

The ViewsLetter

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Prescription Drug Costs Continue To Rise

As we first reported in our February 1998 ViewsLetter, prescription drug costs continue to rise at a rate higher than that for other medical services. According to a recent Wall Street Journal article, national managed care statistics show that prescription drug costs are increasing at a current rate of over 16% per year. Within the national survey group, prescription drug expenses now account for between 11%-14% of total medical expenses. This compares to an approximate 7% prescription drug expense share in the early 1990's.



Locally, Blue Cross Blue Shield of Michigan reported that prescription drug expenses

accounted for 28% of insured premium revenue for 1998. This compares to a 20% share for outpatient physician services. Escalating prescription drug expenses are in large part responsible for the double digit rate increases which Michigan Blue Cross Blue Shield is imposing on its insured customers.

A primary reason for the increase in prescription drug expenses is the development of thousands of new and expensive medications, many of which are intended to replace existing prescription drugs. Viagra, one of the most widely publicized new medications of 1998, took the market by storm, taking a 97% share of the impotence medication market in just 3 months. In the Viagra example, the thera-

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About the ViewsLetter

We welcome you to the first issue of Volume Two of the McGraw Wentworth ViewsLetter. It is our mission to be the leader in the employee group benefits brokerage and consulting industry.

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. **MW**

DID YOU KNOW THAT?

Today, many employers and managed care plans are placing increased emphasis on the prevention of “modifiable” health risks. As the facts below illustrate, there are good reasons to pay attention to lifestyle-related claims.

Workers with multiple lifestyle risk factors incur claims at a rate of three times higher than those with low risk factors (\$3804 vs. \$1166)

Individuals suffering from depression have costs up to 70% higher than those without.

High stress accounts for a 46% increase in average claims incurred.

Being overweight results in a 21% increase in expected health plan costs.

Current tobacco use increases health plan costs by 15% on average, while former tobacco use increases costs by 20%.

Employees who exercise have health care costs that are 10% lower than those who do not.

Source: “The Relationship Between Modifiable Health Risk and Healthcare Expenditures”, Journal of Occupational And Environmental Medicine, October 1998

Prescription Drug Costs, cont.

peutic benefits of the medication are undisputed. Nonetheless, the impact of this prescription drug expense on many insurers and employer plan sponsors was substantial.

As new and more expensive medications continue to be developed, insurers and medical claim payers are adapting several strategies to cope with increasing expense levels. Some insurers, such as CIGNA Health Plans, are developing “closed formulary” plans, under which consumers pay listed co-payments for prescriptions within the formulary, and full price for prescription medications outside the formulary list. PacifiCare, which also uses a closed formulary, has declined to include several new drugs for the treatment of Parkinson’s

disease on its preferred drug list. The reason is that the new \$100 per month medications did not produce a demonstrably better result than L-Dopa, a PacifiCare formulary drug available for about \$10 per month.

Other managed care organizations and prescription drug vendors are developing tiered co-payment systems which of-

fer employees the choice to pay higher amounts for brand name or non-preferred drugs. A typical three tiered co-payment system would work as follows:

- A \$5 co-payment would apply to generic drugs.
- A \$10 co-payment would apply to brand name medications appearing on a “preferred” list.
- A \$20-\$25 co-payment would apply to any prescription medication not appearing on the preferred list.

As managed care plans and employer plan sponsors struggle to cope with ever



increasing prescription drug choices and expenses, numerous states are moving to restrict health plans from keeping certain

drugs off from preferred formulary lists in order to control costs. In 1998, California, New York and Connecticut all rejected Kaiser Permanente’s initiative to exclude Viagra from coverage under its non-profit HMOs. This year, more than 20 states are expected to debate bills aimed at preserving consumer choice by limiting the scope of preferred lists or closed formularies. MW

Leading Cause of Disability: Back Pain

A recent Gallup survey conducted for CIGNA Integrated Care has confirmed what many employers have long suspected: employees are more likely to miss work and collect disability income because of back sprains, strains and other soreness than from any other single type of injury or illness.

The Gallup survey, quoted in the November 16, 1998 issue of Business Insurance, included a randomly selected national sample of over 7,500 adults, all

of whom indicated that they currently work or had worked outside of their homes within the past three years. Within the sample group, 10.3% had missed at least 5 consecutive workdays due to a variety of work and non-work related injuries and illnesses. Among the group, absence from work due to musculoskeletal conditions accounted for a median of 5 weeks of disability. The average, however, was 144 days absent from work, compared to an average of 89 days absence for workers with other medical problems, including heart disease and cancer. On average, workers were absent 111 days with a variety of

other health problems, including mental illness, substance abuse, poisoning and burns.

