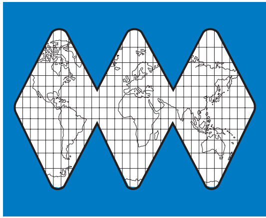

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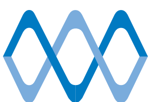

1998 Legislative Outlook

by Adrien R. LaBombarde, A.S.A., and Marjorie N. Taylor

New employee benefits legislation emerging through the remainder of the century will be conceived in a very rare environment: a balanced federal budget. Since before enactment of the Employee Retirement Income Security Act of 1974 (ERISA), the federal government has been running budget deficits, with broad and deep influences on all social and economic policy. For pensions, healthcare coverage, and other employee benefit plans, the effect has frequently been negative, with many unwelcome provisions enacted almost entirely because they would bring money into the federal treasury while more worthy provisions were left untended because they could not "pay their way."

Of course, the deficit-era budgetary controls will continue to be enforced. Now able to afford a longer-term vision, however, policymakers will be more open to ideas for expanding pension coverage and improving the opportunities available to employers and employees. At the same time, expect a greater emphasis on expanding participant "rights and protections" to closely accompany any new incentives for sponsorship of employee benefit programs.

Legislative initiatives leftover from last year may need to be retooled to adapt to budgetary freedom, and newly emerging proposals have yet to fully recognize the new game in town. Still, just as the budget deficit was the most influential force in benefits policy during the past three decades, the budget surplus clearly will be the most consequential theme behind benefits developments through the year 2000.

Healthcare Initiatives

Coming before Congress with the most momentum is a healthcare reform bill introduced last year, the Patient Access to Responsible Care Act (H.R.1415/S.644). Already, PARCA has gained broad bipartisan support in the House, with more than half of the representatives signed on as cosponsors of the measure. Numerous other proposals impose various new mandates on health benefit plans or restrict managed care arrangements, but PARCA is particularly troublesome because of its comprehensive scope and potential cost. M&R's actuarial analysis of H.R.1415 as introduced estimates that, if it is enacted, health care premiums could increase by 7% and if some provisions are interpreted in a broad and far-reaching fashion, by as much as 39%.

One PARCA provision generating a great deal of concern among employers would grant health care plan participants the right to file a medical malpractice claim under state law against "any person" who provides insurance or administrative services to an employer-sponsored plan if a plan decision results in injury or death. PARCA's sponsor, Rep. Charles Norwood (R-GA), attempted to respond to employers' concern over this provision by proposing an amendment (H.R.2960), but this "fix" would permit such suits if the employer exercised "discretionary authority to review and make decisions on claims for plan benefits." Any possible good intentions in this provision are quickly lost in the far-reaching negative implications of the huge potential increase in plan liability—even for plans not involved in abusive practices—and in the replacement of ERISA uniformity with the complicated patchwork of different rules for different states.

PARCA and other pending legislative initiatives also include new requirements that would affect plan participants' access to services and choice of providers, plans' information disclosures, grievance and appeals procedures, and the confidentiality of patient information. Congress also could tackle other incremental health reform bills that would mandate minimum lengths of stay or benefit coverage for mastectomy procedures or impose high ($5 million or more) or no lifetime limits on coverage. Additional attention could be paid to children's health issues.

While Congress grapples with health bills, efforts are underway to shape aspects of the healthcare marketplace through regulatory channels, with some likelihood of follow-up legislation. For example, the President's Advisory Commission on Consumer Protection and Quality in the Health

Care Industry's final report recommendations were released in March. The commission's "bill of rights"—covering access to information, choice of providers and health plans, access to emergency care services, participation in treatment decisions, nondiscrimination, confidentiality of information, and grievance and appeals procedures—is being translated into a legislative proposal.

