

The ViewsLetter

VOL. One • No. 1

February 1998

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Introducing The ViewsLetter

Welcome to the first issue of the McGraw Wentworth ViewsLetter. Our mission is to be the leader in the employee group benefits brokerage and consulting industry. We have established the ViewsLetter as an integral part of our commitment to keep you informed of benefit trends, legislative developments, and marketplace developments that may affect your group benefit programs.

Specifically, our ViewsLetter is designed to offer you information on:

- *Emerging marketplace and legislative trends in the group benefit field*
- *The potential impact of these changes on group benefit programs*
- *The ways in which we can help you to effectively plan for and manage these changes*

Of course, we also welcome your comments and suggestions regarding the



The McGraw Wentworth Team

ViewsLetter. You can pass your comments directly to your McGraw Wentworth Account Director or Account Manager, or you can reach us through our website at www.mcgrawwentworth.com. **MW**

Health Care Costs on the Rise

After several years of stable, and even declining, rate levels, it appears that health care costs are on the rise in 1998. Depending upon the type of Medical care coverage an employer provides, estimates for 1998 increases range from 3% - 7%. HMOs, where national average costs have declined by over 6.5% since 1993, are now distributing some of the largest increases in premium rates.

In a survey of 150 large employers released on January 8, Towers Perrin determined that the average expected increase in 1998 health care plan costs was approximately 4%.

Broken down by covered employee class, the projected increases were:

- *Active employees: + 4%*
- *Retirees less than age 65: + 4%*
- *Retirees 65 or older (Medicare eligible): + 5%*

Anticipated 1998 medical plan increases also varied by the plan delivery system, as shown below:

- *Indemnity (Traditional): + 7%*
- *PPO: + 5%*
- *Point of Service (POS): + 2%*
- *HMO: + 5%*

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Reach us on the world wide web at the McGraw Wentworth Interactive web site. Check it out at www.mcgrawwentworth.com. Additional copies of the ViewsLetter are available in PDF format in the MW Xchange.

DID YOU KNOW THAT?

Three out of every ten people between the age of 35 and 65 will become disabled for 90 days or longer



Nearly one in five working people will become disabled for 5 years or more prior to reaching age 65



Between 1990 and 1997, disability claims for Epstein-Barr Syndrome rose 800%, carpal tunnel syndrome rose 250%, back disorders rose 120%, and psychiatric disorders rose 85%



Employers now spend approximately 8.3% of total payroll, or approximately \$2717 per employee, on disability related costs



Only 1.2% of disability related costs, or about \$32 per employee, is spent on disability management



Data provided through UNUM/Rutgers University joint study of 25 large employers with over 250,000 employees and \$9.3 billion in covered payroll (1992-1996).

Health Care Costs, cont.

Medicare Risk HMO plans, which can cost as much as 75% less than traditional retiree health plans, are raising rates at an average rate of 8% for 1998.

In a second national study, William M. Mercer and Company found that 1997 health care costs remained relatively flat due in large part to employer-initiated enrollment shifts from the more expensive indemnity and PPO programs into HMOs and point of service plans.

Surveyed employers with ten or more covered employees indicated that where enrollment shifting was encouraged, 1997 plan cost increases averaged approximately 0.2%. Where plan options and enrollment patterns remained static, increases in 1997 averaged 4.0%.

It remains to be seen whether plan sponsors will be able to minimize anticipated 1998 cost increases by encouraging further enrollment shifts to lower cost plan options.

Rate increases issued by local healthcare plans, driven in large part by poor 1997 financial performance, are consistent with the national survey averages of 3% to 7%. Among Southeastern Michigan based managed care organizations, the eleven largest HMOs recorded combined net losses of \$20.8 million through the third quarter of 1997. This figure compares to net income gains of \$7.9 million for the third quarter of 1996. Factors driving the HMO losses and resultant 1998 rate increases include:

- Mandated 10-20% rate reductions in order to qualify for participation under the state Medicaid program, which targeted \$111 million in cost cuts (\$236 per recipient per year) for the July 1997 – June 1998.

- Start up costs associated with the development and marketing of Medicare Risk contracting HMOs, which affected operating results for MCare, Blue Care Network of

Southeast Michigan and Care Choices.

- Balancing of competitive pressures to grow membership with escalating cost of care, particularly in the Prescription Drug arena. Health Alliance Plan estimated that Prescription Drug costs in Southeastern Michigan were rising at an annual rate of 12%, six times the



trend level for other medical services. Prescription costs currently make up 15% of the total "cost of care" for HAP. Similarly, Blue Cross Blue Shield indicated in a Fall 1997 mailing to participating physicians that Prescription Drug therapy had replaced physician services as the second largest component in BCBS health care expenditures behind hospitalization. **MW**



"Even if you are on the right track, you will get hit if you just sit there."

Will Rogers

Health Care Bill of Rights

President Clinton has called for federal legislation to implement a proposed "Consumer Bill of Rights and Responsibilities" for managed health care plans. The Consumer Bill of Rights is a controversial set of recommendations that is, in many ways, a continuing "back-lash" to the advance of managed care in American society. The bill could set the stage for a confrontation with Congress next year reminiscent of the Clinton administration's battle over health care reform in 1993/1994.

