BENEFIT
Plan Developments

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Private Industry Paid $6.43/Hour In Average Benefits

The average cost for employee compensation in private industry and state and local governments averaged $24.59 per hour during the final month of 2003, according to a report issued by the Bureau of Labor Statistics of the U.S. Department of Labor.

According to the report, wages and salaries averaged $17.56 per hour and accounted for more than 71% of the compensation cost, while benefits, which averaged $7.03 per hour, accounted for nearly 29% of the hourly cost. Meanwhile, 8% of all benefit costs ($1.96) were earmarked for legally required benefits, such as Social Security, Medicare, unemployment insurance, and workers compensation. Employee costs for paid leave benefits averaged 6.7% ($1.65); life, health, and disability insurance benefits averaged 7.6% ($1.88); and retirement and savings benefits averaged 3.7% (90 cents).

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For private industry alone, compensation costs averaged $22.92 per hour, with wages and salaries accounting for nearly 72% ($16.49) and benefits averaging about 28% ($6.43). Employer costs in private industry for insurance benefits averaged $1.62 per hour (7.1%); paid leave $1.48 (6.5%); retirement and savings 70 cents (3.1%); supplemental pay 64 cents (2.8%); and legally required benefits $1.96 (8.6%).

Meanwhile, total compensation for state and local government workers was $33.91, with benefits accounted for 30.5% of total compensation, or $10.35 per hour, while costs for insurance benefits averaged $3.39 per hour, or 10% of total compensation. The largest component of insurance costs for government employees was health insurance, which averaged $3.26 per hour.

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82% of the health plans surveyed received a D or an F.

Health Insurers Told To Be More Informative

Health insurance companies are being encouraged by New York State Attorney General Eliot Spitzer to reveal to their policyholders which medical procedures are considered to be medically necessary.

In anonymously surveying some of the nation's largest insurance companies, Attorney General Spitzer discovered that they had been withholding such information from patients. Spitzer said he has notified the insurance companies to begin living up to statutory mandates. If not, the attorney general said prosecutors would "do what we need to do."

The attorney general's office, which has been in the forefront of investigating abusive mutual fund trading practices, surveyed the insurance companies by sending them letters from hypothetical customers seeking information about coverage. Each insurer received five letters inquiring about coverage for five different medical treatments: insulin pumps for diabetics, surgery for Crohn's disease, arthroscopic knee surgery, enteral formulas for people unable to swallow, and breast reduction surgery. Those medical conditions were selected because they involved procedures that typically can be performed only after they are declared medically necessary using objective criteria.

In gathering survey results, Spitzer found that several letters went unanswered by the health plans, while others provided inadequate or incomplete responses. In grading responses on a scale of A–F, the attorney general's office gave 18 of 22 health plans surveyed either a D or an F.

LTD Benefits Denied Due To 'Substantial Evidence'

Based on "substantial evidence" and its discretionary authority to determine a participant's eligibility, an insurance company's decision to terminate a beneficiary's **long-term disability (LTD) benefits** was reasonable, according to a ruling by the Eighth Circuit U.S. Court of Appeals.

In issuing the ruling *(McGee v. Reliance Standard Life Insurance Co., No. 03-2372EM),* the appeals court overturned an earlier decision by the U.S. District Court for the Eastern District of Missouri, which had concluded that termination of the LTD benefits had been arbitrary and capricious. Not so, said the appeals court after a review of the records.

Robert C. McGee, who was an employee of Hasco International, Inc., filed a claim in December 1999 seeking short-term disability benefits. He stated he was unable to work because of major affective disorder, anxiety, and various physical pains. Reliance Standard, Hasco's insurer, granted the short-term benefits from December 1999 to March 2000. In March 2000, McGee sought long-term benefits based on the same disabilities. Although it initially approved the LTD benefits, Reliance Standard eventually determined McGee should have returned to work by June 1, 2000, based on medical records provided by physicians and a psychologist.

Reliance Standard ultimately hired a psychiatrist to review McGee's medical records. In a letter to Reliance Standard, the psychiatrist wrote: "The records do not substantiate that Mr. McGee has a significant psychi-

atric impairment that would interfere with his ability to function in a work setting." In the end, the psychiatrist concluded McGee was not disabled, leading Reliance Standard to terminate his LTD benefits.

After the district court found in favor of McGee, Reliance Standard appealed to the circuit court of appeals, arguing that its decision was based on substantial evidence, including inconsistent medical records from McGee's caregivers. The district court, Reliance Standard said, had erred in its review of the evidence by substituting its own judgment for that of Reliance Standard.

