

The ViewsLetter

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How is Managed Care Managing Tobacco Use?

More than 400,000 Americans die each year due to smoking related diseases. A study last November revealed that tobacco use among teenagers has risen 28% in the last four years. What more can be done to help people to quit smoking or not to start at all?

office visit the physicians have the patient's undivided attention. Previous research shows that even the briefest message delivered by a physician to his/her patient can be a powerful motivator for helping a smoker to quit.

The American Association of Health Plans (AAHP), which represents more than 1,000 HMO's, PPO's and other managed care networks, believes there is an influential resource that has not been tapped – Managed (health) Care Organizations (MCOs). MCOs are in an excellent position to sponsor smoking cessation programs. The physicians that make up the MCO networks already have an intimate relationship established with the patient. During an



Through a survey of selected MCOs, AAHP was able to determine what type of smoking prevention and cessation programs are being implemented and the extent of service offered under the plans. Many HMOs and PPOs have some type of smoking cessation programs in

place but no tracking mechanism to evaluate the effectiveness of these programs; others had very extensive programs and were able to accurately track the effectiveness of the program.

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About the ViewsLetter

We welcome you to the second quarterly issue in Volume 2 of the McGraw Wentworth ViewsLetter. It is our mission to be the leader in the employee group benefits brokerage and consulting industry.

and marketplace developments that may affect your group benefit programs.

We have established the ViewsLetter as an integral part of our commitment to keep you informed of benefit trends, legislative

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**

Reach us on the world wide web at the McGraw Wentworth Interactive web site. Check it out at www.mcgrawwentworth.com. Additional copies of the ViewsLetter are available in the MW Xchange.

YOUR QUESTIONS

Q. Our health care carrier provides us with booklets that describe the benefits, COBRA rights, conversion information and termination provisions (among other information). We distribute these to all of our employees. Are we meeting our ERISA obligation to communicate benefits to our employees?

A. Maybe, but maybe not. ERISA requires plan sponsors to provide all participants with a written summary of each of their benefit plans. The regulations require that these summary plan descriptions (SPDs) must be "written in a manner calculated to be understood by the average plan participant."

Under current law, SPDs must contain the following information:

- Official name
- Name/address of administrator
- Name/address of person on whom legal process can be served
- Record keeping year (calendar, policy or fiscal)
- Plan year
- Employer Tax ID Number
- Plan number
- Effect on participants of plan termination
- Type of plan (defined benefit, defined contribution or welfare plan)
- Name, title, address of trustees
- Source of financing of plan
- Relevant provisions of applicable bargaining agreement
- Procedure for appeal of denied claim
- ERISA rights statement
- Name of organization through which benefits are provided.

The importance of SPDs should not be underestimated. Employers have lost cases because their SPDs implied that an employee was entitled to coverage and the plan documents did not provide for such. It probably makes sense to have a benefits professional audit your plan documents and SPDs for ERISA compliance.

Managing Tobacco Use, cont.

The survey sent to the MCOs by the AAHP was designed to address five areas of interest:

● MCO knowledge of the Agency for Health Care Policy and Research's (AHCPR) Smoking Cessation Guidelines.

● How MCOs monitor the success of their efforts to incorporate tobacco prevention and cessation into routine care.

● How MCOs work to influence tobacco policies at the state, local and national levels.

● The barriers faced by MCOs in their efforts to address tobacco control.

● The processes used by MCOs to overcome barriers that discourage people who want to quit smoking.

The results of the survey were that only 9% of MCOs have a fully implemented tobacco cessation and prevention program that meets all the AHCPR's guidelines; 39% have partially implemented the guidelines, and 53% have not implemented them at all.

Specific major managed care organizations are already being

recognized for their efforts. Kaiser Permanente – Northeast was recognized by the AAHP for integrating their "Tar Wars" education program into fifth grade curriculums. It involved clinicians, educators, businesses, legislators and the media in the critical effort to get the non-smoking message out to children. Healthsource Maine, Inc. has a telephone based



smoking cessation counseling program for members of rural populations using telephone support and nicotine replacements including gum and patches.

In the future, you can expect to see a major shift in the role that health care organizations play in the prevention and cessation of smoking. There are also other ways to educate and persuade people to quit smoking or not to begin smoking in the first place.

If you are interested in learning more about the AAHP survey or implementing your own employer-sponsored smoking cessation plan, look up AAHP at www.aahp.org or the health care page at the Prudential Health Care web site at www.prudential.com.

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NOTABLE QUOTE

"Be careful about reading health books. You may die of a misprint."

Mark Twain (1835-1910)

A Look At Long Term Care

The Healthcare Financial Management Association defines long-term care as “coordinated medical, nursing, rehabilitation, maintenance, and support services provided in the home, community, or institution for an extended period of time to patients of all ages with severe chronic diseases or disability, involving substantial functional impairment, regardless of diagnosis. The primary goal of long-term care is to maintain the patient’s maximum functional independence.”

