McGraw Wentworth

The ViewsLetter

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Are Health Care Cost Trends Cooling?

Mercer recently released selected results for its National Survey of Employer-Sponsored Health Plans for 2004. The results offer good news for employers; the overall rise in health care cost was just 7.5%, a much lower number than most expected.

Does this mean the health care cost crisis is officially over? Probably not. However, two major factors contributed to cooling trends:

- Fully insured plans have had smaller annual increases.
- More of the cost of care has been shifted to employees.

The small increases in fully insured premiums are a result of the current market situation. Not-for-profit insurers' reserves have increased significantly, resulting in surpluses. Therefore, renewals for non-profit carriers were in the low single digits to reduce surpluses in their reserve accounts. For-profit competitors needed to follow suit to retain market share. For-profit carriers have also experienced several years of healthy profits making the smaller increases more acceptable.

In fact, small employers often bore a higher percentage of the burden. In the last 5 years as cost increased dramatically, often smaller employers' annual premiums increased significantly. Their size limited their ability to negotiate lower cost increases. For 2004, however, the Mercer survey shows smaller companies' costs increased by just 5.5% while larger employers' costs increased by an average of 9%, a correction of prior trends.

Shifting costs to employees has also had an impact on the annual cost increases. From 2000 to 2003, most employers' health plan costs increased in double digits. The yearly increases were too large for most companies to absorb or even to make small plan changes to lessen the impact. These continual cost increases caused a universal push toward consumerism in the health plan

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About the ViewsLetter

We welcome you to the first quarterly issue in Volume Eight 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.

Are Health Care Cost Trends Cooling? cont.

arena. National studies that received significant press coverage indicated as much as one-third of all health care services consumed in the United States did not improve health and in some cases, actually worsened a patient's condition. Organizations began to look closely at how participants use their plans and began to research strategies designed to influence employee health care decisions.

What became clear over the course of this research is that employees do not really understand the true cost of the care they seek and ultimately how the cost of care impacts health plan expenditures and corporate profitability. The focus of consumer driven health plans is to re-introduce the true cost into the buying decision for health care services. Most consumer driven health plans have significantly higher deductibles and accounts with funds that can be used at the employee's discretion. If funds are left in the account at year-end, many plans allow those funds to rollover and continue to accumulate. The overall effect is that plan participants are using their own funds to pay for health care and therefore tend to make wiser purchase decisions.

DID YOU KNOW?

A recent Hewitt Associates survey indicates employees are more willing to take greater control of their health care decisions, but really aren't sure how to do it.

Currently:

- More than 80% of employees don't estimate their health care expenses each year.
- Almost as many (79%) don't think they can do anything to control health care costs.
- Just over half (57%) have never researched provider costs or quality.
- Almost a quarter (24%) have never asked about their prescription drug options.

However, if offered the proper support, employees indicate they would be more involved:

- 81% indicate they would be willing to discuss treatment and prescription options with their physician.
- 71% would feel comfortable deciding when to seek a second opinion.
- 69% would take the time to research their medical conditions.
- 65% would research their physician choice.
- 63% would research the best hospital for any necessary treatment.

Most employers have not introduced full fledged consumer driven health plans. The Mercer study indicated only 1% of surveyed employers offer a consumer driven health plan. However, it appears consumer driven arrangements may be here to stay. Among large employers, 14% indicated they would offer a consumer-driven health plan in 2005 and 26% are likely to offer a consumer-driven option in 2006.

The increases in copays and deductibles and decreases in coinsurance levels affect plan use. Participants aren't seeking unnecessary services because they must pay more of the cost. In addition, many plans have included incentives for participants to seek the most cost effective care. For example, plans may require one copay for primary care provider visits and a higher copay for specialist visits. If the difference in cost is significant, participants will choose the least expensive and, in many cases, the most appropriate provider.

Mercer also indicates that longer term cost management strategies such as disease management and wellness plans are gaining traction in the marketplace and ultimately are having an impact. Wellness initiatives have steadily gained momentum. Mercer reports that 31% of employers sponsoring these initiatives have indicated they are receiving a return on their investment. Almost 60% of employers sponsor wellness initiatives but have not attempted to measure their return on investment.