Under the deferential standard of review accorded to a plan administrator's denial of benefits, the court of appeals concluded that Reliance Standard's decision was reasonable and it reversed the district court's judgment.

High Court Ruling Expected On HMO Courtroom Venue

The U.S. Supreme Court has agreed to hear arguments as to whether suits brought against a **health maintenance organization (HMO)** can be brought in a state court system or a federal one. Which courtroom venue is selected can have major financial consequences because a state court can award high amounts of punitive damages, whereas, in a federal court, participants would be limited to the value of the benefit denied by an HMO.

Two cases involving patients' rights will set the stage for the high court ruling. Both cases coming before the high court are from Texas. One involves an Aetna Health plan participant who was required to use a cheaper alternative to the painkiller Vioxx, which his physician had prescribed for arthritis. The patient alleges that the cheaper drug caused him to have bleeding ulcers and suffer a near heart attack. The second case involves a Cigna Healthcare plan participant who had a hysterectomy and claimed she was forced to leave the hospital after one day of recovery—despite a doctor's recommendation that she have a longer hospital recovery period.

The cases are *Aetna Health Inc. v. Davilla (02-1845)* and *Cigna Healthcare of Texas v. Calad (03-83)*.

Both cases were filed under a 1997 Texas law allowing patients to sue HMOs. They were then transferred to federal court after the insurers said the plaintiffs should have contested the refusal of their claims under the **Employee Retirement Income Security Act (ERISA)**. In 2002, a federal appeals court ruled HMOs could be sued in state court for malpractice and Aetna and Cigna then appealed to the supreme court.

Disproportionate Impact Ruling Is Expected

A case to determine if the **Age Discrimination in Employment Act (ADEA)** permits lawsuits on the grounds that an employer's action had a "disproportionate impact" on its older workers, will be heard by the U.S. Supreme Court next fall. A similar suit has already been settled by the high court, allowing "disproportionate impact" under the Civil Rights Act.

The case involves police officers in Jackson, Mississippi who are over

High court to rule on venue for HMO suits.

age 40. The officers sued the city over a pay plan they said gave larger increases to city employees under age 40 and, thus, caused them a disproportionate amount of harm.

In bringing the case before the U.S. Supreme Court, Attorney Thomas Goldstein, who is representing the police officers, said statutes across the country are not unified. As a result, Goldstein said some older workers receive federal protections against "disproportionate impact" while others do not.

Legislative Action

Women's Health

The Pregnancy and Trauma Care Access Protection Act of 2004 has been introduced by Sen. Judd Gregg, R-NH. The proposed legislation (S. 2207) is intended to improve women's access to health care services and provide access for all individuals to emergency and trauma care services. S. 2207 would encourage the speedy resolution of claims to "reduce the excessive burden the liability system places on the delivery of such services."

National Program

The Universal Access to Affordable Insurance for all Americans Act of 2004 has been introduced by Sen. Barbara Boxer, D-CA. The proposed legislation would establish a national health care program administered by the Office of Personnel Management (OPM) to offer federal health care plans to individuals who are not federal employees. The bill, S. 2161, has been referred to the Senate Finance Committee. S. 2161 would direct the OPM to enter into a contract in each calendar year with one or more carriers to make available to eligible individuals one or more federal health care plans. An "eligible individual" would be defined as any nonfederal employee who is younger than age 65, not enrolled or eligible to enroll for coverage under a public health insurance program, and not a member of the uniformed services.

Drug Imports

A bipartisan group of senators has introduced a bill that would allow re-importation of lower-cost prescription drugs—that have been approved by the Food and Drug Administration (FDA)—from other industrialized countries. Under the proposed legislation, pharmacists, drug wholesalers, and qualifying individuals could import FDA-approved drugs if they are packaged and shipped using counterfeit-resistant technologies approved by the Bureau of Engraving and Printing.

'Family Friendly'

Rep. Lynn Woolsey, D-CA, has introduced the Family and Workplace Balancing Act of 2004 (H.R. 3780). The proposed bill, which has 20 co-sponsors, is intended to encourage the establishment of "family-friendly" workplaces.

H.R. 3780 proposes to establish a program to support the states in providing partial or full wage replacement to new parents. It would authorize the Secretary of Health and Human Services to make grants to states or political subdivisions to pay part of the cost of wage replacements for employees with caregiving needs resulting from the birth or adoption of a child, or other family caregiving needs. The bill would also amend the Family and Medical Leave Act (FMLA) by providing additional leave for "parental involvement."

H.R. 3780 encourages "family-friendly" workplaces.