



The ViewsLetter

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Quality and Accountability in Health Care

The National Committee on Quality Assurance (NCQA) recently released its "State of Health Care Quality, 2005 Facts in Brief" report. The report discusses quality health care and its effect on this country. Health plans, the government, and even employers are now studying the impact of quality on health care costs.

The NCQA report offers both good news and bad news. The good news is the quality of health care for many Americans continued to improve in 2004. For the sixth straight year, individuals with health benefits through **health plans that measure and report performance data** more often received appropriate preventive care and treatment for chronic illness. They were less likely to be given unnecessary prescriptions and more likely to express satisfaction with their health care. The NCQA attributes improvements in preventive care and chronic conditions to the accountability of participating health care providers.



The bad news is that these improvements may not be sustainable. Many employers struggling to provide health care options to their employees are moving to consumer driven health plans. Many of these plans do not report performance data.

These plans depend on consumers to make informed health care decisions, but the information needed to make these decisions is not always readily available.

The NCQA report makes a strong case for measuring provider and health plan performance and holding providers accountable for their practice patterns. The NCQA is not the only organization that believes improving the quality of health care will help control skyrocketing health care costs. Many organizations are supporting "pay for performance" measures. These measures basically hold providers accountable for the quality of care delivered by requiring a certain level of performance to receive a specific income.

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About the ViewsLetter

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

Quality and Accountability in Health Care, cont.

Pay for performance initiatives are being hotly debated among health plans and providers. Providers agree that they should be held accountable for the care they provide. However, they are concerned with how quality care is measured. Many health plans have adopted pay for performance measures, but their providers are still debating how to empirically measure such an abstract concept as "quality of care."

The data supporting quality care is compelling. The NCQA report findings include:

- For the sixth straight year, the health care quality for the 65 million Americans enrolled in health plans holding providers accountable improved substantially across almost all clinical indicators. On average, care improved regardless of payer (private employer, Medicare or state Medicaid agencies).
- Improvements in clinical measures include:
 - In commercial insurance plans, the percentage of adolescents receiving all

appropriate immunizations rose from 58.7% in 2003 to 63% in 2004.

- The percentage of individuals with hypertension whose blood pressure was adequately controlled increased from 62.2% in 2003 to 66.8% in 2004.
- The percentage of heart attack victims whose cholesterol is managed to appropriate levels rose from 60.4% in 2003 to 64.8% in 2004.
- Medicare managed care plans that measure and report clinical quality also posted impressive gains.
- One of the few measures to lose ground was the rates for breast and cervical cancer screenings which actually declined in some populations. Debate over the effectiveness of mammograms may have contributed to the decline of this screening measure.

Since the NCQA has been measuring health plan quality, performance has improved considerably. The NCQA be-

gan accrediting managed care organizations in 1991 to meet the need for standardized objective information about the quality of managed care organizations throughout the country. The accreditation process is voluntary and rigorous. The NCQA evaluates patient safety, confidentiality, consumer protection, access, service and continuous improvement. The evaluation measures performance in many clinical areas, as well as, the health plan's administrative systems.

NCQA measures performance and quality using HEDIS (Health Plan Employer Data and Information Set) data. HEDIS measures over 60 different aspects of care and service performance. Because this data is collected on such a large portion of the health plan market and because the health measures are so specifically designed, it is possible to compare health plans that participate on an "apples to apples" basis. In addition, health plans use this data to benchmark against the competition and determine what areas need improvement.

HEDIS measures include a broad range of health issues, such as:

- Using asthma medication
- Controlling high blood pressure
- Managing antidepressant medication
- Advising smokers to quit
- Treating heart attacks with beta-blockers
- Screening for breast cancer
- Immunizing children and adolescents

There is no doubt improving the quality of health care can assist in managing the long term cost of providing health care and improve the quality of life for many. It seems lately

DID YOU KNOW?

The average employer pays \$26.06 for each hour an employee works. This amount is distributed as follows:

- ➞ Basic salary or wages: \$18.28 (70.2% of total compensation).
- ➞ All benefits: \$7.77 (29.8% of total compensation). The total benefit cost per hour is distributed as shown below:
 - Health, life and disability: \$2.10 (8% of the total).
 - Paid leave: \$1.72 (6.6% of the total).
 - Retirement and savings benefits: \$1.13 (4.3% of the total).
 - Legally required benefits (such as Medicare): \$2.13 (8.2% of the total).

Source: U.S. Bureau of Labor Statistics, September 2005.

