners.

Hospice Coverage

Hospice treatments can produce savings in the range of 20-30% over hospital-based treatments.[19] These facilities represent perhaps the single most important plan design feature for minimizing the total cost of treating AIDS patients.[20]

Coverage for hospice services has been rising steadily for several years. The Bureau of Labor Statistics (BLS) indicates that hospice care was available to 31% of medical plan participants in medium and large firms in 1986.[21] The survey of one national consulting firm shows that 64% of employer-provided medical plans (rather than participants) offer coverage for hospice programs.[22] Hospices reduce costs by providing treatment outside the hospital and, if possible, allowing the patient to die at home. Two more subtle reasons for this stable lower cost for hospices are the traditionally semivolunteer nature of many hospices and the high proportion of hospice residents covered by Medicare. Looking forward, however, the AIDS epidemic may reduce the cost savings provided by hospices. The increased dependence on hospice facilities by AIDS patients with their longer average lengths of stay and higher level of care is expected to put upward pressure on the price of hospice services.[23]

Home Health Care

Another important alternative to hospital treatment is home health care. Much of the medical treatment of AIDS patients consists of physical therapy to prevent loss of muscle strength in order to retain as much of the body's natural ability to fight opportunistic infection as possible. Home administration of drugs also will become possible as more pharmaceutical treatments are discovered and approved. Such treatments increasingly are provided on an outpatient basis, and the availability of home health coverage encourages such cost effective treatment methods.

The BLS study shows 66% of plan participants had home health care coverage in 1986.[24] The J&H survey indicates that 79% of employer plans offer coverage for home health care.[25] Yet only two in three insurers provide home health care benefits for group policies if requested by employers.[26]

The only cost figure available today for home health care is the average cost per claimant reported in the HIAA survey. The HIAA survey reported an average cost per claimant of $7,603. This figure should be viewed with caution, however, because it is based on data that truncated at the end of 1985. Many or all of the claimants included in that number still could be receiving covered treatments today. Also, only 14 claimants were identified among the 187 companies that reported they provided home health care benefits.[27]

Medical Necessity

The *medical necessity* provision of most benefit plans includes a requirement that the service must not be educational or experimental in nature. Determination of which treatments are to be considered *experimental* and whether coverage is to be provided for such experimental treatments is crucial in determining coverage for AIDS patients. AIDS is a medical condition that first was discovered in 1981. As such, all of the treatments likely to become available in the future will be experimental for at least several years.

No hard data have been discovered to date indicating the proportion of medical expenses for AIDS patients that remain uncovered as experimental treatments. The actual hardship imposed on the patient by such denials will vary inversely with federal and private funding for research into such *experimental* treatments. Denying coverage

for experimental treatments in some cases may be tantamount to denying coverage totally.

Continuation Benefits

Most medical expense plans in the past have continued eligibility for medical benefits during a leave of absence. One hundred ninety-eight of the 224 insurance companies (88%) responding to a question on this subject indicated that their policy language provides continuation of coverage due to disability. The continuations were for varying periods of time. Eighty-one (41%) continue coverage for one year; 27 (14%) continue coverage for as long as the employee remains disabled.[28] Following is a typical leave-of-absence provision taken from a Blue Cross/Blue Shield contract:

> A subscriber who is granted a leave of absence by the employer can continue coverage for up to three months. If the leave of absence is granted because the subscriber is disabled, coverage can be continued for up to six months. For us to grant continued coverage for a disability leave of absence, we must be supplied with medical evidence, acceptable to us, that the subscriber is prevented by illness or injury from performing his or her regular work or job.

Under an insured plan containing such a provision, the plan sponsor generally will continue to fund premium contributions on behalf of such a person if he or she still is considered to be an employee; if the person is considered to have terminated employment, then the coverage is continued by the carrier on a basis that resembles a waiver of premium.

Such disability extensions of coverage can become extremely complex in the wake of COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA's basic requirement is that an employee whose employment terminates or whose hours are reduced (e.g., through an unpaid sick leave) is entitled to purchase coverage under the group's medical plan for a period of 18 months following that termination. This provision would include employees who leave the workplace because of AIDS. Therefore, if a disability extension of coverage exists, an employee leaving the workplace would be entitled to elect continuation of coverage under COBRA and make the required contributions to the plan. On the other hand, he or she could elect not to purchase the COBRA continuation and risk coverage terminating before the need for medical treatments does.[29]

Many insurers and plan sponsors are eliminating or reducing the disability extensions of coverage previously provided by their plans as a way to avoid the complications described here. A rational and administratively efficient compromise that permits the plan sponsor to retain the equivalent of the previous benefit without expanding COBRA liability is to establish a policy waiving COBRA contributions for disabled persons leaving the workplace for the period of time benefits previously were extended. The employee electing such coverage will have the 18 months of coverage assured by COBRA with the same six months (or whatever other period is selected) of employer-paid coverage historically provided to employees requesting a disability leave of absence.

