

# The ViewsLetter

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## Importing Drugs - The Canadian Connection

For the last five years, the trek of senior citizens across the Canadian border to purchase reasonably priced medications seemed a regular topic for television news programs. Seniors, however, are not the only people in this country struggling with the high cost of prescription medications; because the rising cost of prescription drugs has become widespread concern, people of all age groups are seeking relief across the border.



Many municipalities and states are investigating the prospect of purchasing Canadian drugs for their employees. Even employers are investigating the possibility of using Canadian vendors for mail order prescription drug programs. The interest is peaking as the costs of prescriptions continue to rise annually at a frightening rate. Organizations have adjusted copays, strongly encouraged employees to use generics when available, and analyzed alternative pharmacy benefit managers to tackle the cost increases. Importing drugs from Canada

has become a popular consideration for managing cost.

Canada is just one of many industrialized countries that regulate the cost of prescriptions. A prescription manufactured in the United States and shipped to Canada for consumption can cost between 20% and 80% less than the same drug purchased in the United States.

Although the practice of importing drugs from Canada seems like a win-win situation, unfortunately, it is illegal. Federal

law only allows pharmaceutical manufacturers to import prescription drugs from abroad. Therefore, the practice of companies and even individuals importing drugs from other countries is illegal. The Food and Drug Administration (FDA) is aware of the illegal practice but has tended to ignore it, not prosecuting those involved.

Because the practice of importing Canadian drugs has increased dramatically over the last

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## About the ViewsLetter

We welcome you to the fourth quarterly issue in Volume Six of the McGraw Wentworth ViewsLetter. It is our mission to be the leader in the employee group benefits brokerage and consulting industry to mid-sized organizations.

We have established the ViewsLetter as an integral part of our commitment to keep

you informed of benefit trends, legislative and marketplace developments that may affect your group benefit programs.

We welcome your comments and suggestions regarding the ViewsLetter. You can pass your comments directly to your McGraw Wentworth Account Director or Account Manager, or you can reach us at [www.mcgrawwentworth.com](http://www.mcgrawwentworth.com).

Reach us on the web at the McGraw Wentworth web site. Check it out at [www.mcgrawwentworth.com](http://www.mcgrawwentworth.com). Additional copies of the ViewsLetter are available in the MW Xchange on our website.

# Importing Drugs - The Canadian Connection cont.

five years, the FDA is finding it difficult to remain passive. Pharmaceutical manufacturers are calling foul and pushing the FDA to take action. Four manufacturers in particular are limiting their Canadian exports to discourage the re-importation of the drugs from Canada.

Congress is currently debating legalizing this process. The House recently voted on a measure that would legalize the practice of drug re-importation. The House Republican leadership did not support the measure but the majority favored the passage of the bill.

Support for this practice comes from consumers and health plans that shoulder the burden of increasing costs. Recently, the states of Illinois and Iowa have established committees to investigate the feasibility of re-importing drugs from Canada for their state programs. Rod Blagojevich, the governor of Illinois, has directed this action because "the status quo on prescription drugs is intolerable and unacceptable." Illinois experienced a 15% increase in

prescription drug expenditures just in the last year. The state is spending \$340 million annually for prescription benefits for state employees. A move to securing prescription drugs from Canada is expected to save millions of dollars.

Springfield, Massachusetts launched a program in July for city employees and retirees to purchase prescriptions from Canada. Springfield uses a company called CanaRx to supply prescriptions for the new program and encourages employees to use the program by waiving prescription drug copays. Michael Albano, the Mayor of Springfield, expects the program will save between \$4 million and \$9 million dollars annually.

Programs, such as the one in Springfield, have garnered the support of advocacy groups for seniors. The American Association of Retired Persons (AARP) and the Alliance for Retired Americans support these cost effective programs.

The practice of importing drugs from Canada also has its critics. The phar-

maceutical manufacturers and the FDA are opposed to the practice.

Pharmaceutical manufacturers are opposed to re-importation of drugs because of their concern over the growing danger of counterfeit medications. Drugs imported from Canada are not subject to FDA monitoring and could prove unsafe. In fact, the FDA has documented a few cases of serious injuries from counterfeit medications. While the number of documented cases of serious injury remains relatively small, the prevalence of counterfeit medications in the United States has increased dramatically over the last few years. The increase in counterfeit medications is due to weaknesses in the medication distribution system, the rising use of Internet pharmacies and large disparity in drug cost across borders. Many individuals, however, believe the reluctance of the pharmaceutical companies to allow re-importation of drugs stems from the companies' concerns over loss of profit, not necessarily their concern with the dangers of counterfeit medications. Surely their profits would indeed be dramatically affected if the practice of re-importing drugs from Canada is legalized; it could become a popular cost containment strategy for most group health plans.

The FDA cites safety as its primary concern regarding the re-importation of drugs.

The safety risks include importing drugs that:

- Are not made in the USA and not approved for use by the FDA.
- Have reached their expiration date.
- Have not been stored properly.

