

The ViewsLetter

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A Review of Demand Management Programs

Employer sponsors of health care programs are increasingly turning to "demand management" for help in controlling health care cost. As the name implies, the goal of the demand management firms is to reduce unnecessary healthcare utilization by providing plan participants with information regarding treatment options.

AN OVERVIEW

Demand management is designed to help plan participants receive appropriate levels of care at the appropriate time. In doing so, health plan expenses are reduced. Most demand management services center on a 24-hour nurse phone line. Demand management is not about limited access to health care; rather, it is about providing information and decision support to plan participants.

The cost reduction obtained by use of demand management programs is invisible to plan participants. However, it is extremely visible to the sponsor of the health plan. In many instances, plan participants believe they (or their dependents) are sicker than

they really are. As a result, it is often lack of information that triggers trips to the emergency room or the doctor's office. Demand management is an education process. In educating the callers, nurses often encourage them to seek a more appropriate level of health care.



FUTURE OF DEMAND MANAGEMENT

Demand management programs are generally voluntary. However, health insurers and health plans are developing a more sophisticated and aggressive system of health care controls called "disease management." Health care underwriters realize that up to 80% of health plan assets are utilized by 12% -16% of plan participants. Therefore, insurers believe that if they properly identify and intervene with the high-cost users to teach them how to better manage chronic illnesses, the health plan will obtain substantial savings. At the same time, there is also a belief that many high-cost utilizers are overutilizing health care services and that, if properly educated as to appropriate levels of care, savings will result.

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About the ViewsLetter

We welcome you to the fourth issue of the McGraw Wentworth ViewsLetter. We have established the ViewsLetter as an integral part of our commitment to keep you

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

YOUR QUESTIONS

Q. We provide our employees with \$50,000 of group term life and Accidental Death and Dismemberment (AD&D) coverage. One of our employees was disabled last year (1997). We have continued to pay the premiums for his Life and AD&D coverage, but now the insurer is telling us that his coverage terminated because he did not apply for "Waiver of Premium." How does this work? If he dies, are we liable for the \$50,000 benefit?

A. Most group term life insurance policies contain a Waiver of Premium (W of P) provision that extends life insurance protection to individuals who are totally and permanently disabled. For those who qualify, premium payment is waived.

Provisions vary, but a common W of P provision states that if an employee is totally and permanently disabled prior to age 60, his/her life insurance coverage will be extended until the insured is no longer disabled, or until he/she reaches age 65 or "normal retirement age."

The employee must submit proof of disability to the insurer within the specified timeframes to qualify for W of P protection. Generally, insurers require written proof of disability within 6, 9, or 12 months of the date the disability began. The insurer will then "approve" the disability status, and waive premiums for the life insurance coverage. Normally, only life insurance coverage is protected by W of P - AD&D coverage customarily terminates shortly after the disability begins (check your insurance policy).

In your case, the employee was disabled more than 12 months ago. Your life insurance policy states that to qualify for W of P, the employee must submit proof of the disability within 12 months of the date the disability began. The employee failed to submit proof and he "forfeited" his eligibility for W of P. His benefit coverage terminated, even though you were willing to continue paying premiums for the coverage. You may appeal to the insurer to extend the W of P timeframe, but they have no legal responsibility to approve the request.

As to whether you, as the employer, are liable for paying the benefit, the answer rests with whether the employee was provided with a Summary Plan Description that clearly outlined the W of P requirements. Such requirements generally make clear that the employee - not the employer - must submit proof of disability. As a result, you should not be held liable for paying a claim if he dies. As always, review each situation with your legal counsel.

Demand Management, cont.

SELF VERSUS CLINICAL MANAGEMENT

There are two key components of disease management: self-management and clinical management. Self-management is the action taken by the plan participant. Clinical management is the action taken by the physician concerning the appropriate treatment of a patient.

Most disease management situations involve a combination of self and clinical management steps.

As an example, a patient with high blood pressure fails to keep her diet at an appropriate nutritional level. The telephone nurse discovers that the plan participant is not adequately informed about eating/nutritional options and appropriate self-care for her condition. With this information, the nurse problem-solves with the plan participant while teaching and reinforcing necessary ideas. The nurse also discusses the importance of controlling blood pressure over the long term and reiterates the patient's vulnerability to serious cardiovascular disease if proper care is not taken.

COMMON TARGETS IN DISEASE MANAGEMENT

Some of the conditions targeted for disease management include asthma, diabetes, hypertension and arthritis. Other targets include coronary artery disease, congestive heart failure, depression, osteoporosis and lower back pain. Disease management tools and protocols for these conditions are already in place. Protocols are being developed for other conditions as well.

SUMMARY

Demand and disease management programs are flourishing because of the need for health plan sponsors/underwriters to control costs. Over the last five years the number of plan participants with access to demand management services grew from five million to thirty-five million Americans. The growth rate is expected to continue as we head into the twenty-first century.

Information is critical in the appropriate use of resources. That is the key idea behind demand management.

NOTABLE THOUGHT

"It is unwise to be too sure of one's own wisdom. It is healthy to be reminded that the strongest might weaken and the wisest might err."