Finessing the legislative initiative, the President has directed all federal health programs to comply with the patients' bill of rights by the end of 1999. Already, federal agencies are reviewing ways to implement the President's directive. The Department of Labor has announced its intention to propose amendments to ERISA regulations, including:

- a requirement that plans resolve claims decisions within 72 hours for urgent care and 15 days for nonurgent care and that plans consult qualified medical professionals;
- a requirement that summary plan descriptions include clear and understandable information on coverage of out-of-network services, conditions for access to specialty medical care, and preauthorization and utilization review procedures; and
- a clarification along the lines of a recent Advisory Opinion letter that plan fiduciaries have a duty to take into account quality when selecting healthcare service providers and are at liberty to consider issues such as the scope of choices and qualifications of medical providers and enrollee satisfaction statistics.

Pensions and Other Retirement Programs

Employers can expect Congress to tinker with pension issues rather than make wholesale changes to the private retirement system. Much of the focus will remain on the perennial quest to find a plan design and other incentives—such as a tax credit for start-up costs—that might encourage greater pension sponsorship among small employers.

Ideas being advanced by the Administration and in various congressional proposals include:

- accelerated vesting schedules for 401(k) employer matching contributions: three years for cliff vesting, and six years for graded vesting;
- more simplification of pension qualification rules, including further streamlining of the definition of highly compensated employees;
- allowing older workers to contribute more under salary reduction arrangements;
- new pension notification and disclosure requirements, including renewed efforts to require spousal notification for transactions under 401(k) plans; and
- new rules for audits of pension plans.

New legislative ideas can also be expected to emerge from a pension bill enacted in 1997: the Savings Are Vital to Everyone's Retirement Act (SAVER). The SAVER Act was designed to encourage greater retirement savings by launching a public relations campaign and convening a national retirement savings summit every four years. The first summit, scheduled for midsummer, will focus on public education and develop specific recommended actions to be taken by the public and private sectors to promote retirement savings. Although it could take some years to see any broad, long-term policy changes emerging from the SAVER Act efforts, expect to see Congress use the high profile of the summit to unveil incremental pieces of legislation before the 1998 election break.

Social Security and Medicare

The influence of a federal budget surplus will be most evident in the looming debate over the future of Social Security and Medicare. Both programs will come under microscopic scrutiny by congressional commissions this year, probably yielding a bumper crop of ideas— some of them familiar from previous Congresses—but with little likelihood of any major action anytime during the remainder of the Clinton term.

President Clinton has framed the Social Security debate with his vow to first use the surplus to "save" the system before considering tax breaks or new programs. Although he has his supporters, Congress might take the opportunity presented by the easing of the budget to give more serious consideration to a complete overhaul of the system, such as that suggested by Sens. Daniel P. Moynihan (D-NY) and Bob Kerry (D-NE), as part of the effort to save it.

There is growing interest by some key members of Congress to consider individual account plans as a solution to the problems facing Social Security. Following a recent two-year study of the system by the Social Security Advisory Council, not one of the three proposals made garnered majority support from the 13-member panel. But five members did recommend a "Personal Security Account" (PSA) option. This plan would change the Social Security system from the current one in which each worker receives a guaranteed lifetime benefit with automatic cost-of-living increases to a new system in which each worker would have an individual account. PSAs would be created by a reallocation of a portion of the current payroll tax, coupled with decreases in the benefits provided under the main system. Most recently, Senate Finance Committee Chairman William V. Roth, Jr. (R-DE) announced his similar proposal, which would use the federal budget surplus to fund individual Social Security accounts.

The Administration also has its eyes on Medicare, but more as a program to expand health care coverage to certain groups of individuals than as a program in dire need of a fix. On the White House agenda is a proposal (S.1789/H.R.3470) to expand health care coverage by allowing retirees aged 62 through 64 to purchase Medicare coverage. Those who are "displaced workers" could buy into Medicare at age 55. Retirees over age 55 whose

employers drop retiree health coverage would be permitted to elect COBRA continuation coverage through age 65. If enacted, these changes could influence the design of employer-sponsored retiree health plans, which have traditionally had to carry the full healthcare load until workers become eligible for Medicare.