Safety concerns are real. In recent sting operations, the FDA has received insulin that was not stored properly

## TREND TIDBITS

According to the Kaiser Family's Foundation's 2003 Employee Health Benefits Survey:

- The cost of employer-sponsored health insurance rose 13.9% between 2002 and 2003. The average annual premium for single coverage increased to \$3,383; and for family coverage the average annual premium increased to \$9,068.
- Employee contributions remained unchanged on a percentage basis. On average, employees pay 16% of the cost for single coverage and 27% for the cost of family coverage. In dollar terms, the annual contribution for single coverage was \$508 in 2003 and for family coverage, the employee cost was \$2,412.
- Copayments for prescription drugs in 2003 increased to \$9 for generic, \$19 for preferred brand drugs, and \$29 for non-preferred brand drugs.
- Nearly 80% of employees have a deductible associated with their medical plans. The average deductible for a PPO plan is \$275 in-network and \$561 out-of-network.

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## Importing Drugs - The Canadian Connection, cont.

and in another instance it was provided a prescription for a drug not approved for use in the United States.

The FDA is cracking down on these programs. It recently issued a warning letter to CanaRx that their operations are illegal. CanaRx has until early October to respond to the complaint but CanaRx has indicated it does not intend to cease operations. The FDA is pursuing action against the companies that import the drugs, but are not yet taking action against the individuals using the service.

The re-importation of drugs from Canada and other industrialized nations will remain a hot topic for the

next year. With the economic downturn, companies and individuals have become increasing conscientious regarding their medication expenditures. It does not seem logical that a prescription in the United States could cost between 20% and 80% more than the same prescription across the border. However, a lack of FDA monitoring of these prescriptions should be a real concern to those who choose to use re-imported medications. Congress will be influenced by equally strong lobbies supporting and opposing this practice. The House passed a bill legalizing the process, but the bill has a long road ahead before it may become law.

If health plans and individuals are considering securing Canadian drugs, the practice is risky. As of today, it is illegal. There is the potential that the FDA may pursue health plans and even individuals who engage in this activity at some point, even though to date that has not been its enforcement approach.

Of greater concern would be the potential risks of potentially less safe medications or even counterfeit medications because of the lack of FDA oversight of the re-importation process. If re-importation is legalized, appropriate oversight programs should be developed to insure the safety of the imported medication.

MW

## Prescription Drug Benefits and Medicare

Adding an outpatient prescription drug benefit has been a debated issue over the last several years and with the House and Senate passing separate bills this summer, it appeared Medicare would be covering outpatient drugs in the near future.

Both the House and Senate have passed variations of the bill with different parameters (see table below).

The Senate bill allows for additional coverage for beneficiaries with additional drug cost liabilities once the individual's out-of-pocket reaches \$3,700 in the year. The House bill allows for additional coverage once

the \$2,000 maximum is reached, based on need.

A committee is currently working on the developing a bill that blends these two bills together. The committee has a deadline of October 17 for the completion of their negotiations. Aside from blending the new bills, the committee is also addressing:

- Coverage of beneficiaries who are eligible for both Medicare and Medicaid
- Provisions relating to health savings accounts

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	House Bill	Senate Bill
Monthly Premium	\$35	\$41
Annual Deductible	\$250	\$275
Initial Coverage Limit	\$2,000	\$4,500
Coinsurance	20% for drugs covered between the \$250 deductible and \$2,000 annual limit	50% for drugs covered between the \$275 deductible and \$4,500 annual limit

## DID YOU KNOW?

In 2004:

- 51% of employers are "very likely" to increase the amount employees pay for health insurance coverage.
- 20% of employers are "very likely" to increase the amount employees pay for prescription drugs.
- 14% of employers are "very likely" to increase the deductibles attached to their medical plans.
- 3% of employers are "very likely" to launch a high deductible medical plan option.
- Only 1% of employers are "very likely" to drop medical coverage for their employees entirely.

Source: Kaiser Family Foundation, 2003 Employer Health Benefits Survey

# Prescription Drug Benefits and Medicare, cont.

- Health plan competition

The addition of prescription benefits, however, has become a lukewarm issue. While this remains a key issue for the President and Democratic Party leaders, other parties have major concerns with adding this benefit to Medicare:

- The deficit is a big problem in Washington. The cost of war in Iraq has shocked many and the \$400 billion price tag for Medicare prescription benefits seems very high.
- Republicans are concerned with the long term cost control of a benefit that has increased in cost and utilization over the last 5 years. They are looking to pass provisions to help control drug cost over time. Many individuals will not approve a Medicare drug benefit without legalizing the re-importation of drugs. Clearly, Congress is concerned about the long term cost of the plan and would like cost controls instituted when a bill is passed.
- Many believe the \$400 billion dollar price tag established for the program is too low. A recent Congressional Budget Office report indicated the price would be closer to \$450 billion to add this benefit.