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Quality and Accountability in Health Care, cont.

with all the heightened attention to health care cost, there is a lack of consensus on how to tackle the issue across the country. Instead, we are seeing entities with the largest financial stakes embarking on variety of efforts to help manage cost. And many of these isolated activities will undoubtedly impact cost for the organization that implemented them. The problem, however, is larger in scale than discreet programs can adequately address. What is lacking is the participation of individuals who don't necessarily have large financial stakes in helping solve the problem.

Providers do not generally have an interest in controlling health care costs. In fact, in many cases, it is just the opposite. Some providers are paid for the quantity, not the quality, of the care they deliver. However, support for pay for performance strategies that reward providers for improving quality continues to grow. CMS and the Medicare program have several pay for performance pilots underway. The private sector is also embracing pay for performance strategies that may decrease costs and should improve quality. Many of these are now merely grass roots programs. To be effective, pay for performance measures should be adopted across the country. Health plans need to work with providers, perhaps using HEDIS measures, to determine basic quality requirements and tie pay to meeting those requirements.

Many consumers also do not have a strong incentive to help control health care costs. Their concern really depends on their out-of-pocket costs. Employers over the last few years have transferred more of the cost to their employees but certainly not to the extent that most really

YOUR QUESTIONS

- Q.** An employee on an unpaid, approved FMLA leave agreed to pay her portion of the premiums for health coverage during the leave. The employee agreed to send a personal check each month for her coverage. She has missed the first due date for the premium. Can we terminate her coverage? If we can terminate her coverage, what should the effective date of the change be and are we required to notify her of the termination?
- A.** The FMLA allows an employer to terminate coverage if the premium payment is more than 30 days late, unless the company has implemented a longer grace period. In order to terminate coverage for late payments, your organization must send the employee a written notice that it has not received the required payment and notify the employee of the date coverage will end. This notice must be sent to the employee's home address at least 15 days before the coverage expires. If the employee does not make the payment before the end of the grace period and your company has sent all required notices, your company may terminate the employee's coverage.

What is the effective date the coverage ends? You can use either the date the coverage is paid through or the last day of the grace period. Under the current DOL regulations, the DOL will defer to your policy on any other form of unpaid leave of absence. If your organization has an established written policy allowing coverage to end retroactively on the date when the unpaid premium was due, the coverage can end on that date. If your organization does not have any written policies on this issue, coverage should end at the end of the grace period. Also, the plan must issue a HIPAA Certificate of Creditable Coverage when coverage ends. The loss of coverage because of non-payment of premiums is not a COBRA qualifying event.

Your organization must meet additional DOL notice requirements for FMLA leaves. You must notify the employee in writing of his/her specific obligations, including the requirement to pay any required portion of the health plan cost and the options for payment. In addition, your organization must spell out premium due dates, grace periods and the consequence for non-payment of premiums.

When the employee returns to work at the end of the FMLA leave period, the employer must reinstate health plan coverage. Failure to return from an FMLA leave is viewed as a COBRA qualifying event. If the employee had health plan coverage the day before the leave began, even if coverage was terminated during the leave due to non-payment of premium, COBRA rights must be extended. The qualifying event date is the date the employee should have returned from the FMLA leave.

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Summer is Just Around the Corner

recognize the true cost of care or feel compelled to help manage that cost. When employers change plan designs and increase their employees' portion of health care costs, they need to inform employees of quality and cost. Providers, too, need to offer the information necessary to steer consumers to the least expensive, best quality care available.

Finally, it may make sense to require providers to participate in performance and quality reporting measures. Many HMO and POS plans have voluntarily participated in the NCOA accreditation process. However, PPO and traditional plans have historically not participated in this process. In 2004, the NCOA had 41 PPOs report quality data. However, accountability needs to increase in all sectors of the health care system. To that end, health plans and the federal government need to encourage and reward accountability.

Continuous review of the problems of maintaining affordable health care costs always brings a wide range of strategies to consider. Quality care and cost accountability are key considerations. Pay for performance strategies are emerging as an option for introducing provider accountability and providing incentives to provide quality cost-effective care. **MW**

Summer is Just Around the Corner

In the dead of winter, the idea of summer approaching is an energizing thought for almost everyone except, perhaps, working parents who need to find care and entertainment for their children in those summer months. The idea of finding the

TREND TIDBITS

- \$ Total 2005 health benefit cost (medical, dental and other health benefits) for active employees was \$7,089. This figure represents just over a 6% increase from the total 2004 cost of \$6,679. These figures represent cost after employers accounted for the cost savings from plan design changes.
- \$ Employers had expected a gross cost increase of 10% for 2005.
- \$ Employers are anticipating a 6.7% increase in health plan costs for 2006.
- \$ Prescription drug costs are cooling as well. Employers report only an 11.5% increase in drug cost for 2005, down from the 14.3% increase they had expected.

Source: 2005 Mercer National Survey of Employer-Sponsored Health Plans

right child care solution in the summer months is challenging parents in your workforce right now.

