



The ViewsLetter

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Coordination of Benefits Conundrum

Most group health plans contain coordination of benefit provisions. These provisions dictate how your organization's plan will pay benefits when a plan participant has coverage in addition to your plan coverage. With the increase in cost to participate in group health plans, dual coverage situations are not as common as they were even five years ago. However, some employees still decide to elect coverage under both their employer's and their spouse's group health plans.



Generally, plans dictate which plan will pay primary and which plan will pay secondary. In dual coverage situations, the plan that covers the employee will usually pay primary and the plan that covers the employee as a spouse will be secondary. The "birthday rule" usually determines payment order for children. This rule says the health plan of the parent whose birthday falls first in the calendar year will pay primary. The health plan of the parent whose birthday falls second in the year will pay secondary.

These coordination of benefits provisions are fairly common. However, a recent court case may have employers looking at their coordination of benefits provisions and possibly making changes. The court case was decided in the Seventh Circuit Court which encompasses Illinois, Wisconsin and Indiana. In this case, an individual who incurred sizable medical expenses was covered under two group health plans. Plan A covered the individual as an employee; Plan B covered the individual as a dependent.

Under the most common coordination of benefits provisions, Plan A would pay primary on the individual and Plan B would pay secondary. In this situation, however, Plan A contained the following eligibility and benefits provisions:

Plan A: If an employee is covered under another employer-sponsored group health plan, that employee will automatically be covered under a "sub-plan." The sub-plan lim-

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About the ViewsLetter

We welcome you to the fourth quarterly issue in Volume Eight of the McGrawWentworth 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 McGrawWentworth Account Director or Account Manager, or you can reach us at www.mcgrawwentworth.com.

Coordination of Benefits Conundrum, cont.

its coverage to \$1,000 for each individual per calendar year.

The plan also contained a “no loss” provision. If an individual covered by the sub-plan receives less coverage (once the secondary plan pays a benefit) than Plan A offers employees without other group health plan coverage, Plan A would pay an additional benefit. Overall, the employee would not lose benefits in a coordination situation with this provision.

The coordination of benefits provision on Plan A states that under no circumstances will coordinated benefits pay more than 100% of the covered charges.

Plan B contained the typical coordination of benefits provision that set forth primary responsibility on employees and secondary responsibility for dual covered spouses.

A dispute arose when Plan A paid only \$1,000 of benefits on the covered employee and Plan B received the remainder of the bills. Plan B filed suit against Plan A, contending that since Plan A was the primary payer; it was responsible for the majority of the expense.

Unfortunately for employers, the court ruled in favor of Plan A. Plan B appealed the decision and the appellate court confirmed the ruling in favor of Plan A. The court stated that ERISA mandates neither the type nor the amount of employee benefit, nor does ERISA provide guidance on coordination of benefit provisions. In this case, the coordination of benefit provisions under both plans were clear and could be coordinated as each plan document was written. The court did state the outcome of the decision was somewhat “inequitable”; however, Plan A was “more efficaciously drafted” than Plan B.

This court case may have employers reviewing their coordination of benefits plan provisions. Employers may want to seek legal counsel to deter-

mine the most effective coordination of benefits provisions to avoid the fate of Plan B. Some options may include:

- Adopting a rule excluding or specifically limiting secondary coverage when covered individuals are eligible only for token coverage or a stated low coverage amount if they have any other coverage.
- Putting a cap on the benefits a plan will pay on a secondary basis when a spouse has dual coverage through his or her employer.
- Not offering any coverage under your group health plan to spouses that are covered by another employer’s group health plan.

If your plan is fully insured, your insurance carrier will determine how the Coordination of Benefits plan language should be drafted. After all, the carrier is liable for the claims incurred by the plan. In fully insured situations, it will be important to communicate to plan participants how the plan will handle coordination of benefit situations.

For self-funded plans, the situation is a bit more difficult. A good first stop would be a conversation with your Third Party Administrator or TPA. Determine how often these types of Coordination of Benefit (COB) situations occur. If the prevalence of these “sub-plan” designs is pervasive, it may make sense for your firm to consult an attorney to determine the possibility for changing COB language. However, if there is not a predominance of these types of coordination of benefit claims, it may not make sense to amend your document at this point. However, keep an eye on your

DID YOU KNOW?

- Sixty-four percent of U.S. adults are overweight or obese.
- Obesity costs U.S. employers approximately \$13 billion a year.
- Thirty-nine million workdays are lost each year as a result of obesity and related illnesses.
- Annually, almost \$4 billion are spent for inpatient hospital visits for diabetes complications, a common ailment for obese individuals.
- Thirty-four percent of human resources professionals have seen an increase in employee requests for bariatric or gastric bypass surgery in the past year.

