



The ViewsLetter

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Health Care Contribution Strategies

Many organizations are getting ready to begin discussing employee benefit plan options for 2006. If your organization begins analyzing possibilities for 2006 now, you should have the time to determine the best course of action to meet your budget and benefit goals.

This process has become an annual event that begins earlier and earlier every year. Health plan costs have become so substantial that employers must really study their options. How do your benefits compare with your competitors' benefits? Weigh the costs. Although health plan costs have become the critical story over the last five years, most employers feel strongly about providing health plan benefits that will cover both catastrophic situations and everyday health care needs. Employees should be able to afford these benefits.

What is affordable? The answer to that question really is "it depends." Individual income and family situation determine

affordability. Employees' incomes vary widely; therefore, ability to pay for health care coverage also varies widely. As health plan costs have increased dramatically for organizations, often, costs are managed by increasing employee contributions for coverage. Many employers are now concerned that their lower wage earners may have difficulty affording their portion of the premiums.



Affordability is a real concern and not one that is easily solved. Some organizations are tying contributions to the employee's annual earnings

to make health care coverage more affordable for their lower wage earners. Employees who make less money, pay less. This approach is gaining in popularity. Hewitt conducted a recent survey indicating 18% of organizations used this strategy in 2004 and 21% were planning to use it for 2005.

These tiered contributions complicate plan administration. The first step to take in using this approach is to define annual

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About the ViewsLetter

We welcome you to the second 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.

Health Care Contribution Strategies, cont.

earnings; how will the plan define individual earnings to determine the correct contribution tier? The question seems simple, but there are many issues to consider:

- Will hourly workers' income be solely the hourly wage for a 40-hour work week? Will it include overtime income?
- Will income include incentive pay or performance bonuses?
- Will your organization calculate income using the previous year's W-2? This approach would reflect overtime and bonus payments. However, you need to consider how to handle individuals with lower than normal W-2 earnings because of a significant leave of absence.

Clearly define earnings so your employees can determine which contribution bracket applies to them.

Your payroll vendor will need to accommodate multiple options for different income brackets and those amounts will also vary across coverage status (single, couple, family). Find out whether your payroll vendor can handle a sliding contribution structure.

To manage some of the administrative complexity, limit the number of tiers. Many organizations set contributions based on a four-category structure as follows:

- Annual earnings under \$30,000.
- Annual earnings between \$30,000 and \$49,999.
- Annual earnings between \$50,000 and \$99,999.
- Annual earnings of \$100,000 or more.

Employees in the lowest tier would pay the least to participate in the

medical plan, and employees earning \$100,000 or more would pay the most.

This strategy may help organizations that have kept contributions relatively low out of concern for the lower tier wage earners. The tiered contribution structure allows employers to raise premiums for the higher tiers without hurting lower wage earners. Employers would present this strategy as a way to make sure health care benefits are affordable for everyone in the company from the maintenance department to the corporate executives.

Companies using this strategy report most employees accepted it. Only a few people felt the situation was unfair because all plan participants would receive the same health care benefits without having to pay the same premiums. Yet, organizations that adopted this approach received far fewer complaints than they had anticipated.

Most organizations are at point in their health plan management where the low hanging fruit has been picked; meaning the easy changes to control health plan costs have already been made. Now, they have to make the tough decisions so that they can continue to offer comprehensive health coverage. A strategy that ties health plan contributions to income may help your organization save money while it eases the burden on employees that can least afford significant cost increases. **MW**

DID YOU KNOW?

- ➔ 45% of Americans take at least one prescription medication.
- ➔ 17% take at least three prescription medications.
- ➔ 10% of women and 4% of men over age 18 are taking antidepressants.
- ➔ The price of prescription drugs has risen 15% every year since 1998.
- ➔ Private health insurance covered almost half of the prescription cost in 2002; that is up from 25% in 1990.
- ➔ Individuals paid, on average, 30% of the actual cost of their prescription medication expenditures.
- ➔ Almost 29% of Americans stop taking their medication before the prescription runs out.
- ➔ 12% of Americans do not fill their prescriptions at all.
- ➔ 12% of Americans do not take their medications at all after filling their prescription.

Source: Centers for Disease Control and Prevention, 2004

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How Are My Health Care Dollars Spent

Most households operate on a monthly budget, dividing income among the various household expenses. Most families know how their money is spent each month.

Health plans operate on a much larger budget and, shockingly, many organizations would not know how to answer what appears to be a simple question – how are my health care benefit plan dollars spent? Health care cost increases are on everyone’s radar. A recent Business Roundtable survey of CEOs indicates rising health care costs are their biggest worry.