Beyond this known circumstance when COBRA applies, a question of even greater concern to benefit managers may exist. In view of the AIDS crisis, will COBRA regulations remain in place long enough to be implemented? At least one economist has called for an extension of coverage beyond the 18 months called for in the present legislation in direct response to AIDS costs.[30]

Leave of Absence

Most employers' personnel policies permit employees to take an unpaid leave of absence for personal reasons. *Collective Bargaining Negotiations and Contracts* shows a leave of absence as an almost universal benefit in the 400 labor contracts contained in their database. The only exceptions are contracts within the construction industry.[31] As leaves of absence are probably more common among large white collar populations than for the union contracts discussed above and less common among smaller nonunion employers, statistics on these negotiated contracts are presented here as an approximation of their popularity and typical provisions.

Of particular interest are the provisions for unpaid sick leaves contained in 52% of the contracts. An AIDS patient who had used all of his (over 93% of U.S. AIDS patients are male) paid sick leave could request an unpaid leave typically ranging in duration from one month to three years. Under many employer leave policies, this request would be granted regardless of prospects for the employee to return to active work. One Kansas City, Missouri employer has added the following restrictions in the

final paragraph of its policy for medical leave of absence:

> A medical leave of absence contemplates the employee's return to active employment. Should the company determine that an employee commenced a leave intending not to return, or if the employee does not return after the medical disability is removed for a period of time equal to the medical leave, the employee will be required to reimburse the company for all salary benefits received during the leave period.

Clearly such an unpaid leave would be appropriate for a patient whose condition improves sufficiently following treatment for him or her to return to work for a period of time. Provisions could be added to such a policy, however, to clarify whether it is the employer's intent to permit leaves of absence for terminal illnesses.

The corporate leave policy (or lack thereof) governs many of the costs that will be incurred under the medical plan and is related to pension, life and disability benefits as well. Unless an employer's leave policy is clearly written and consistently administered, denial of an AIDS patient's requested leave could easily result in an awkward and expensive discrimination claim.

Outpatient Prescription Drugs

About 97% of full-time participants in medical expense plans of medium and large firms have coverage for outpatient prescription drugs. This coverage most often is included in their major medical benefits. The availability of this coverage became critical to AIDS patients with the 1987 approval of azidothymidine (AZT) as the first U.S. drug for treatment of AIDS.[32]

During a 24 week study of 282 AIDS patients reported in the July 23, 1987 *New England Journal of Medicine,* 19 subjects in the placebo group and only one in the AZT group died. The drug was shown to reduce dramatically the number of opportunistic infections that occurred in AIDS and AIDS-related complex (ARC) patients. Some increase also was observed in the number of disease-fighting CD4 cells present.[33] Burroughs-Wellcome, which distributes the drug under the name Retrovir, is reputed to have invested $8 million in testing that drug for use with AIDS patients. The cost of this drug, at $10,000 to $12,000 per year,[34] has caused a great deal of public controversy.

With AZT and most other AIDS drugs to be developed, the research community predicts a short product life cycle. Just as one drug is approved for use, a new and better one may be announced to replace it. This combination of high development costs and short product life cycle inevitably causes high prices. Only when research hits a plateau—when no significant new developments are expected for some time to come—can the medical consumer expect to see prices start to drop for AIDS treatment drugs.

Any drug that portends costs approaching $1,000 per month and that must be taken for the duration of the patient's life will contribute greatly to an increase in the prescription drug component of medical costs. As this component is driving a rise in total medical costs, plan sponsors may find themselves weighing the value of high limit (or unlimited) prescription drug coverage against other benefits that can be purchased with those dollars.

Mental Health Benefits

Mental and nervous benefits of medical expense plans are critical to some AIDS and AIDS-related complex (ARC) patients. One manifestation of the AIDS virus is a severe mental disorder termed *AIDS dementia.* As costs and abuses have grown in recent years, many plan sponsors have attempted to regain control over their plan expenditures by tightening the provisions for mental and nervous benefits. While the Bureau of Labor Statistics indicates that 99% of all participants in medium and large firms' plans receive mental health benefits, only 37% of those participants have mental health benefits covered on the same basis as other illnesses. Sixty-one percent of participants are subject to separate limitations on this type of treatment, with the most common limitations being: (1) the number of days or visits that will be covered (38%); (2) the total dollar expenditure that will be paid (26%); and (3) removal of the major medical ceiling on out-of-pocket expenses that would apply for other illnesses (13%).[35]

Preexisting Condition Clauses

Most group medical expense plans that have preexisting condition clauses include one of these three forms:

1. An exclusion of any preexisting condition until a specified number of months after joining the plan
2. An exclusion of any preexisting condition un-

til the individual has received no treatment for a specified number of months
3. A dollar limitation on the amount of charges to be paid for the preexisting condition.

