McGraw Wentworth

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The Focus Returns to Universal Health Care

It is hard to miss the debate raging in editorial columns across the country. Democrats positioning for next year's primaries have brought the issue of universal health care back to the front burner. Two presidential hopefuls, Senator John Edwards and Senator Barack Obama, are strongly advocating universal health coverage.

Universal health care coverage has been a back burner issue since the Clinton administration failed to implement national health care in the 1990s. The issue is significantly different today. According to a 2006 Kaiser Family Foundation and Hewitt study, health care premiums have risen 87% since 2000. This survey data corroborates the results of previous studies. Employers are struggling to pay for health care coverage. Most industries' profit margins have not increased 87% since 2000, yet employers face rising health care costs adding substantially to labor cost.

American employers are at a severe disadvantage when they compete in the global marketplace because of higher labor and health care costs for both active and retired employees. Employers, saddled with large retiree populations and their health care costs, are starting to think universal health care may not be such a bad idea.

Other employers recognize the burden of health care costs and the need for system improvements to help manage cost, but question whether the government should own the problem. These organizations have spent time and resources analyzing in depth the issues that are driving their own cost. Their concern is that those issues will not go away under a government-sponsored (and possibly administered) health care system. If certain conditions are identified as driving health care cost up, the key to managing cost is solving those problems in the most efficient way possible, not necessarily shifting responsibility to the government.

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About the ViewsLetter

We welcome you to the second quarterly issue in Volume Ten 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.

The Focus Returns to Universal Health Care, cont.

The proposals on the table are not as simple as "Clinton Care." Both state and federal law makers are reviewing measures to support national health care. The proposed measures vary and take very different positions. On the federal front:

- Senator Edward Kennedy and Representative John Conyers are pushing to gradually expand eligibility for the Medicare program until it essentially covers all Americans.
- Senator Ron Wyden introduced the Healthy Americans Act requiring employees to pay for their own health insurance coverage and requiring employers to increase wages to cover that cost. Premium subsidies would be available for low income individuals so they could also afford coverage.
- Senator Jeff Bingaman and Representative Tammy Balwin propose to authorize federal funding for individual states and tribal organizations to expand health insurance coverage.

The states have been more aggressive in taking action to assure universal health coverage for their residents:

- Perhaps the most discussed state action is the plan passed in Massachusetts requiring state residents to have health insurance. The provision is similar to a state law requiring vehicle owners to carry auto insurance. Employers and state-sponsored, state-subsidized insurance programs provide the coverage.
- Maine's 2003 universal coverage legislation works toward covering every resident by 2009. Vermont has also passed legislation to ensure all residents have health coverage.
- The universal coverage issue is being debated in California, Minnesota, Pennsylvania and Washington. Many of these states are considering programs similar to the one introduced in Massachusetts. Universal coverage measures have also been introduced in Connecticut, Hawaii, Indiana, Maryland, Missouri, New Hampshire and Oregon.

TREND TIDBITS

$ For large employers (500+ employees), health care costs increased at 6.1% in 2006 to $7,523 for each employee.

$ For employers with fewer than 500 employees, health care costs rose 7%.

$ The number of consumer driven health plans tripled from 2005 and 2006, with 6% of employers sponsoring a CDHP.

$ Employee monthly contributions vary significantly by plan option. CDHPs have the lowest monthly employee contribution at $41 compared with $85 a month for a PPO and $76 for an HMO.

Source: 2006 Mercer Health & Benefits

Many of the measures states have introduced do not eliminate the employer's role in covering employees. Most measures are aimed at encouraging the uninsured to obtain coverage, either independently or through a state sponsored health insurance pool. The number of uninsured people in this country has grown steadily and contributes to rising health care costs. Charity care is not truly charity. In the end, insured patients pay more for services to offset the cost of charity care.

The problem of the uninsured is very complex and not as one-dimensional as many may think. Uninsured people fall into three categories. One group is comprised of people who meet all the Medicaid requirements yet fail to apply for the program. The next group is the working poor. They do not qualify for Medicaid but cannot afford to pay for coverage on their own even if coverage is available through an employer. The final group includes people making $75,000 or more but do not have health insurance. Although people in this income bracket should be able to afford health insurance, coverage may not be available through their employers. This group may have trouble obtaining coverage because of their health history or the high cost.