A CFO magazine survey shows a wide range of strategies aimed at coping with these cost increases (see table).

Interestingly, not one organization indicated that it would analyze health claims to determine whether the benefit plan was operating efficiently or review the benefit plan to determine whether the plan should continue to cover certain services.

Understanding where your benefit dollars are spent can help you save health care dollars. Do you know which medical services your health plan beneficiaries need now and which services they will need in the

TREND TIDBITS

- \$ In 2003, employees paid 21% of the cost for employee-only coverage; in 2004 that increased to 22%.
- \$ In 2003, employees paid 25% of the cost for dependent coverage and that increased to 26% in 2004.
- \$ For 2005, 24% of employers are already planning to increase the percentage of premiums employees pay for employee-only coverage.
- \$ For 2005, 30% of employers are planning to increase the percentage of premium employees pay for dependent coverage.

Source: Hewitt’s Health Care Expectations: Future Strategy and Direction 2005

future? Advances in medicine are amazing, but should your plan pay for cutting edge diagnostic services when other diagnostic services may be just as effective for most participants and significantly less expensive? Discuss current services with your plan vendor and ask which services the plan should cover.

For example, gastric bypass coverage has received significant press in the last few years. Some organizations choose to cover gastric bypass surgery after an obese plan participant exhausts alternative treatment therapies.

Other plans do not cover the gastric bypass procedure at all. The surgery is fairly expensive and complications following surgery are not uncommon. Do you know whether your health plan covers this procedure? Does your health plan want to cover this service? It can be expensive, but it can improve employee health by helping obese individuals lose a significant amount of weight. The individual’s improved health may result in fewer claims paid for chronic conditions.

Another good area to review is preventive care services. Are your plan participants scheduling the routine care initiatives the American Medical Association recommends? Does your plan encourage or discourage annual preventive screenings? Look carefully at your preventive care coverage. Does your plan offer a low annual maximum for this benefit and do your plan results show most participants reaching their maximum? If that maximum has not been increased in the last decade, it is probably not adequate. Restrictive dollar limits can have the unintended effect of discouraging plan participants from receiv-

51%	Increase employee contributions to health care premium
51%	Increase plan copays
48%	Increase deductibles
28%	Switch health plan vendors to obtain a lower rate
25%	Institute Health Savings Accounts with high deductible health plans
19%	Reduce scope of coverage
18%	Institute wellness and disease management programs
7%	Use more contract employees who are not offered benefits
7%	Purchase health care coverage jointly with other businesses
5%	Introduce more restrictive eligibility requirements
2%	Integrate disability and health care plans

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How Are My Health Care Dollars Spent, cont.

ing their recommended annual preventive screenings. In the long run, these limits can hurt the health plan. If chronic conditions are not caught early enough, it can increase the severity of the condition and ultimately impact, the cost to treat the condition.

Your health plan most likely will have internal management programs. It is not uncommon for health plans to include special networks for transplant cases or large case management programs. While the transplant cases or critical cases requiring large case management are not common, they are very expensive. Are you familiar with the measures your health plan vendor will take to help you manage these potentially high costs? Many organizations are not aware of the benefits of a transplant network or do not understand the process of large case management. Find out how cases are identified and routed into the various management programs and how these cases are managed to ensure cost effective, but appropriate, care.

Managing health care costs is a continuing process. While you can control some costs by cost-shifting and cost-cutting tactics, you can also control costs by making sure your plan is paying for medical services necessary for your health plan participants' quality of life. Consider what services will be essential in the future, so your health plan can operate as efficiently as possible. You may not see significant cost savings year over year but analyzing these issues will help your organization understand how much your health plan is paying for various types of service. This understanding will help you improve the health of your organization and the satisfaction with your health benefit plan. **MW**

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Technical Corner

Technology in the workplace has made time management and other critical functions more efficient. However, organizations often use this technology without considering its downside. Unfortunately, the potential abuse of an organization's technical infrastructure can be a significant problem.

Liability concerns include:

- Privacy
- Instant Messaging
- Handhelds, wireless devices and camera phones

Privacy Concerns

Employers need to consider liability when employees use electronic tools. Downloading and using copyright protected materials, downloading inappropriate or illegal materials, and so on, can lead to legal problems. Your organization should have a policy on personal use of employer resources. The best way to prevent problems is to notify your employees that their activity is monitored, they should not expect privacy in the workplace and your organization will cooperate with any criminal investigation.