This care comes at a cost – sometimes a very high cost – that most of us are not financially prepared to handle. A recent study indicates that 60% of all persons will require long-term care at some point. In addition, 70% of all married couples will be affected by long-term care needs in some way. As our population ages these statistics are likely to show an increase.

How high are the costs?

According to the Department of Health and Human Services, the average cost of nursing home care in the United States is about \$100 a day (and much more in some parts of the country) and the average stay is 2½ years. This translates to a total cost of almost \$100,000 per stay. Care received in the home, though more economically delivered, is still costly.

Government programs are not generally the answer. Medicare typically pays 100% of the costs for the skilled or rehabilitation services provided in a nursing home for days 1-20 of an admission. After that the patient must pay a deductible of approximately \$100 day for those services for days 21-100 of that stay. After 100 days, all Medicare reimbursement ends.

This leaves the burden for most of the expense – remember, Medicare is only paying for certain services while nursing home confined – on the person who can least afford it. As a result, 75% of all individuals receiving nursing home care deplete their assets to the poverty level in one year.

At that point, benefits are provided by Medicaid – but only after the patient has spent their life savings.

Who pays for the nursing home services?

Private Insurance	2%
Medicare	6%
Out of Pocket	42%
Medicaid	48%
Other	2%

The answer for a growing number of Americans is long-term care insurance. These policies are designed to offset the costs of providing the care for someone needing assistance with daily living for an extended time. Long-term care policies can be complicated and are often expensive. It is critical to understand how a policy works.

What should I look for in long term care insurance?

What triggers the benefit? The medical community has long used six standard “activities of daily living” (ADL). These include bathing, dressing, toileting, transferring, continence and feeding. Benefits should be paid if a

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DID YOU KNOW?

Regarding FSA’s...

Health care accounts are offered by 56% of employers



Employee participation in health care accounts averages 19%



The average annual contribution for health care accounts is \$844



Only 4% of health care account funds were forfeited in 1997



Dependent care accounts are offered by 59% of employers



Employee participation in dependent care accounts averages 8%



The average annual contribution for dependent care accounts is \$2,743



Only 2% of dependent care account funds were forfeited in 1997

Source: Mercer/Foster Higgins National Survey of Employer Sponsored Health Plans 1998

TECHNICAL CORNER

It seems like discussion of a “patient’s bill of rights” has been going on for a long time. The issue has generated heated debate from politicians, doctor and hospital groups, HMOs, insurance companies, employers and consumer advocates.

The U.S. Senate Committee on Health, Education, Labor and Pensions has approved legislation that is smaller in scope than other plans currently under consideration.

According to its sponsors, Senate bill S.326 is designed to provide consumer protection, improve the quality of healthcare and improve access to care.

The bill also mandates that all plans have written grievance procedures as well as formal internal and external appeals processes.

The bill does not include language exposing health plans to liability for pain and suffering under state law or allocation of funds for a national “health care ombudsman” program. These are prominent features in other plans.

Some components of Senate Bill 326 include:

- A prudent layperson’s standard for emergency care



- A point-of-service option for network only plans (with an exemption for small employers and plans offering two or more

options)

- Direct access to OB/GYNs and pediatricians

- Continuity of care for those under plans which terminate providers from their network for up to 90 days

- Access to specialists within the network, or outside if necessary

- Prohibition of “gag clauses” in provider contracts that might discourage doctors from describing all available treatment options.

A complete summary of Senate Bill S. 326 is available on the U.S. Senate web site: www.senate.gov.

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Long Term Care, cont.

person needs assistance with two or more ADLs. This includes a “cognitive impairment” such as Alzheimer’s disease.

Are all levels of care covered? Care required as a result of the loss of two ADLs can be provided in a nursing home or at home, and the policy should cover all care regardless of where it is received or who administers the care.

What is the benefit? There is significant flexibility in designing the plan. Components include monthly benefit, benefit duration, maximums, and elimination period.

Other features that should be explored include guaranteed renewability, portability, no prior hospitalization requirement, inflation protections (i.e. 5% cost of living adjustment annually) waiver of premium and pre-existing condition exclusions. Policies can also cover the employee’s spouse, parents and parent-in-law.

Why should an employer offer long-term care insurance?

Long term care can be offered as a voluntary benefit, allowing employees to pay most or all of the cost through payroll deductions. In other words the program can enhance the benefit package without increasing the company’s expense. Besides adding to the menu of options available to employees, the benefit can result in direct savings to the employer. It is estimated that long term care related issues cost companies \$30 billion dollars a year in lost time, lost employees and lost productivity.

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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.

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