President Bush has also introduced a tax plan designed to make health care more affordable. It allows a standard deduction for single and family coverage. The key provisions are as follows:

- This proposal creates a standard health care deduction for either employer-sponsored or individually purchased health care coverage. For the first year, the deduction would be $7,500 for one person and $15,000 for a

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The Focus Returns to Universal Health Care, cont.

family. (The proposed first year is 2009.) If you pay less than the standard deduction for your health plan, you still get to take the standard deduction. If you pay more than the standard deduction amount, your deduction will be capped at the standard deduction limit.

- Under the Bush proposal employers can still deduct the cost of the health care coverage they provide for their employees. This proposal will not affect the company's tax breaks. Employers will not have any tax incentive to stop offering health care coverage.
- The standard deduction will rise annually at the general inflation (CPI) rate.
- It appears this tax proposal would end the practice of paying health care premiums with pre-tax dollars currently permitted under Section 125. In the examples the Bush administration released, the value of coverage (both the employer amount and the employee paid amount) is added back to taxable income and the employee takes the standard deduction.
- HSAs (health savings accounts) will look better and better if this tax proposal becomes law. HSA contributions remain tax favored over and above these standard deductions. To maximize the tax benefits, many people will seek a low cost HDHP with not too high a deductible and then take the full standard tax deduction. At the same time they will deposit the maximum amount allowed into their HSAs. This would be the best way to maximize tax saving under this proposed system.

It remains to be seen whether the Bush tax proposal will make it through Congress. It looks as if the chances of this tax proposal becoming law are slim. However, with all the attention focused on health care, President Bush needed to offer some solutions in his State of the Union address in January.

Democratic and Republican presidential hopefuls will likely spend a good portion of 2007 discussing solutions to our health care problems. To be effective, their solutions must include suggestions for reducing some of the key health care cost drivers.

Key health care cost drivers include:

- The steadily increasing rate of obesity, in both adults and children.
- The rising cost of malpractice coverage for health care providers.

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YOUR QUESTIONS

Q. I just received a court order requiring our plan to add the dependent child of one of our employees to our coverage. I did some research and determined this court order has all the elements necessary to be considered a Qualified Medical Child Support Order (QMCSO). What date is our organization legally required to add the child?

A. The law does not specify an exact date when employees need to add a dependent child. Once a plan verifies a court order is a QMCSO, the child must be enrolled as soon as possible. The DOL has stated if your organization regularly adds new participants and beneficiaries as of the first of the month, the child could be added as of the first of the month following the determination.

If the employee is in the new hire waiting period for coverage when you receive the QMCSO, the plan should review the order to make sure it qualifies and have procedures in place to add the child as soon as the employee completes the new hire waiting period.

QMCSOs don't occur every day in most organizations. These coverage requests must be handled promptly and correctly. The Department of Labor has published *A Compliance Guide for Qualified Medical Child Support Orders* to help employers with the process and answer questions on QMCSOs. The guide can be found at http://www.dol.gov/ebsa/publications/qmcso.html.

Depression in the Workplace

- The cost of scientific breakthroughs in the treatment of various conditions.
- Overuse of health care benefits because many patients never see the "full cost of care."
- Declining health as the population ages.
- Cost-shifting by providers to cover the increasing cost of charity care.
- Inefficient treatment and health care administration.

Unless candidates suggest ways to rein in these key health care cost drivers, they will simply be shifting the cost problem to the government and not actually improving the situation. MW

Depression in the Workplace

Depression in the workplace is a problem most employers face and its economic impact is substantial. Experts estimate depression affects approximately 8% to 10% of adults at some point in their lives and costs employers in this country between $31 billion and $43 billion in lost productivity and medical expenses every year. With the current economic downturn in Michigan, depression may be more prevalent as employees struggle with economic uncertainties.

New research suggests undiagnosed bipolar disorder may add a disproportionate amount to the cost of treating depression. Bipolar disorder is different from general depressive disorders and, if it is not treated properly, will continue to be a significant problem. An important National Institute of Mental Health study shows that even though major depressive disorder is six times more prevalent in the workforce, bipolar disorders are associated with nearly half of the cost of depression in the workplace. In addition, patients with bipolar disorder are often misdiagnosed. They may be treated for depression, but those treatments are not effective for bipolar disorder. In fact, standard antidepressants may even trigger manic episodes in these patients. It is critical bipolar disorder be diagnosed properly so it can be treated appropriately.