Incremental adjustments to both Social Security and Medicare have been attempted and could be retried this year, whether or not a more comprehensive reform package emerges. For example, considerable interest has been shown in accelerating the change in eligibility age for Social Security to 67 over fewer years than current law provides. And only last year the Senate approved a bill containing a provision (dropped in final negotiations with the House) to adopt an income-related test for Medicare Part B premiums.

Tax Reform and Beyond

So, what became of the flat tax campaign that seemed to have so much momentum when the second Clinton term began? The effort to reform and simplify the tax system or replace the income tax with a consumption tax is far from dead. And given the extreme changes—from the financial incentives to the technical requirements to the practical day-to-day operation—that would be brought to employee benefit programs by a flat tax system, employers and employees alike should remain alert to the emerging congressional debate on the issue. But election speeches aside, don't expect to see the Internal Revenue Code abolished before the polls open this November.

This being an election year, the legislative session will be short as members of Congress who are up for reelection head home to campaign. There are few priority and "must pass" bills to work on, and still fewer containing benefits-related provisions. Besides completing the required federal government appropriations and spending proposals, House and Senate leaders would like to complete IRS restructuring and highway/transportation legislation. The Republican Congress would like to use the federal budget surplus to boost its efforts to pass tax relief. Besides the benefits issues already mentioned, items that could be picked up in a tax relief bill include education, child care, capital gains, and taxes for the unemployment system, any of which could have implications for employers' compensation programs.

For updates on benefits-related legislative action throughout the year, see:

http://www.milliman.com/pension/research/

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When Pension Investigators Come Knocking

by Gerald E. Cole, LL.B.

Pension plan sponsors increasingly are facing a new breed of claimants—the "pension investigator" who comes knocking at the door on behalf of participants who believe their benefits have not been correctly calculated. These pension sleuths attempt to dig up anything and everything they can from the employer. What can employers do to protect their pension plans from meddling and from disruptive claims? What should employers do when an investigator shows up with authorization from a plan participant demanding all pension records and documents?

This article focuses on the steps an employer can take to ensure that its benefits determination process is sound and explains what an employer should do if a pension investigator comes knocking.

An Ounce of Prevention…

The single most important thing for a pension plan sponsor can do is make sure the plan is properly drafted and that the benefits determination process follows the language of the plan. There are many instances in recent years where, as a result of changes in the law and in the plan, a plan's benefits determination process has become out of date. For example, a plan may have:

- failed to use the current interest rate to determine early retirement benefits or lump-sum cash-out amounts;
- used an interest rate that, when applied to prior accruals, violates the rule prohibiting plans from reducing earned benefits;
- changed the timing and calculation of gains and losses for individual account plans in the plan document without making the corresponding changes in accounting procedures; or
- incorrectly applied the limit on benefits for a defined benefit plan under Internal Revenue Code Section 415.

An employer can take steps to keep its determination process up to date. Every plan should have a manual describing in detail the steps used to determine a participant's benefit. The plan sponsor should also establish procedures to ensure that plan participants receive all required notices about the plan. Performing an audit of plan procedures can be very valuable; it will reveal whether all relevant records are consulted and whether the formulas used to determine benefits accurately reflect the current plan document. As part of the audit process, an employer can have its staff determine the retirement benefits of a few randomly selected participants and then have the results checked by a knowledgeable professional. Or the entire process can be given a complete administrative audit by the benefit plan consultants.

With these practices in place, there is still no guarantee that something will not be overlooked when determining a given participant's benefit. Retirement plans are often complex, as are employment patterns. Mistakes will and do occur, and a plan sponsor should act quickly to investigate any complaints and to correct any errors.