Such clauses in the past have dealt with pregnancy and diseases that a doctor determines to have manifested themselves. Patients diagnosed as having AIDS will present no special problems, except that the definition of what constitutes AIDS still is evolving. Common sense dictates that the plan be interpreted so that patients diagnosed under a former CDC definition are not treated substantially differently than those diagnosed under a newer definition. Also, plan designers should be aware of the apparent reluctance among the medical community to assign an AIDS diagnosis. This is discussed further below in the case management section.

What distinguishes AIDS from most old diseases are two key characteristics of the disease: (1) the cause of the disease has been shown by intensive research efforts to be a single agent, the HIV; and (2) the virus has a latency period of over five years in most patients. Because of the first characteristic, its singular cause, insurers and/or plan sponsors may consider denying coverage to infected individuals who may have been infected but were asymptomatic at the time of their hiring as having a preexisting condition. The second characteristic—the fact that infected individuals may show no symptoms for five years or longer—combined with the mobility of younger U.S. workers could result in a denial of coverage for many employed AIDS patients.

To determine whether such a strict interpretation of the preexisting condition clause would be appropriate for a particular sponsor's plan, consider this example. Suppose that medical science determines in late 1988 that an individual's cholesterol count is more than just a risk factor for heart disease. Research proves that it is the singular cause of heart attacks. In addition, a high cholesterol count in most individuals is a result of personal behavior patterns the individual has chosen not to modify. Further, such behavior modifications usually can be made after danger is observed; i.e, the effects of the endangering behavior are at least partially reversible. Given these facts, should medical expense claims be administered on the basis that an individual between the ages of 30 and 40 whose cholesterol count exceeds 280 at the time of hiring has a preexisting condition? If such an interpretation is deemed to be unduly harsh, consistency would demand that treating asymptomatic HIV infection as a preexisting condition also would be unduly harsh. If a sponsor would not be willing to take such a harsh position on heart disease on the basis of medical science, the corresponding position on HIV infection is unwarranted.

Other Benefit Provisions

The list of medical benefit plan provisions critical to coverage for AIDS patients discussed in this article is admittedly incomplete. A minority of AIDS patients would be affected by plan provisions governing the coordination of benefits, the maximum benefit period before a new deductible must be satisfied and special provisions for outpatient treatments. These provisions appear relatively unimportant to AIDS coverage at this time, but that assessment may change as new treatments evolve and as the demographic characteristics of those infected with the HIV change. Benefit designers and administrators should monitor such changes as a way of forecasting the rate of medical cost inflation and the distribution of plan expenditures among various categories.

Case Management

Lloyd's of London made headlines when it purchased cost management services for AIDS patients who belong to the groups on which it provides the excess group health insurance. An external firm supervises and authorizes the medical services to be provided to the patient. Home health and hospice care are emphasized as the most cost effective and humane form of treatment for AIDS victims.[36] The use of a case management approach for AIDS is likely to grow in popularity in the next few years. The variations of the disease are numerous, and the treatments available are evolving rapidly. Full-time experts are needed to track ongoing research and make appropriate care decisions for individual patients in whom the syndrome manifests itself in such a variety of physical problems. Such expertise is available on a stand-alone basis to self-insured plans and is included automatically through the insurance company's case management department for insured plans.

Case management firms are finding that one important service they can provide is counteracting some of the inefficiencies and inconsistencies in the medical establishment. The reporting system for diagnosed cases of AIDS involves significant delays in tabulating the statistics involved. One study has reported that about 11% of AIDS cases take over a

year to be included in the CDC statistics; 15 cases of AIDS diagnosed in 1981 were not reported until 1986 or later.[37] A unique service available from some case management firms is computer software designed to analyze patient medical records and unmask an AIDS patient not formally diagnosed as having AIDS. Similar research has proven successful in the past at identifying patients whose alcoholism or mental illness was disguised to protect the patient from the associated social stigma.[38] Overcoming physician tendencies to disguise AIDS with less stigmatized diagnoses, and thereby begin management of the case at an earlier date, is one advantage touted to customers of case management services.

