



The ViewsLetter

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Health Advocates: A Cost Control Strategy on the Cutting Edge

Seeking health care in the last decade has gotten much more complicated. While many individuals have at least one physician they see on a regular basis and consider their primary care doctor, time spent with the physician is minimal. Gone are the days when your physician spent time discussing your total health instead of the symptoms prompting the latest of-office visit.



In addition to doctors not having the time for lengthy office calls, health care treatment options have made great strides in the last 20 years. These strides have had an impact on the quality of life for many individuals. These advancements have also complicated the decisions on seeking care and what type of treatment is the best option for any given condition.

As these advancements become part of medical treatment, the cost for care has grown substantially. Employer health

plans only pass along a marginal percent of the cost to employees, so cost is often not a factor in considering treatment options. This has led to a difficult situation where employers are looking for ways to re-introduce cost into the purchasing decision and engage employees to make the best treatment options based on cost, quality and expected outcomes.

Many employers think that type of engaged consumer may be a pipe dream. How do you get employees to make better treatment decisions, better understand their health and the impact of their lifestyle choices when their primary care doctor doesn't have the time to treat their total health?

It is a vicious circle and one of the reasons so many parties are frustrated with the health care system in the United States. It contributes to the problem of the United States spending far more on health care than

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About the ViewsLetter

We welcome you to the second quarterly issue in Volume Eleven 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 Advocates: A Cost Control Strategy on the Cutting Edge cont.

any other developed nation and only achieving moderate outcomes. It is not a problem that is easily addressed or that will be solved quickly. It has taken twenty years to get to this critical tipping point and there is no one guaranteed solution to the problem.

One of the options that looks promising to many employers is a Patient or Health Advocate program. These programs can encompass a number of services depending on the vendor used, but the primary goal typically is to provide an independent, non-biased resource to provide accurate information, support and assistance in navigating the health care system.

Patient advocacy programs can vary greatly. Some programs are sponsored by hospitals or non-profit organizations and are designed to provide emotional support and assistance to a patient through a difficult course of treatment, for example, the treatment of breast cancer.

The programs some employers are offering are a bit more expansive.

Typical program objectives should include:

- Increase patient awareness of health care resources and patient safety concerns. The primary objective should be to empower patients to play an active role in guiding their care.
- Encourage patient involvement in the care process. This includes teaching the patient to obtain copies of all their medical tests and to question the results. It is too easy nowadays to assume no news is good news, when in fact, many health care providers struggle with office organization and results are sometimes overlooked. In addition, as a patient navigates the health care system, providers do not always "talk to each other". Bringing your medical records with test results allows specialists to gain a better understanding of where the patient is at in the diagnosis and treatment process.
- Offer custom information to patients on their condition that encompasses any special con-

cerns that should be addressed because of lifestyle choices or family history.

- Focus on quality care by providing the patient the knowledge, care and thoughtfulness that only a person with a background in medicine and experience navigating the system can bring. It is like having your own personal nurse to describe your condition and treatment options with the inside track on what is thought to be the most successful treatment approaches.
- Provide patients with insider knowledge of the best health care provider to use when managing a serious health condition. Advocates can often expedite the treatment with a quality provider because of their connections.

When employers ask employees to become more involved in their health, employees struggle. It is not an area that many feel comfortable making decisions; most patients will simply defer to their physician when making treatment choices. An advocate is an independent source, it is important they do not have ties to your health plan or the health care provider. A good advocate represents the best interest of the patient.

Some common services advocate organizations provide include:

- Tailored, reliable health information on health risks or medical conditions.
- Information on providers that specialize in specific areas that may result in optimal treatment.

TREND TIDBITS

Health plan cost increases are expected to be slightly higher in 2008. Buck Consultants projects the following trend for these plan types in 2008 (before any employer plan changes):

- \$ Preferred Provider Organization (PPO) - 10.75%
- \$ Point-of-Service (POS) - 10.54%
- \$ Health Maintenance Organization (HMO) - 11.14%
- \$ High Deductible Consumer Driven Health Plan - 10.36%

According to Mercer, employers have managed to lower increases to a little over 6% with plan changes over the last three years.

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Health Advocates: A Cost Control Strategy on the Cutting Edge cont.

- If a diagnosis is rare, information on the physicians and hospitals that specialize treating the condition, even if the providers are located in another state.
- Assure a patient that the recommended tests are necessary to the diagnostic process.
- Facilitate more productive discussions between a provider and a patient by taking the time to evaluate options and discuss potential risks and outcomes.
- Provide assistance with insurance carriers and help troubleshoot and resolve claim disputes.

Advocate service programs are attracting the attention of employers. These organizations can remove many of the barriers a typical patient may encounter while trying to secure appropriate and effective care. The ultimate goal is to help patients identify the right provider, for the right diagnosis and the right treatment. In the long run, this could result in a much more efficient delivery of health care. If the advocate can steer the care in the right direction, the employer's plan is not stuck paying for various specialists and diagnostic tests that are

common when patients are not sure what their symptoms may indicate.