In nearly all cases, errors uncovered will be operational in nature; that is, the plan is not being operated in accordance with its written terms. Most errors do not stem from a failure of the plan documents to comply with legal requirements. Fortunately, the Internal Revenue Service has made it clear that employers have up to two years to discover and correct operational errors, no matter how serious, and an unlimited period of time to correct minor and isolated mistakes, provided that the plan has established procedures for its administration.

Showdown

Regardless of how careful an employer is, a time may well come when a letter from a pension investigator arrives announcing that it represents a named participant and is requesting all plan documents and records on which the participant's benefit is based. Do not ignore the letter. Participants have the right to all documents related to the plan and may appoint a representative to make such a request. In cases where a participant's representative requests the information, however, the plan need only furnish the materials if the participant has given the representative written authorization to make the request on his or her behalf.

The Employee Retirement Income Security Act (ERISA) requires employers to provide the requested information within 30 days or be subject to a penalty of up to $100 per day for noncompliance. Courts have the discretion not to impose the penalty and will decline to do so if there is no indication of bad faith or prejudice. In this regard, simply ignoring the request can constitute bad faith. Courts have also awarded attorney's fees to plaintiffs who are forced to sue to get requested information.

Even if plan administrators believe that the request is overly broad, they should respond in writing within 30 days, furnish whatever information they believe is appropriate, and state the reasons for not furnishing other

Mining for Gold

Pension plan participants increasingly are becoming the target of firms engaged in pension investigative work. These emerging firms attempt to get retirees to challenge the benefit plan calculations, claiming that companies large and small frequently determine benefits incorrectly. The firms say they will look into the benefits on behalf of a participant, and, if mistakes are uncovered to the participant's detriment, they will recover the amount for a cut of the additional monies. In some cases, reduced rates are offered for groups of participants in the same pension plan.

Pension inspection firms cite a number of problems that can lead to benefit miscalculations, ranging from fiduciary violations to recordkeeping errors. Problems with software, use of the wrong actuarial factors, application of the wrong plan provisions, and vesting violations also create wrong determinations.

The message from these firms is simple: Call us for help, because there is a good chance that you are being robbed of your rightful pension.

Meanwhile, the Clinton Administration is supporting increased pension benefits disclosure. Included in the President's budget proposal for fiscal year 1999 are several pension "right to know" provisions, such as a requirement that employers give defined benefits plan participants a statement every three years that shows what their benefits would be if they terminated as of the date of the statement. For defined contribution plan participants, these benefits statements would have to be provided annually.

requested materials. Some requests will be for the worksheets used to calculate the participant's benefit. These should be disclosed.

Sometimes a request for information will go beyond a particular participant's benefits and include a request for information on all participants or similarly situated participants. Such a request is often an attempt to determine if there are grounds for a lawsuit against the plan sponsor on behalf of a broad class of participants. Such class action suits are particularly attractive to a plaintiff's lawyers because of the large fees that may be awarded to the prevailing party. An employer does not ordinarily have to comply with a request for information beyond that relating directly to the participant making the request. As the U.S. Court of Appeals for the Ninth Circuit observed in denying a request for the names and addresses of participants, "[W]e find nothing in ERISA suggesting that Congress intended to help plan participants amass a litigation war chest by soliciting donations from other plan participants and beneficiaries."

If the person making the request has written authorizations from other plan participants, the employer should consult with plan counsel to determine the extent, if any, to which disclosure is required.

No Fear

ERISA requires that plans maintain a full and fair claims review procedure. This means that the plan administrator (or responsible committee) must carefully review any claim for additional benefits and award those benefits if a mistake is discovered. Stonewalling in the face of a valid claim is the worst course of action, often leading to litigation and the award of attorneys' fees. If, however, after carefully reviewing the participant's claim, the plan administrator determines that it is without merit, the claim should be denied and a full explanation for the denial should be furnished to the participant.