The good news doesn't stop for 2004. Early projections for 2005 indicate that health plan costs are expected to rise on average 6.6%. These lower trends may provide employers some relief for health plan cost; however,

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YOUR QUESTIONS

Q. We recently launched flexible spending accounts at our organization. In March, we are planning layoffs that may last up to 3 months. We continue all benefits for our employees until the end of the month in which the layoff begins. At that time, we send employees COBRA notices and conversion information for our life plan. How should I handle the spending accounts?

A. The process for handling dependent care accounts is different from the process for handling medical flexible spending accounts. You can continue dependent care accounts until the end of the month, as with your other benefits. Be sure your payroll company deducts the correct amount to pay the account current to the end of the month. When your employees return to work, you can allow them to make new elections according to your return to work policy (the first day they return to active work or when they complete any necessary new hire waiting period). You should make sure your summary plan description accurately explains this situation.

Medical spending accounts are more complex. They are viewed as self-funded medical plans and may be subject to COBRA if an employee has funds remaining in the account at the time employment terminates. Your plan can take several approaches to handling medical spending accounts while an individual is laid off:

- **Terminate FSA coverage as of the end of the month.** COBRA must be extended for employees who have <u>funds remaining</u> in the account. When an employee returns from a layoff, you can allow him or her to make a new election for the remainder of the plan year according to your return to work policy. Laid off employees are not entitled to greater benefits than active employees.
- **Continue the current FSA election but discontinue contributions during the leave.** You can continue the current FSA in a number of ways:
  - ➢ **Option 1:** Offer prorated coverage. You can allow employees to reinstate their per pay election when they return to work. The account would not cover any medical expenses they incured during the layoff. In addition, the total annual election will be reduced by the amount of the contributions missed during the layoff.
  - ➢ **Option 2:** Offer reinstatement coverage. This approach allows employee access to account funds during the layoff and allows the employer to collect all payroll deductions. You can handle this option in two ways:
    1. Allow employees to make post-tax contributions during the layoff.
    2. Reinstate coverage when the employee returns to work. In this case the employee's contributions would increase to compensate for the missed contributions. For example, let's say an employee elects to contribute $1,200 annually and is then laid off at the end of February after contributing only $200. The employee returns to work on April 1 and has 16 remaining pay periods (assuming 24 pay periods per year). The employee's contribution increases from $50 to $62.50 to reinstate coverage for the full year.

Your plan document should explain fully how layoffs and leaves of absence will be handled for your flexible spending accounts.

Are Health Care Cost Trends Cooling? cont.

health care remains a large expenditure. According to the Mercer survey the average cost of an employer–sponsored health care plan was $6,215 in 2003 and it jumped to $6,679 in 2004. While the percentage of the cost increases is abating, in absolute dollars, health plan costs are a significant addition to the compensation equation. Employers should continue to encourage their employees to develop good health habits and to look for opportunities to involve them in health care cost decisions to influence smart health care service consumption. MW

Workplace Depression

As we enter the New Year, some of your employees will continue or begin a struggle with depression. Depression is far more prevalent than many of us realize. It affects nearly 19 million adults. Roughly one in every 10 Americans is battling this condition. Common symptoms of the disease include sadness, feelings of hopelessness, fatigue, difficulty concentrating, weight loss or gain, or unexplained pain.

Employers may not think they need to be concerned with depression in the workplace, but it does have a significant impact on your organization. Depression affects productivity. The Work Loss Data Institute's Official Disability Guidelines indicate a case of depression can result in 2-3 weeks of lost work time or $1,500 per case (assuming an employee earns an average wage). Loss of work time is a concern, but an even greater concern is presenteeism. People that come to work every day may still suffer the effects of depression. They may not be able to produce or participate in their regular work activities. Depression also has a direct cost to the health plan. A recent study indicated the direct cost of depression treatment averaged $968 per claimant over a two year period. These claimants' health care costs for other conditions were also higher. Their per claimant cost for non-depression treatment averaged almost twice as much as individuals not being treated for depression.

Depression manifests itself in a number of ways in the workplace. Employees with absence issues, low energy or coworker conflicts may be struggling with depression. Although a large percentage of the population suffers from depression, only about 50% seek treatment. Effectively managing depression in the workplace and facilitating treatment for employees can have a positive impact on employees and your organization.

Employers can encourage employees to be screened for depression to help catch the disease early and help them seek treatment. However, relatively few employers offer these screenings. Depression, even in this day and age, has a negative stigma in the workplace. Many employers feel this type of treatment is very personal. Employers do not want to violate their employees' privacy.