The proposed "Consumer Bill of Rights and Responsibilities" seeks to:

- Challenge all private health plans to adopt the Consumer Bill of Rights;
- Call on Congress to pass appropriate federal protections into law;
- Direct every federal agency that manages health care plans to adopt features of the Bill of Rights and to advise the President whether they need additional legislative authority to do so.

President Clinton, in a White House ceremony held in support of the Consumer Bill of Rights and Responsibilities, noted that some of the Rights and Responsibilities can be ensured with administrative procedures. Other Rights and Responsibilities can be obtained through accreditation procedures. But others, contained in recommendations, will require federal legislation.

President Clinton's 34 member Advisory Commission has recommended the following Rights and Responsibilities in their report to the President:

- Choice of providers and plans for all Americans
- Reasonable access to emergency services
- Active patient participation in treatment decisions
- Information disclosure regarding health care plans
- Confidentiality of health information and internal and external review of complaints and appeals

One notable Commission recommendation is that persons with serious medical conditions who require frequent specialty care have the option to directly access a qualified specialist of their choice within a plan's network of providers. In other words, this type of patient should not have to go through a Primary Care Physician in order to access specialists.

Another key recommendation from the Commission promotes the idea that when symptoms are such that a "prudent lay person" could reasonably expect the

their decisions on recommended care. The Commission also recommended prohibition of "gag clauses" that restrict health care providers' ability to communicate with patients about medical treatment options.

We expect health insurers, managed care providers and employers to disagree with federal legislation for consumer protection in health care. All of these constituents will advocate the position that managed health care is working properly in holding down the rate of health care inflation in the U.S. economy. Opponents of the Commission's recommendations will argue that federal intervention into the health care economy represents "micro management" and an inappropriate intrusion of government authority. Indeed, the Business Round Table has already warned against further government intrusion into the health care marketplace, stating that private sector initiatives are improving the quality of healthcare throughout the United States. **MW**

need for medical attention, he/she should have access to emergency health care services.

A prominent issue in the managed care debate has been the effect of provider compensation arrangements on patient treatment plans. On the matter of patient participation in treatment decisions, the Commission recommended that providers disclose any incentives – financial or otherwise – that might influence



NOTABLE QUOTE

"About one-third of the cost of health care in the United States—some \$300 billion—is the cost of capturing, storing and processing such information as patients' records, physicians' notes, test results, and insurance claims."

Phillip B. Evans and Thomas S. Wurster
"Strategy and the New Economics of Information"
Harvard Business Review, January/February 1998

TECHNICAL CORNER

EMPLOYEEASE is an Internet based solution for managing your company employee information from one common database. The system is designed to provide companies with access to a sophisticated Human Resource Information System at a reasonable cost.

EMPLOYEEASE requires the following computer hardware and software:

- Personal Computer with Internet access
- Netscape browser

The benefits of EMPLOYEEASE for your organization are as follows:

- You can maintain an online database of all information on each employee such as address, benefit election, salary, occupation, termination information, etc.
- The system tracks all changes made in the system and monthly addition/deletion/change reports can be printed to forward to each appropriate carrier.
- Billing systems that can produce invoices based on current month that can be used to audit the carrier bill each month. The billing system can also be used to produce internal billings for various divisions and cost centers.
- The system maintains a historical file on benefit elections that is important to comply with HIPAA requirements for issuing certificates of coverage.

- Reporting function can produce reports based on the parameters you choose.

- The system can also be designed to maintain information on Primary Care Physician elections, which can be an important tool in evaluating possible network replacement plans.

- The system will eventually have the capability to print simple benefit statement ("extra paycheck" concept) that demonstrates the value of the employer provided benefits.

- Data can easily be downloaded into an Excel, Lotus or Word format to use for various applications.

- The system will allow a company to have Human Resource personnel input information at locations globally and maintain one centralized information database.

EMPLOYEEASE maintains the same security and encryption procedures that the Federal Government and most financial institutions use to protect your employee data on the Internet. In addition, they offer different levels of security access for certain information (for example, only one person may have access to salary information).

EMPLOYEEASE charges a base fee per month plus a per month per employee fee. Please contact your McGraw Wentworth Account Manager for more details. **MW**

Our newsletters are written and produced by the McGraw Wentworth staff and are intended to inform our clients on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Consult your legal counsel or tax advisor in matters that directly affect your benefit plans.

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YOUR QUESTIONS

Q. Our company is based in Michigan and we have other locations as well. One of our employees in Texas asked us to enroll his common law wife for medical coverage. Are we required to allow her to enroll?

A. Although couples may not be married by "traditional" or "conventional" means, common law marriages are considered legal and binding unions by the states that recognize them. And, as a general rule, welfare benefit plans provide coverage to the "legal spouses" of their employees. As a result, employers must extend coverage to common law spouses on the same basis as traditionally married couples.

Currently, just a handful of states recognize common law marriages. Each has its own criteria for what constitutes a "common law" marriage; for instance, some require that a couple live together a set number of years before they can be considered common law spouses, others require that such couples present themselves as "husband and wife" to neighbors, co-workers, etc.

A Plan Administrator needs both a reasonable and systematic approach to administering coverage for those in a common law marriage. Having such an approach reduces the risk of employees casually adding dependents to the plan and putting your firm at risk for large claims.

We suggest you contact us if such a situation arises at your company. We can help you implement procedures in your company that will both protect your firm, and allow for a fair and reasonable approach to what can be a difficult situation. **MW**