In addition, advocates increase the value of your health plan. The lowest cost provider or treatment may be appealing at first. However, if that provider handles the treatment poorly or the lowest cost treatment does not help the patient, the treatment provided still costs money but it has offered no value to the patient. Value is an important goal of advocates.

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YOUR QUESTIONS

- Q.** We offered an employee whose coverage terminated due to loss of employment the opportunity to elect COBRA. He was hospitalized the day after employment terminated. He indicated on the 55th day of his election period that he wanted to elect COBRA but only for the month immediately following his termination (to cover his hospital stay). Does our plan need to allow him to elect COBRA for only one month?
- A.** Your question is somewhat complicated. Your plan has to allow the employee the ability to elect COBRA continuation coverage. Since he indicated well within his election period that he would like to elect continuation coverage, your organization needs to allow the COBRA election. However, the first required payment is the issue that needs to be addressed.

COBRA discusses payment requirements in two terms: the initial payment and subsequent payments. The initial payment is determined by the date the employee elects continuation coverage. The initial payment is the amount of premium that brings the employee's paid coverage up-to-date. In order to better understand the question, we need to use more detail:

- Assumed coverage and job termination date: January 15th
- Election notice sent: January 20th
- COBRA election date: March 15th
- COBRA initial payment due: April 29th

If the former employee did not include payment in the March 15th election notice, you would calculate the amount of premium needed to bring the coverage paid to date. In this case, it could be up to two and half months of premium. If the former employee only paid one month of premium, that would be an insufficient payment. You would need to notify the employee of the additional amount due and follow the COBRA regulations regarding when an insufficient payment is submitted. If the employee fails to pay the amount needed in the initial payment, your organization is not required to reinstate coverage. Your organization must allow all the time COBRA requires for the payment amount to be corrected and paid. If the employee fails to follow through and you choose not to reinstate coverage, make sure your organization returns the insufficient COBRA premium.

Short Term Disability: ERISA Benefit or Payroll Practice?

Only a small percent of employers extend patient advocacy services to employees today. Interest is certainly growing. If your organization is evaluating a patient advocacy program, some important factors to review include:

- **Organization ownership and history:** Many of the organizations offering advocate services may be affiliated with your health plan or local hospital system. Your organization wants to make sure your advocate service operates in the best interest of your employees. If the organization shares common ownership with your health plan, the advocate may be serving two masters - the health plan and the patient. Independent ownership and a history of providing independent advocates services are important.
- **Detailed services:** The type of services advocates offer can vary widely. It is important to secure a detailed description of the services provided. Will services be provided tele-

phonically only? Will the advocate accompany the patient to an important doctor's visit if necessary? Does the organization provide a base level of services for a monthly fee and charge extra for services that fall outside the basic program?

- **Staff competencies:** How is the service model built? What are the educational requirements needed to become an advocate? What is the actual work experience of the individuals staffing the advocate position (do they have real experience in the provider community)?
- **Resources available:** What resources does the organization subscribe to that advocates use to help patients? Medical resources should be available to the advocates from various reputable resources. Ask specifically what measures are used to determine provider quality.

It is important to carefully review and understand the services provided by the patient advocate. This service will be very important to employees when they are most vulnerable, battling a

serious health condition. Check references on these organizations before making your final decision.

Most employers know there is no one solution to controlling health plan costs. The leading strategies employers are embracing are consumerism and wellness. Patient advocate service can provide a nice added benefit when consumerism is a key strategy. It provides a needed resource to help patients make the best treatment decisions. These services can also complement wellness programs as well. Ultimately patient advocates can drive home the importance of maintaining the best health when battling difficult health challenges.

More employers are reviewing patient advocacy services and trying to determine if they will fit in their current health care cost control mindset and if they fit in their corporate culture. **MW**

Short Term Disability: ERISA Benefit or Payroll Practice?

Most employers, 84% according to the *McGraw Wentworth Southeast Michigan Mid-Market Benefits Survey*, offer short term disability benefits to their employees. Many assume the short term disability plan is subject to ERISA (Employee Retirement Income Security Act). However, in many cases, these plans are not considered ERISA plans. It may seem like an unimportant point, but it is important to understand if your plan is subject to ERISA to make sure your organization is meeting the requirements under ERISA and to understand which courts may handle disputes relating to the benefit.

DID YOU KNOW?

- 3 out of 10 workers entering the workforce today will become disabled at some point before retiring.
- A disabling accident occurs every two seconds in the United States.
- The average length of a disability is 2.5 years.
- Over 90% of disabling accidents and illnesses are not work-related.
- 9 out of 10 workers grossly underestimate their chances of becoming disabled.

Source: *The Council for Disability Awareness, 2008*

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Short Term Disability: ERISA Benefit or Payroll Practice? cont.

Some employer benefits that might technically fit the definition of an employer provided welfare benefit are specifically excepted by the Department of Labor (DOL) for ERISA compliance. The DOL has an established safe harbor for “payroll practices”. In many cases, short term disability benefits provided by employers are considered payroll practices and exempt from ERISA.