A more difficult situation arises if the plan sponsor discovers that there has been a systemic mistake, such as using the wrong date for determining the interest rate, using the wrong actuarial tables, or applying the wrong plan provisions. In such a case, the employer should correct the mistake for the participant who has made the claim and determine whether the mistake affects other participants.

Correcting the mistake for all affected participants can be very burdensome and costly. Nonetheless, the plan must be administered in accordance with its documents, and a plan administrator will be violating its fiduciary duties if it fails to do so. Accordingly, it is almost always advisable to make the best possible effort to redress these errors. In some cases, it may be prudent to apply to the IRS's Voluntary Compliance Resolution Program, which can preserve the plan's qualified status without having heavy sanctions imposed.

Conclusion

Employers that sponsor a retirement plan should review and formally document their benefit determination procedures. An audit of the process can be helpful in pinpointing possible problem areas that need to be corrected. If a participant or his or her representative requests documents relating to the retirement benefits under the plan, an employer should respond appropriately and in a timely manner. Corrections to benefit calculations should also be

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Retention and Claim Costs:

A Look under the Hood of a Group Health Insurance Contract

by Albert E. Easton, F.S.A., and James C. Modaff, F.S.A.

For many employers, health benefit costs are a significant part of the total cost of doing business. A good understanding of what goes into these costs is essential to an efficient and competitive operation. Most employers with group health insurance contracts have watched costs climb steadily for as long as they have had the contract. Improvements in medical care have been a big factor in the rising costs, but other influences are at play as well.

The largest part of every health insurance premium pays the hospitals, doctors, and others who provide health services. Insurers call this part of the premium "claim costs." The remainder of the health insurance premium, called "retention," is used by the insurer for purposes other than claim costs, as described below. Some of the retention costs directly benefit the group contract holder, others benefit the covered individuals, and still others primarily benefit the insurer.

This article will explore health insurance retention and claim costs, describe the main reasons for retention, and suggest what factors might influence retention costs. Armed with such knowledge, employers that provide

health benefits under a group insurance contract will be able to assess—and thereby possibly reduce—their plan's overall costs. Employers interested in administrative costs should also examine the results of M&R's survey of self-funded plans (see "self-funded costs" article on page 8).

Retention Costs

A *pooling charge (or risk sharing cost)* is the amount the insurer charges to cover the possibility that claim costs will be higher than expected. If the insurer has done a good job of calculating the expected claim costs, one could argue, when claim costs are greater than expected, they will be covered by the savings made when claim costs are less than expected. Insurers will quickly point out, however, that in practice this doesn't always work because most health insurance is "experience rated." This means that employers with contracts that have good experience will expect a discounted rate the following year. Those with poor experience will expect a rate increase, but may elect to go to another insurer rather than pay the increased rate. Thus, the insurer really has no way to recover the excess claim costs for a losing year.

To avoid drastically increasing premiums for employers with contracts with poor experience (and to reduce the risk that they will go to another insurer), most insurers assess a pooling charge to cover the random fluctuations that can cause the claim costs to be higher than expected. Such a charge is especially common for smaller groups, when the chance of a random fluctuation is greater. The insurer usually requires that the group pay an annual charge in exchange for absorbing claim costs that exceed a percentage, such as 110% or 125% of the expected claim costs. Typical pooling charges as a percentage of expected claim costs might look like this:

Table 1

RISK SHARING COSTS

Typical Charges as a Percentage of Expected Claim Costs

Size of Group	Pooling Percentage	
	110%	125%
100 lives	10%	2.5%
1,000 lives	2.5%	0.5%
10,000 lives	1%	0.2%

Pooling charges that cover the risk of large claim costs for a single individual (for example, in excess of $50,000) are also common. Some contracts have both individual and aggregate pooling charges. Pooling charges help both the group contract holder, who is protected against unusually sharp premium increases, and the insurer, who is protected against the loss of business that would occur if it the contract holder decides not to renew as a result of a significant premium increase.