Government Coverage

Under current law, AIDS victims qualify for Social Security disability income benefits after being totally disabled for a waiting period of five full months. If the total disability continues for two years, then the patient becomes eligible for Medicare. Because of short life expectancy for AIDS patients, Medicare is likely to become available to fewer than half of all AIDS patients during their lifetimes.

The Social Security Administration has taken steps to expedite disability benefits under Title XVI for individuals unable to work because of AIDS. That policy is due to expire in February 1988, however, unless further Social Security Administration action is taken. Hearings held September 10, 1987 by the Subcommittee on Social Security and Family Policy of the Senate Finance Committee represented some of the first steps toward making of U.S. policy in these areas.[39]

As swift action is needed in most policies concerning AIDS, the time for public input into these decisions is likely to be short. Individual plan sponsors and appropriate representative organizations should begin immediately to formulate their positions on the role of government in AIDS funding and communicate them to appropriate legislative representatives. Should rules be proposed for AIDS that differ from other diagnoses, those differential benefits would find precedent in the Medicare rules on dialysis. Patients receiving treatment for renal failure are subject to rules different and separate from other disability recipients. When kidney dialysis and/or transplant is provided to a participant in a group medical plan, the group plan bears primary responsibility for treatment costs during the first year; Medicare assumes primary coverage after one year.[40]

Trends for the Future

This author is willing at this time to make a few predictions about changes that will occur among medical benefit plans as a result of AIDS. These conclusions are based, of course, on the research of many experts in AIDS and benefits and on observation of current changes. They also are based upon this author's previous study of the future of the life and health insurance industry. In that study, begun in 1981, a Delphi panel of insurance executives and others responded to a questionnaire that asked the impacts expected from and strategies expected to be effective should the following event occur:

> Hundreds of thousands of deaths are caused by an acute contagious disease that sweeps the U.S.[41]

The first expected change relates to plan funding rather than the plan coverage issues discussed in this paper. Benefits professionals almost certainly will witness a decrease in the attractiveness of self-insured financing for medical expense plans. No longer does a young and apparently healthy employee population assure savings from self-insurance. Small to medium employers will decide that self-insurance is not worth the risk. Larger employers will be reluctant to increase the stop-loss limits of their insured coverage and may seek excess-loss insurance where none was used before. This increased risk aversion on the part of plan sponsors, quite predictably, will clash with insurers' increasing premium charges for excess coverage.

Second, coverage for home health care and hospice services can be expected to continue their rise over the next few years. Such coverage represents a responsible, humane balance between the medical needs of AIDS patients and the needs of the plan sponsors to control medical plan inflation.

Third, considerable time will be invested by employers to formalize their policies and administrative procedures on leaves of absence. The company policy on leaves of absence and the group medical plan provision on leave of absence at last will be integrated and coordinated. Direct and indirect costs will be assessed for the extension of medical benefits, particularly in light of COBRA extensions that also must be provided.

Fourth, coverage for outpatient prescription drugs will be scrutinized carefully over the next several years. The current price of AZT and the

price uncertainty likely to remain a part of the AIDS crisis will focus the attention of plan sponsors on drug coverage, which was previously viewed as a relatively insignificant component of the overall cost of coverage. In addition, some sponsors are likely to consider an internal plan limit on that coverage as a means of restraining unanticipated cost escalations in future years.

Fifth, the decline in coverage provided for mental and nervous benefits will slow. AIDS demonstrates an indisputable physical cause for mental illness. This direct link will diminish the image of the mental patient who abuses the system and increase the perceived need for complete and adequate mental and nervous coverage.

The single most contentious area of potential benefit redesign activity will, this author predicts, be the preexisting condition clause. Employers that experience unanticipated heavy costs for AIDS will look for ways to reduce those costs. The first target is likely to be those newest liabilities—costs that never before have appeared in the plan and that, despite media attention, many still expect to remain someone else's problem. Because the AIDS population is mostly young, plan sponsors will be tempted by the many dollars that could be saved by denying AIDS coverage to those employed fewer than five years. Proponents will argue strongly that such action is justified because infection probably occurred before employment. Any such position will be fought vehemently by patient rights groups and others as unfair and discriminatory. This battle should be waged carefully. Plan sponsors who project images of greed may bring upon themselves legislation outlawing the use of preexisting condition clauses in any group medical expense plan.

Conclusion

The cost of AIDS to employer-sponsored medical plans depends heavily upon policy decisions made by Congress and the Social Security Administration, i.e., whether those dying from AIDS should receive expanded coverage. Despite the attention that AIDS will draw from benefits professionals in the coming months and years, that profession is, in a very real way, helpless.

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