The effort to find the solution often spills over into the workplace. According to a survey conducted by ComPsych, an employee assistance program provider, 38% of working parents spend more than 12 hours planning for summer child care and another 30% spend at least 5 to 8 hours. Since most care options are only staffed during working hours, this investigation is generally done on work time.

It takes a great deal of time to find the right child options. Children quickly outgrow child care centers. Most parents look for various summer camps that will provide full day care as well as an interesting and stimulating experience for their children. Sports, computers, and drama are common camp offerings in many communities. Many of these camps may operate for only 6 hours a day and for a few weeks of the summer. These limited hours create stress for many parents trying to secure child care for the full summer.

Some organizations recognize the burden working parents are under in securing summer child care and help employees deal with this difficult task. The approaches vary, but can include:

- Coordinating camp fairs
- Securing partnerships with camps
- Offering on-site summer camps

Before your organization launches a formal plan to offer summer child care options, make sure your employees really need these programs. Understanding the demographics of your population will help. How many of your employees have children under 14? Of those families, how many have both parents working full time outside the home? Because this information is not readily available in most organizations, it may be wise to survey your employees to determine whether they need summer child care assistance. During the survey process, you should also ask which camp options your employees would find most interesting.

Camp fairs may be the easiest way to present all the various summer camp programs available. To avoid duplicate efforts, it is best to have one Hu-

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man Resources representative do the research into existing options. Then set a day for representatives from each camp to attend the camp fair. Provide refreshments and encourage employees to spend time with the camp representatives that fit their children's interests. Before the fair, you could offer employees a "key considerations" information sheet to help pinpoint the key issues to evaluating camp options. This information sheet will help your employees focus on the camps that meet their criteria. The first informational fair will require more work because of all the research necessary. But these annual fairs will become a low cost, much appreciated benefit for working parents.

Partnering with a camp is another option. For example, your organization could partner with the local YMCA to offer summer camp for your employees' children. If you have a large number of campers, your camp partner may be able to offer a discount. Be sure to ask your attorney about potential liability before your organization partners with a summer camp provider.

Other organizations sponsor on-site summer camps. Employees will cherish this benefit if it offers interesting activities. Parents value this approach because they have the opportunity to spend some time during the day with their children. This approach is costly as most organizations subsidize at least a portion of the program cost. Again, before your organization launches an on-site summer camp program for your employees' children, ask your attorney about potential liability.

Any help you can offer your employees in locating summer child care will be much appreciated. It will reduce the stress employees feel in March and April as they try to find summer activities for their children. **MW**

TECHNICAL CORNER

Proposed IRS Regulations in Electronic Communication

The IRS recently issued proposed regulations on using electronic media to distribute notices, elections, and other communications to employee benefit plan participants or beneficiaries. The IRS has requested comments on these proposed regulations before they become final. When final regulations are adopted, they will become the rules the IRS will require for communicating participant rights electronically. The regulations will also provide a safe harbor for electronic communications that are not required to be in writing.

Many employers deliver information electronically. These employers are often frustrated by the sheer number of government rules on electronic communications. Unfortunately, the proposed rules affect only the plans and notices **the IRS regulates** such as:

- 401(k) and other qualified retirement plans
- Cafeteria plans
- HSAs and Archer MSAs
- Accident and health plans
- Qualified transportation plans and so on

These IRS regulations do not necessarily apply to electronic delivery requirements established by ERISA and regulated by the DOL or PBGC, such as SPD delivery requirements and COBRA notice requirements.

In general, these new IRS requirements will become effective when they are adopted as final regulations. They include the following provisions:

- **Notice requirements:** The proposed regulations offer two sets of rules. Employers can choose to comply with the set that will work best with their processes:

- Consumer consent rules that follow the E-Sign requirements. These rules require a recipient's written consent before the plan can deliver a notice electronically. The consent should make it reasonably clear that the recipient can access the information electronically. In requesting consent, the plan must inform recipients in writing of their right to obtain a paper copy, the right to withdraw consent, the scope of the consent, how to update contact information, and any hardware or software requirements.
- The alternative rules require that recipients have access to the electronic medium providing the information. Also, the plan must notify recipients of their right to request a free paper copy of the notice.
- **Elections and consent requirements:** Separate requirements are established for elections, consents or similar communications made by a plan participant or beneficiary:
 - The participant must be able to effectively access the electronic system.
 - The system must have measures to ensure that only the appropriate individual is making the election or consent. Generally, this will involve a user name and a PIN (personal identification number).
 - The system must allow the participant to review, confirm, modify or rescind an election or consent.
 - The system must send a written or electronic confirmation within a reasonable time.

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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