Source: Society of Human Resources Management, US Centers for Disease Control and Prevention and www.businessgrouphealth.org.

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Coordination of Benefits Conundrum, cont.

coordination of benefits management to determine if the frequency of these coordination of benefit provisions increase in the future. If the occurrences increase, it may make sense to amend your COB language in the future.

While some may admire the ingenuity of Plan A in dodging primary claim payment responsibility for an employee with their plan language, these strategies in the long run will hurt your employees. Employers fearful of ending up in Plan B's situation will draft complicated plan language to make sure their plans will not pick up primary responsibility on dependents. Other plans will follow Plan A's lead and draft language to avoid taking on significant claim liability on dual covered employees.

Employees in these situations lose because they will have to struggle to get either plan to pay a benefit for their eligible claims. **MW**

The Cost of Obesity

Employers recognize that obese employees have higher absence rates as well as higher medical expenses, primarily because of weight-related conditions. These medical costs can be substantial. A recent study indicates medical benefits for people at least 30 pounds overweight can cost an additional \$460 to \$2,500 for each obese person. Employers or employees participating in the medical plan generally absorb these higher costs.

The problem of obesity received significant press several years ago as it seemed to be poised to overtake smoking as the most preventable cause of death. An error in the Cen-

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YOUR QUESTIONS

- Q.** Our company does not offer retiree health coverage. Will the new Medicare Part D outpatient prescription drug benefit affect our plan?
- A.** It depends. The legislation that introduced the new Medicare Part D prescription benefits included a notice requirement for all group health plans. This could even include the health plan you offer to your active employees.

A notice must be delivered to any plan participant (any employee and/or any dependent) that is Medicare eligible. This could include any employee over age 65 who is enrolled in Medicare Part A or Medicare Part B. It could also include any employee or dependent that is enrolled in Part A or Part B as result of disability or an End Stage Renal Disease diagnosis.

You will need to issue either a Notice of Creditable Coverage or a Notice of Non-Creditable Coverage. This notice should state whether the coverage under your health plan is equal to or better than the Medicare Part D coverage (Notice of Creditable Coverage). Your notice also must inform your participants if your plan is not equal to the Medicare Part D coverage (Notice of Non Creditable Coverage).

The notice is necessary because individuals who do not enroll in a Part D plan when they initially become eligible will have to pay a late fee if they enroll later. The penalty may be sizable because it will be 1% of the premium for each month they are not covered by Medicare Part D or a comparable plan.

If your plan is equal to or better than Medicare Part D, your plan will need to send a Notice of Creditable Coverage. The notice informs your Medicare eligible plan participants that they can keep your plan coverage and not have to pay a late enrollment penalty for Part D if they enroll on a timely basis.

If your plan is not as good as Medicare Part D, your plan will need to send a Notice of Non-Creditable Coverage. The notice must inform your Medicare eligible plan participants that they may choose to keep your coverage instead of enrolling in a Medicare Part D plan. However, if they decide to enroll in Part D in the future, they will have to pay a late enrollment penalty.

The notice requirement is complicated. You can find more details on the Medicare Notice requirements at the following http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue7.pdf. Contact your health plan insurer or plan administrator to see if they can assist in determining creditable coverage status.

The Cost of Obesity, cont.

TECHNICAL CORNER

Using Technology to Manage Health Care Costs

For health plans, technology typically revolves around the enrollment process. However, some organizations are using technology for another purpose: they are analyzing their claim data to help them manage their health plan costs.

Employers really want to understand the types of services driving up their health care costs. Certainly, many publications discuss the general trends contributing to overall health care cost increases, but employers are more interested in what their own claim data indicates about what is driving their health care cost increases. Identifying the most common claims specific to your health plan experience means your organization can develop targeted strategies to help control your costs.

For example, a lumber company recently conducted a detailed analysis of its claim experience. The results showed a large number of claims relating to back pain. In addition, the company discovered a high rate of emergency room visits. Armed with this information, the company launched a disease management initiative on proper back care and treating back injuries. In addition, to decrease the inordinately high number of emergency room visits, the company doubled the emergency room copay, launched a 24-hour Nurseline, and developed a focused communication plan describing appropriate medical care facilities and options. The lumber company hopes these focused changes will help lower health plan costs.