Instant Messaging

In the 2004 Workplace E-Mail and IM Survey, nearly 80% of employers indicated they had a policy on e-mail, but only 20% had a policy on Instant Messaging. Instant Messaging can be a powerful communication tool, but it can also expose employers to many risks.

The 2004 survey indicates that 31% of employees used Instant Messaging for jokes, gossip, rumors and disparaging remarks. Nine percent used IM to discuss confidential corporate or personal information regarding a co-worker.

Because IM is a discreet software program loaded individually on each computer, it is difficult to monitor and secure. IM software is not included in many organizations' security measures.

Cameras

Some organizations will want to consider a ban on camera phones. With these sophisticated phones, confidential documents could be photographed and reproduced.

Concerned Employers Should Implement These Security Procedures:

- Publish policies on e-mail, Internet and Instant Messaging.
- Have employees acknowledge they understand these policies.
- Inform employees your organization will monitor usage.
- Notify employees you will cooperate with official investigations.
- Be sure to enforce your policies.
- Keep informed on new technologies and modify your policies as needed. **MW**

Sleeplessness: An Epidemic

Many Americans have difficulty sleeping. A recent poll conducted by the National Sleep Foundation indicates 75% of adults have at least one symptom of a sleep disorder, such as waking up in the middle of the night or snoring. These symptoms indicate an overwhelming majority of Americans are not getting a good night's sleep.

Lack of sleep affects many aspects of an individual's life:

- 60% of adult drivers have driven drowsy in the last year while 4% have had an accident or near accident.
- Sleep-related problems are the most common reason people are late to work. One third of adults have missed work or made errors at work in the last 3 months as a result of sleep problems.

The study indicates on average, adults sleep 6.9 hours per night. The National Sleep Foundation recommends between 7 and 9 hours of sleep per night. The most alarming study result is that almost half of the adults participating indicated they felt they were getting a good's night sleep on a regular basis. This indicates most employees may feel they are getting good sleep when in fact, their sleep quantity and quality is not adequate. This does impact absenteeism and work effectiveness.

Organizations may want to educate employees on the importance of a good night sleep. Individuals need to learn about quality sleep and the impact poor sleep patterns can have on their life. Employers can educate employees on the importance of good sleep. They can even provide tips and techniques to help employees practice behaviors that will help improve sleep quality.

Improving the sleep quality and quantity of your employees can impact the bottom line. **MW**

YOUR QUESTIONS

- Q.** Our cafeteria plan year and our health plan year run on a June 1 to May 31 plan year. We are preparing to inform our active employees of our open enrollment changes and rights. Do we have to offer open enrollment to our COBRA participants?
- A.** This vague area of COBRA was clarified in the 1999 final regulations. Organizations must offer COBRA-qualified beneficiaries the same open enrollment rights as similarly situated non-COBRA beneficiaries.

However, this simple answer has many underlying complexities:

- **Medical Flexible Spending Accounts:** COBRA's medical FSA rules are very detailed. COBRA applies only to medical FSAs with positive balances that exceed what the plan could require as payment for the remainder of the plan year. In these positive balance situations, COBRA only needs to be extended for the year in which the qualifying event occurs, assuming an employer does not provide any seed money to the medical FSA. Therefore, ongoing open enrollment will generally not be an issue for medical FSAs.
- **Adding New Dependents:** A COBRA-qualified beneficiary can add or delete dependent coverage, just as a similarly situated non-COBRA beneficiary can. However, dependents added during open enrollment are not considered qualified beneficiaries under COBRA. Therefore, if the original qualified beneficiary's COBRA ends, coverage for any dependent added at open enrollment also ends. Since the dependent added to coverage is not considered a COBRA-qualified beneficiary, the maximum coverage period should not be extended to 36 months in the event of a secondary qualifying event.
- **Adding new coverage:** If your organization adds a new vision program to your benefit offerings, COBRA-qualified beneficiaries should have the same option as similarly situated non-COBRA qualified beneficiaries to elect the new vision program. The qualified beneficiary will need to pay the premium for the additional coverage.
- **Changing plan options:** A COBRA-participant should be able to choose any plan you offer at open enrollment. The COBRA-participant will have to pay the required premium for the plan elected. For example, if your organization offers a PPO plan, an HMO plan and a Consumer Driven Health plan; the COBRA participant has the ability to change plan options at open enrollment in the same manner as a similar-situated non-COBRA beneficiaries.

Your organization should notify COBRA participants of open enrollment when you announce the new COBRA rates for the next plan year.

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THE VIEWSLETTER

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