With the October 17 deadline drawing near, the debate will heat up again. Many strong advocacy groups, such as the AARP, as well as most large corporations support the inclusion of a prescription benefit in Medicare, but deficit spending is not the most sound economic policy. It will be interesting to note the progression of the revised bill, and to see if the bill is delayed indefinitely.

MW

## YOUR QUESTIONS

- Q.** I have retiree coverage through my former employer. I recently heard my former employer will discontinue the retiree health plan. Will I be offered COBRA?
- A.** It depends on your circumstances. A group health plan provided to retirees is subject to COBRA. In order for COBRA continuation rights to apply, two circumstances must be met:
1. Loss of coverage.
  2. Qualifying event.

You will experience a loss of coverage when the retiree plan is discontinued, but have you experienced a qualifying event? COBRA defines qualifying events for an employee as termination of employment or a reduction of work hours. While the termination of employment may not have occurred concurrently with your loss of coverage, it did occur when you retired.

A loss of coverage and a qualifying event do not need to occur concurrently for COBRA to apply. If you did not experience a loss of coverage at retirement (you were offered the same coverage you had as an active employee for the same cost), you were not offered COBRA. If you lost coverage anytime during your maximum benefit period (18 months), your former employer must offer you COBRA for the remainder of the maximum benefit period.

This is a difficult situation to understand, so let's walk through an example. I retired from my company on June 1, 2003. I am offered the same coverage as active employees for the same cost under the retiree plan. I am not offered COBRA at retirement because I have not experienced a loss of coverage. On January 1, 2004, my former employer discontinues all retiree health benefits and I lose my retiree health coverage. Since my qualifying event occurred on June 1 and I am still in the maximum benefit period for COBRA, my former employer must extend COBRA coverage. COBRA should be made available as of January 1, 2004. I can elect COBRA for the remainder of my maximum coverage period or 11 months.

If I did experience a loss of coverage at retirement, either benefits were reduced or my cost for coverage increased, my employer should have offered me COBRA at that time as I experienced a qualifying event and a loss of coverage. If I failed to elect COBRA and my initial 60-day election period has expired, my employer is not required to offer me COBRA when retiree benefits are discontinued.

### Electronic Distribution of ERISA Plan Documents

As more and more workplaces move into the “technology age,” employers can save time and money on certain administrative tasks. Administrators of group health plans are aware of the many documents that are necessary to distribute to comply with ERISA. Plan participants must be given SPD (Summary Plan Descriptions), SMM (Summaries of Material Modification), SAR (Summary Annual Reports), COBRA Notices, Certificates of Creditable Coverage and Privacy Notices. These are just the requirements for group health plans.

If your workplace offers employees access to computers, distributing these documents electronically will save time and money. Regulations were finalized in April 2002 to allow for certain documents to be distributed electronically. The final regulations addressed two categories of individuals:

- Employees with regular computer access as part of their job duties at the workplace.
- Individuals without regular computer access at the workplace.

The requirements for electronic distribution will be different depending on the individual’s access to a computer as part of their job functions.

#### Employees With Regular Computer Access

In order to meet ERISA requirements, you must ensure the following:

- The delivery method results in receipt of information. If you e-mail the documents to an individual, your e-mail system should have a way to notify you of undelivered mail.
- The delivery method must protect the confidentiality of each individual’s personal information relating to the benefit plan.
- The materials must be furnished in a manner consistent with style, format and content requirements of the specific document.
- The message with the document must address the significance of the document and the right for an individual to receive a paper copy if requested.
- If you intend to e-mail the documents, the individual must provide an accessible e-mail address.
- If, at any point, your organization changes the form in which the information is sent, you must provide a statement regarding the revised hardware/software needs, reiterate the ability to withdraw consent and allow the individual to affirm consent to receive the document in the new format.

#### Employees Without Regular Computer Access

In order to distribute documents electronically to individuals without regular computer access, you must:

- Make a request of the individual that:
  - Identifies any software/hardware requirements the individual will need to access the information.
  - Advises that consent may be withdrawn at anytime and outline the procedure for withdrawing consent.
  - Informs the individual that a paper copy, free of charge, is available upon request.

You must receive an affirmative consent in order to deliver the documents electronically.

The requirements for employees without regular computer access are more restrictive and difficult to administer.

Electronic delivery of certain documents may be a timesaver when the majority of your employees have regular computer access at their normal place of business.

**Important Note:** HIPAA Privacy Notices have a different standard for electronic delivery. All employees must affirmatively consent to receipt of the notice.

Also, although COBRA notices can be delivered electronically, that method will not meet the requirement that a covered spouse receive a copy of the General Notice.**MW**

## MCGRAW WENTWORTH TEAM

### PRINCIPALS

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### ACCOUNT DIRECTORS

### PLAN ANALYSTS

### DIRECTOR OF TECHNICAL SERVICES

### MANAGER, CLIENT SERVICES

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### ASSISTANT MANAGER, CLIENT SERVICES

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## THE VIEWSLETTER

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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