McDonald's Corporation is also using technology in its disease management initiatives. McDonald's uses claim data to target certain conditions. Unlike normal disease management initiatives, when a person with a certain condition is identified, McDonald's analyzes the individual's claims to determine whether the individual is using appropriate resources in managing care. For example, McDonald's disease management firms may look to see if individuals with asthma are using an internist or a pulmonologist to manage their care. If the individual is using an internist, the disease management vendor may recommend using a pulmonologist. Although the pulmonologist office visits may cost more, the pulmonologist can better manage the individual's asthma, theoretically resulting in fewer hospital and emergency room visits.

Clearly, technology is no longer just being used as an enrollment tool when it comes to health plans. Analyzing claim data can help your organization identify the specific steps necessary to manage your actual claim cost. Ask your health plan vendor to provide detailed analyses to help you understand your health insurance claims. In addition, if your organization works with a disease management firm, ask that firm for more detailed claim information. This information may help you design targeted strategies to more effectively manage health plan claim cost. **MW**

ters for Disease Control and Prevention calculations did grossly overstate the role of obesity as a contributing factor in preventable death. However, obesity is still a major problem in the workplace. A recent study indicates the prevalence of obesity increased in almost every state of this country; Oregon was the only state in which there was not an increase in the prevalence of obesity.

The Centers for Disease Control and Prevention worked with the economists of RTI International, a non-profit think tank, to examine the data in two recent national studies. The surveys tracked absences and medical information of more than 20,000 full-time employees, aged 18-64. The following survey results have been adjusted for 2004 dollars:

- Normal weight men miss an average of 3 work days a year compared with 5 days for men who are 60 or more pounds above a healthy weight
- Normal weight women missed on average 3.4 days a year compared with 5.2 days for women who are 30 to 60 pounds above a healthy weight. Women who were extremely obese, weighing 100 pounds over healthy weight, missed on average 8.2 days a year.
- Average medical expenses for normal weight men are \$1,351 a year. Expenses for men who are 30 to 60 pounds overweight are \$462 more when medical cost and missed work are included. Extremely obese men cost \$2,027 more each year.
- Average medical expenses for normal weight women are \$1,956 a year. Expenses for women who are 30 to 60 pounds overweight are \$1,372

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The Cost of Obesity, cont.

more when medical cost and missed work are included. Women who are 60 to 100 pounds overweight cost \$2,485 more.

- The most obese workers (100 pounds or more overweight) account for approximately 3% of the employee population but account for 21% of the cost of health plan.

Employers are well aware of this issue. These statistics simply illustrate that employee lifestyle choices affect medical costs and absenteeism. Maintaining a healthy weight can significantly decrease these costs.

Everyone in an organization shares the burden of the cost of obesity. Employers are shifting cost in health plan design choices and increasing employee health plan contributions. As a result, employees pay more to participate in a health plan. They also pay more out-of-pocket costs when they seek care.

Many employers are implementing programs to help employees handle lifestyle issues, including weight management. These programs are important tools to assist employees in recognizing a need to change and provide assistance in managing their weight.

Combating obesity may be an effective strategy to control health care cost. Study after study demonstrates overweight and obese individuals use more medical services and generate more medical cost. The fewer overweight and obese employees your plan covers, the lower your medical costs become. Also, encouraging plan participants to lose weight will improve their quality of life. The key is to find the incentive that will persuade your overweight and obese employees to participate in a weight management coaching program.

Effective weight management coaching programs should promote healthful lifestyle changes such as increas-

ing physical activity and improving eating habits.

Change will not happen overnight, but clearly, taking steps to control obesity in the workplace can be a strategy to control health plan cost. A wellness program should offer weight management coaching; employers should integrate these programs into the culture of the organization. Support for obese and overweight individuals will also be crucial to help employees take control of and properly manage their weight successfully.

In the long run, health plan costs and absenteeism should decrease if employees lose weight. The biggest losers will be the biggest winners. Their health care costs will fall and their quality of life will improve. **MW**

TREND TIDBITS

- \$ Overall, plan sponsors expect PPO, POS and HMO plan costs to increase by 12% in 2006.
- \$ For the last three years, health plan cost trends have been projected lower than the previous years. However, the cost increases are still 3 to 4 times higher than inflationary increases.
- \$ Prescription drug trend continues to moderate. Prescription drug trends have declined about six percentage points after peaking at 19.7% in 2001.
- \$ Trends rates for various plans are as follows:

<u>Plan Type</u>	<u>With Rx</u>	<u>Without Rx</u>
Indemnity Plan	14.3%	14.4%
PPO Plans	12.7%	12.4%
POS Plans	12.2%	11.8%
HMO Plans	12.0%	11.6%

Source: 2006 Segal Health Plan Cost Trend Survey.

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THE VIEWSLETTER

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