However, most employers do offer Employee Assistance Plans (EAPs). Employers should understand the services their EAP offers employees and the process for securing those services. If you suspect an employee may be struggling with depression, direct him or her to contact the EAP and explain how the process works. The employer's role in the process is really one of outreach, not treatment.

Treating depression is not an exact science. Treatment may consist of antidepressants, therapy sessions with a trained counselor or both. What works for one individual may not be the best approach for another. If an individual is struggling with depression, resources should be available to begin treatment.

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TREND TIDBITS

- $ Average cost for a traditional indemnity plan increased 13.1% in 2004. Cost per employee for 2003 was $5,931 and for 2004 the cost was $6,707.
- $ Average cost for a PPO plan increased 6.0% in 2004. Cost per employee for 2003 was $5,751 and for 2004 the cost was $6,095.
- $ Average cost for a POS plan increased 6.3% in 2004. Cost per employee for 2003 was $5,738 and for 2004 the cost was $6,101.
- $ Average cost for an HMO plan increased 11.8% in 2004. Cost per employee for 2003 was $5,212 and for 2004 the cost was $5,827.
- $ Statistics for consumer driven health plans were not tracked during 2003. For 2004, the average annual cost was $5,233.

Source: 2004 Mercer's National Survey of Employer-Sponsored Health Plans

Workplace Depression, cont.

Organizations may be between a rock and a hard place in trying to help employees deal with depression. If you want to be proactive in helping employees identify their condition and take action to improve their mental health, offer these services under your wellness plan. However, employers may not feel comfortable including this type of screening in a wellness campaign. Depression is viewed differently than other medical challenges in the workplace. Employers can train supervisors on the symptoms of depression in order to recognize potential issues in the workplace. Encourage employees who appear to be struggling with depression to seek professional treatment through your EAP. In the long run, both your employees and your organization will win. MW

FMLA Challenges

February marks the 12 year anniversary of President Clinton signing the Family Medical Leave Act (FMLA) into law. The intentions of the FMLA are noble. The act requires employers provide up to 12 weeks of job protection and access to affordable health care to employees:

- To care for a new child
- Treatment of a serious health condition for the employee or an immediate family member

Employers have struggled with properly administering FMLA leave rights. Leave provided for the birth or adoption of a child has not caused too many difficulties, leave for the treatment of a serious health condition has caused more than a fair share of headaches in Human Resource departments.

The law provides the leave for the treatment of a serious health condition, but the administrative guidelines for the FMLA allow a great deal of flexibility in determining what can be considered a serious health condition. The FMLA does not formally define "serious health condition". It does stipulate, in order for a leave to be approved, the employee must be absent for at least 3 days, receiving treatment and care from a physician.

The lack of true definition allows a myriad of conditions to be considered serious health conditions and has led to many abuses under the FMLA that impact an employer. Many organizations are calling for the government to amend the FMLA to provide more clarity to determining appropriate qualifying conditions.

In lieu of additional guidance, employers should review their FMLA leave policy to ensure the most consistent measures are applied to administering the FMLA. MW

Technical Corner

Technological advances have affected the way employers communicate employee benefit plans. Many employers post benefit descriptions, claim forms and enrollment forms on their Intranet sites to save paper cost, reduce delivery time and improve access. In addition, during the last 10 years, a significant number of employers have begun to encourage employees to enroll electronically.

Employers can also use technology to show the dollar value of the benefits they offer employees. Health care costs have risen so substantially over the last five years that employers should not disregard benefits when they discuss compensation. One method to illustrate the additional cost of benefits is to create an employee benefit statement. While the cost of these statements is not overwhelming, many organizations do not have the room in their budget to purchase these statements from an outside vendor for each employee.

You can use other, less expensive, strategies to illustrate the value of company-paid benefits. For example, you can build a one-page document in Excel with merge cells to show base pay plus the added cost for benefits. Then simply merge this document with an Excel spreadsheet that includes all the employee specific information you want to highlight in the statements. Information would generally include base compensation, health, dental, vision plan elections, any life or long-term disability elections, vacation time, and any other benefits. The spreadsheet would also include formulas to calculate the yearly cost of this employer-provided coverage.

This is a simple way employers can use existing technology to emphasize the cost of all benefits your organization provides. These statements would highlight to each employee the tremendous impact of benefit cost on total compensation. MW

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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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