When is a short term disability plan an ERISA plan or simply a “payroll practice”? If your short term disability plan is a fully insured plan, the plan is considered an ERISA benefit. Therefore, your organization will need to meet all the communication and reporting requirements of ERISA.

If your plan is self-funded, there is a good chance the plan is considered a payroll practice, but it really depends upon some of your plan specifics:

- **How are benefits paid?** If the short term disability or salary continuation benefits are unfunded and paid from an employer’s general assets, it will likely be considered a payroll practice.
- **What if our plan only pays 60% of weekly income up to a maximum of \$1,000 per week?** The amount of the benefit is not taken into account when determining ERISA status. Your plan could provide 100% salary continuation or a percent of salary when the individual is unable to work due to illness or injury, it would still be considered a payroll practice. The safe harbor allows for the payment of normal compensation or less than normal compensation. The safe harbor requires the benefit plan be unfunded.

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Technical Corner - Personal Medical Records

Many health insurance carriers and administrators have robust tools associated with their websites. These tools, in many cases, have improved dramatically over the last two years. Have you checked out your vendor’s site recently?

If not, set some time aside to look what information is available. Many carriers allow members to set up personalized accounts that provide a wealth of information to help them manage their records and their health. Some common features include:

- **Personal health record** – this allows the employee to document care received and health history. Keeping track of treatments, medications, supplements, and so on is all very important. Having this information accessible with print capabilities means a patient can bring a health history to various physician visits. Providing a complete and accurate health history is very important if you need to visit a new specialist. If you fail to mention a prescription medication you are taking or a supplement, this may impact the physician’s prescribed treatment.
- **Online Explanation of Benefit Letters:** Typically, these personalized sites have access to claims payments and histories. This reduces the time an employee may spend searching for the information. It is also helpful in providing documentation in applying for reimbursements from a flexible spending account or maintaining tax proof for HSA distributions. In some cases, members can have online chats with claim representatives to ask about a claim that does not make sense.

- **Health Risk Assessments:** Most carriers now offer the ability for a member to take an online Health Risk Assessment to evaluate their current health status and provide suggestions to improve problem areas.
- **Custom Content:** Some carriers allow members to indicate topics that are of interest, such as heart health or diabetes management and then posts articles of interest on that member’s site.
- **Treatment Reminders:** Many sites will also offer reminders on the member page to get recommended preventive exams for the individual’s age. For example, the reminder may be for a pap smear, a PSA or mammogram.

Encouraging your employees to set up their site will help de-mystify some of the complexities related to health plans. In addition, it is an interactive tool that will help the member become more involved in their health.

And think of the time you will save if employees access EOBs online and chat with customer service representatives online without calling you! **MW**

Short Term Disability: ERISA Benefit or Payroll Practice? cont.

- **What if our plan uses a disability carrier to determine if the claim should be paid?** One of the key factors for ERISA determination is how the benefits are funded. If the disability carrier handles the claims determination and simply notifies your organization that benefits should be paid, that does not create an ERISA obligation. As long as benefits are paid from the employer's general assets, the fact a disability carrier does claim determination has no impact.
- **What if our plan administrator requires us to prefund an account and the vendor cuts benefit checks out of that account?** This arrangement *does* change the safe harbor consideration. At the point funds are transferred to a separate account and assets are held in that account for the purpose of paying plan benefits, your organization has created a "funded" plan. A funded plan would not qualify for the safe harbor and would be subject to ERISA.

- **What if the plan makes payments to former employees?** When an employer's plan pays benefits to former employees, this creates an ERISA plan. This provision is often overlooked and speaks to how long benefits are paid by the plan and at what point your organization formerly terminates employment. If your short term disability plan pays benefits for two years but after 12 weeks the employee is terminated and is still eligible to receive the disability benefit, your plan is considered an ERISA welfare plan.
- **What if our documents refer to the short term disability plan as an ERISA plan?** This question depends on the prevailing opinion in your court system. Merely stating the plan is an ERISA plan in many cases has not created an ERISA plan. But if you include all the short term disability information in your plan document and include it in your 5500 filing, your plan may be considered an ERISA plan. It depends mostly on the factors described above, merely referring to it as an ERISA plan is not enough to pull it into ERISA compliance.

If you are not sure if your plan is an ERISA plan or simply a payroll practice, you should consult an attorney. It is important if your plan is simply a payroll practice that you withdraw any reference to ERISA in your communications and ERISA reporting.

The ERISA determination is also an important factor in how disputes are resolved under the plan. ERISA sets forth claim determination and appeal guidelines and rules. Disputes regarding ERISA plans are handled by the Federal court system.

If your plan is determined to be a payroll practice, it makes sense to document the plan rules and how the claim process will be handled, but you are not required to follow the ERISA rules. In addition, state courts typically handle disputes regarding payroll practices.

Your organization should review your short term disability benefit plan to determine if it qualifies as a payroll practice or ERISA benefit. **MW**

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