In response to the escalation of often-difficult to diagnosis musculoskeletal-related disabilities, many insurance carriers are beginning to include provisions that limit long term disability benefit durations for "soft tissue" or "self-diagnosed" symptoms. Typical long term disability plan provisions of this sort include

a 24 month benefit duration (similar to common limitations on mental and nervous conditions) for self-reported conditions that cannot be confirmed through standard medical diagnostic tools. Certainly, the primary motive of the insurance carriers in implementing the new limitations on self-reported symptoms is driven by the need to limit their reserve liability for such claims. However, a beneficial side effect of this new carrier position will be closer scrutiny and (where appropriate) shorter disability durations for some back injury-related claims. **MW**



NOTABLE QUOTE

"The voyage of discovery is not in seeking new landscapes, but in having new eyes."

Marcel Proust

YOUR QUESTIONS

Q. We are in the process of securing stop-loss coverage for our self-funded medical plan. I understand stop-loss coverage can limit my liability as an employer for individual and group wide claims. Therefore, what key areas should I be sure to review so that I do not leave the company open to excessive risk?

A. Whenever you are obtaining stop-loss coverage, regardless of what type of benefit the stop-loss coverage is for, you must make sure your stop-loss agreement matches your benefit plan's provisions.

For example, if your medical plan defines full-time employees as those employees who work at least 30 hours per week, your stop-loss coverage must reflect the same full-time definition. If your stop-loss coverage outlines full-time status as 40 hours, you are extending benefits to someone who is not protected by the stop-loss carrier, since the policy does not recognize employees who work under 40 hours per week.

Another area to pay close attention to includes the definition of a preexisting condition. If your medical plan does not have a pre-ex and your stop-loss coverage does (for example, a six month pre-ex), and a claim is incurred during the six month pre-ex period, it will not be reimbursed by the stop-loss carrier.

Overall, you should be sure to review all benefits, limitations, and exclusions, including provisions for disabled plan participants, eligibility and wait periods, and preexisting condition limitations. These provisions must be the same throughout the benefit plan and the stop-loss policy to insure that you are not leaving the company open to risks.

If you have any questions concerning stop-loss coverage, please contact your Account Manager.

TECHNICAL CORNER

The Department of Labor has issued proposed regulations on the use of Intranets and the Internet for providing Summary Plan Descriptions to plan participants. The proposed regulations would establish a safe harbor to which all pension and welfare plans covered under Title I of ERISA may satisfy the disclosure requirements using electronic media.

Under the proposed regulations, a safe harbor will be established to distribute the Summary Plan Descriptions (SPDs), Summary of Material Modifications (SMMs) and Summary Annual Reports (SARs) via electronic media. With respect to record keeping, the proposal provides standards for electronic storage, automatic data processing systems and for the maintenance of records required under section 107 and 209 of ERISA. The document also establishes the Department's view that in the absence of final regulations or additional guidance, good faith compliance with the proposed regulations will constitute compliance under ERISA section 107 and 209.

The proposed regulations were developed as an expansion of a separate directive under the Health Insurance Portability and

Accountability Act (HIPAA). HIPAA issued an interim disclosure rule establishing a safe harbor for using electronic media to furnish SPDs, SMMs and SARs to participants under a group health plan. The DOL invited and received many comments on the



interim rule. The Department of Labor is deferring changes on this interim rule pending consideration of public comment on the more expansive proposed regulations.

The proposed regulations provide the following provisions:

- Expands the HIPAA Disclosure Rule to apply to all Welfare and Pension Plans Covered under Title I of ERISA
- Requires a plan to notify each participant via electronic means or in writing about the availability of documents and the significance

of available documents.

- Requires a plan notify the participant that it is the participant's right to request and receive each document in paper copy, free of charge.

- Requires that the plan administrator use a system of electronic communications that will result in the actual delivery of information to plan participants.

- Requires that the format of such information is consistent with the substance and style of materials distributed in the paper format.

- Requires the materials be delivered to the work site of a plan participant. The work site is not defined strictly as the physical location but any location where the employee is reasonably expected to perform their duties and the use of the employer's electronic communication system is an integral part of daily duties.

- Provides that electronic media be used for the purpose of complying with maintenance and retention requirements of section 107 and 209 of ERISA.

- The record keeping systems have reasonable controls to insure integrity, accuracy, and reliability of records kept in electronic form.

- The electronic records are maintained in reasonable order in a safe and accessible place.

- The electronic records can be readily converted into legible and readable copy.

- In regard to the maintenance of records, the plan administrator must use adequate record management practices.

The Department of Labor has requested written comments on the proposed regulations by March 29, 1999. Electronic distribution of SPDs, SMMs, and SARs would result in easier access for employees with Internet/Intranet access as well as distribution cost savings to employers. **MW**

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.

McGrawWentworth
3310 West Big Beaver Road Suite 105
Troy, MI 48084
Telephone: 248-822-8000 Fax: 248-822-4131
Internet: www.mcgrawwentworth.com