The National Institute of Mental Health study followed 3,378 adults employed for a year and examined the severity of their mood disorders and the impact of these disorders on absenteeism and presenteeism. The researcher found that bipolar-associated depressive episodes were much more severe and persistent, affecting between 134 and 164 days compared with only 98 days affected for major depressive disorder. Remember the study did not merely examine absenteeism, it also examined presenteeism, employees unable to work at 100% because of the medical condition. Although the design of the study is limited, the initial results indicate the importance of identifying bipolar disorders correctly and treating them accordingly. The preliminary results certainly indicate a need to study this distinction in depressive disorders more thoroughly.

A Medco study in 2006 reveals that patients being treated with antidepressants often do not seek follow-up care. The Food and Drug Administration recommends weekly follow up visits at least for the first month a patient is treated with antidepressants. The Medco study showed a serious lapse in this treatment protocol. Almost half of patients on antidepressants did not see a health care provider during the four weeks following the prescription. After the first month, a quarter of patients did not seek follow up care.

Study after study shows the most effective treatment for depression includes therapy in addition to antidepressants. However, it appears, many patients are not interested or vested in the process of therapy. Many patients simply want to take a pill to feel better rather than examine the underlying cause of the depression. This attitude should alarm employers. Most employer health plans pay a sizable amount for antidepressant medi-

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DID YOU KNOW?

According to the Society of Human Resource Management (2006), vacations are not always an opportunity to escape the office:

- 33% of employees typically take work with them on vacation; 67% do not.
- 35% of employees feel obligated to stay connected to the office during vacation by cell phone or e-mail; 43% of workers do not feel that obligation.
- 38% of employees combine business trips with personal vacations; 62% do not combine them.
- 27% of employees admit to using sick and personal days for vacation; 73% of employees do not.

Depression in the Workplace, cont.

cations. However, those antidepressants may not be treating the depression effectively and without follow-up visits to physicians, these employees may not realize that the antidepressants are not working.

Employers may not want to be involved with depression, but the impact it has on employees and their productivity certainly warrants their attention. A disease management program may help make treatment more effective. Studies show when depression is effectively treated, productivity increases and absenteeism decreases dramatically. When you offer a depression disease management program, inquire about the process for identifying potential participants. Since these patients may limit their doctor visits, data from the prescription drug program should identify patients taking antidepressants. Cross-referencing this information with your health plan data will help you determine whether the patient is seeking follow up care. In addition, your disease management vendor may have a separate screening program or process to properly diagnose bi-polar depressive disorder.

In Michigan, depression is likely to take its toll on your employees. While your organization may be weathering the economic times, your employee may be affected by a spouse or family member's situation. It may make sense to add programs to help with depression and bi-polar disorder to protect your organization's productivity. MW

Technical Corner

It continues to happen; just recently a Blue Care Network employee's laptop was stolen, compromising the personal information of a number of Blue Care Network's subscribers. Blue Care Network personally notified subscribers that may be potentially affected by the theft.

Blue Care Network is not alone. Major organizations and also governmental entities continue to struggle with the process of protecting personal data. The number of organizations that hold your personal data is alarming. It is equally shocking to think of the number of portable devices your workforce is using to work remotely with your clients' personal data. Protecting data on your local network is complicated enough; protecting data used remotely is much more difficult.

Your average employee may know how to use your software programs, but may not truly understand the risks of using data remotely. Most employees do not understand the potential risks because they really do not understand how remote computer access software works.

Compromised data can be expensive for organizations. Even though federal laws do not require minimum security standards, some state laws do affect compromised personal information. In addition, the Security Rule of HIPAA requires employers to safeguard electronic protected health information associated with your group health plan. Very few direct fines are levied for breaching the security of personal data; however, in these situations most organizations offer to pay for monitoring the affected individuals' credit for a year or so following the theft to determine whether their identity has been stolen.

Organizations should regularly review and revise security measures for portable devices and remote use to keep personal data from being stolen or compromised. Employees must be kept informed as part of this process. Since most organizations do not monitor their employees' day-to-day activities, employers may not realize employees are accessing data remotely without using the necessary safeguards.

IT can design the best procedures possible for protecting your data remotely, but if your employees do not follow or do not understand the procedures, your data will remain at risk. MW

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