Mahatma Gandhi (1869-1948)

DID YOU KNOW?

Between 1990 and 1998 third party payment of prescription drug expenses doubled to 61% of retail drug sales.

Managed care participants are 13% more likely than indemnity participants to request "dispense as written" (DAW) for brand name drugs.

Indemnity plan participants are 14% more likely to request generic equivalents than managed care plan participants.

Direct to consumer drug promotion grew over 50% in 1997 to over \$1.0 billion.

Sources: October 1998 Business & Health; Blue Cross Blue Shield of Michigan

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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Social Security, A Controversial Issue

There is more evidence that Social Security reform will continue to draw the attention of lawmakers. A bipartisan panel of public and private sector officials recently offered opinions on reform. Additionally, Senator Daniel Patrick Moynihan (D - N.Y.) and Bob Kerrey (D - Neb.) offered reform opinions. While the proposals for reform differed in various respects, the most significant common feature of the two proposals was a recommendation to **raise the eligibility for full benefits to age 70.**



The two Social Security plans differ on how the normal retirement age changes would be phased in. The bipartisan panel proposed a steady increase in normal retirement age over the next 30 years until the age for full benefits increases to 70. The panel also recommended raising the eligibility age for early Social Security benefits from 62 to 65 over the next several years.

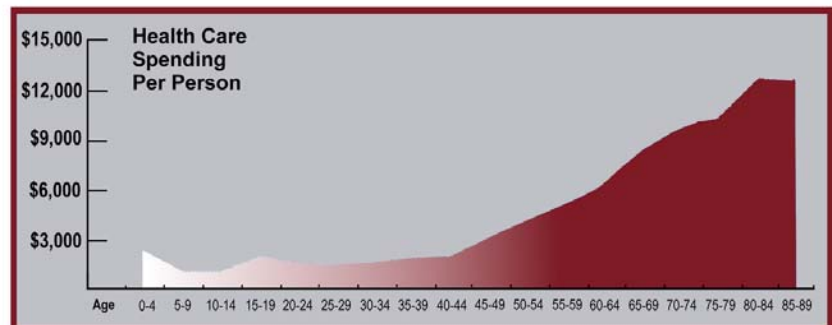
The changes contemplated by the panel and/or the Moynihan/Kerrey

proposal would have the beneficial affect of avoiding the doomsday predictions of having two or fewer active workers funding each retiree by the year 2025. Instead, the ratio would stay at the current level of three or four workers per retiree.

It is nearly certain that the future value of Social Security benefits to Americans will be reduced out of necessity. This now means that Americans will need to save more for retirement or risk a lower living standard in retirement.

Another issue that must be addressed by our legislators includes health care costs and our aging society. The graph below dramatically illustrates the point. It is not just Social Security retirement benefits that will need to change, but the Medicare system and the entire health care sector will continue to undergo severe pressure over the next several decades. **MW**

PER CAPITA HEALTH CARE SPENDING BY AGE



Consider that 13 percent of our population is over 65 today. By 2030, 20 percent will be over 65. That's an explosive shift because health care costs for this segment of society are so much higher. SOURCE: BENEFITS QUARTERLY, THIRD QUARTER 1997

TECHNICAL CORNER

Are you still enrolling your employees for medical benefits with paper enrollment forms? How often does this cause a delay in the issuance of ID cards? The accurate payment of claims?

Results of a survey of over 900 mid-sized companies was released early this month by Benefits Access Inc. A majority of benefits managers criticized the prevalence of paperwork in the benefit enrollment process, according to the study. While more than half of the employers surveyed believed they had quality and cost-effective benefits administration, 888 wished that it involved less paperwork. A total of 747 said they wanted to give employees faster and easier access to their benefits administration. But 91% of midsize companies still relied on paper enrollment, the survey found.

Many medical insurance carriers offer employers the ability to enter their own enrollment data, employee changes and terminations. The enrollment systems are generally available to groups of 50 or more employees. The systems have different requirements depending upon the needs of your insurance carrier. In general, the systems work via modem with various communication software packages.

Under a remote eligibility system, you log onto your insurance carrier's system and you have the ability to enter new employees, make changes to employee information and terminate employees directly on line. This type of administration offers employers several advantages:

- No delays in processing enrollment forms



– no mail time, no time delay at the carrier waiting for changes to be entered.

- Improved response time for ID cards through elimination of front-end delays.
- More control over the accuracy of the data input.
- Easier correction of inaccurate or outdated information.

These systems do require you to spend data entry time to input new hire information, changes and terminations. How-

ever, the time is generally considered well spent if it improves the efficiency and accuracy of your enrollment and eligibility process.

You may find automated remote entry capabilities an important tool to better manage your benefit plan and improve response time to your employees. Your carrier can let you know if they have remote entry capabilities and what their specifications are for using their remote systems.

You can try out a sample open enrollment via the Web through The Guardian Life Insurance Company of America at www.guardianbenefits.com. Enter "000000" (six zeros) when you get there; then enter "000-00-0000" as your Social Security number on the following page; then click "Go".

You can also call your McGraw Wentworth Account Manager for information on your medical carrier's capabilities on electronic remote entry.



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