Network access fees are charges for the use of an insurer's "network" of health care providers. Most insurers have signed contracts with doctors, hospitals, and other providers under which the doctors and hospitals agree to accept fees that are lower than their usual and customary charges for services. Putting together and maintaining such a network is time-consuming and can be costly for the insurer; network access fees help the insurer recover its costs from network users. To get best value for the network cost, the contract holder looks for quality care in a network that offers the largest number of doctors and hospitals in the service area where most of the employees live, giving plan participants a broad choice. To help keep claim costs down, the contract holder also wants the largest possible discounts from the providers. With good discounts and a broad choice of providers, a network can reduce premiums substantially because claim costs will be reduced by much more than the amount that the network access fees add to the premium.

Case management charges are additional charges that allow a contract holder to access a case manager, who is skilled in medical procedures and outcomes and who pre-reviews expected high-cost procedures. Contracts using this feature usually have a penalty for high-cost procedures that are not pre-authorized. A well run case management operation works with doctors and hospitals to ensure that high-cost procedures are conducted in the most efficient way. Case management charges usually vary according to the number of lives covered or are a percentage of premiums. Good case management will always reduce premiums by more than the fee assessed for it.

Administrative charges are fees that support the cost of administering an insurer's business. These charges include claim administration charges and general administration costs (sometimes called "case charges"). The claim administration charges pay for the insurer's staff that reviews and pays claims. Because part of the claim payment function is to identify fraudulent claims while paying legitimate bills quickly and efficiently, the claim administration charges can return good value to the contract holder. Claim administration charges may vary by the number of covered lives or by the total amount of claims, but as a percentage of premiums they generally are not lower for larger groups.

Case charges, on the other hand, are usually lower as a percentage of premiums for larger groups. Typical expenses covered by case charges include printing and issuing contracts and certificate booklets, collecting premiums, preparing accounting materials, and general management costs. Because the first year of an insurance contract is usually the most competitive year, some insurers assess lower case charges in the first year, taking the loss as a general corporate charge that might be made up in later years' profits on the contract.

Commissions pay the insurance agent or broker for placing the insurance in force and for playing a part in ongoing administration and renewal. Usually, a higher commission is paid in the year that the insurance is first placed in force to compensate the agent for the extra effort required in that year. Almost without exception, commissions as a percentage of premium are lower on larger policies. Many insurance companies sometimes waive commissions and rely on the salaried staff to place and administer such policies. In such cases, the fees that would otherwise have been labeled "commissions" are charged as a part of the insurer's annual administrative charge.

Interest on the reserves represents, or should represent, a negative element in retention; that is, a reduction to the other charges. A typical reserve for a group health contract is about three months' premiums, and this reserve usually builds up quickly in the early months of the contract, while the lag time builds up between premium payment and the ultimate payment of hospital and doctors' bills. If the insurer is able to invest this money at 8%, interest on the reserves should offset other expenses at the level of about 2% of premiums each year. Many insurers do not specifically mention the interest component in any analysis of retention that they provide, but take it as an offset to profit or case charges.

Profit is the amount the insurer adds to its corporate income in addition to all the expense charges. Even "not-for-profit" insurers usually have to build up a reserve and use a charge similar to profit to do so. Most insurers do not indicate a special charge for profit in their retention analyses. Rather, such charges are included in general administrative costs or buried elsewhere. Many insurers obtain profit by failing to credit interest on the reserves. In some especially competitive situations, an insurer might take a reduced profit to obtain the contract. For this reason, profit on large groups is usually lower as a percentage of premium than profit on small groups.

Claim Costs

Claim costs almost always represent the largest part of health insurance premiums. But these costs, which pay health care providers, can be contained or reduced through the use of networks and case management. Benefit plan design changes in deductibles, coinsurance, and co-pays have been used for many years as a way to lower costs because they provide an incentive to covered individuals to keep costs down. Today many plans require individuals to pay more for higher-cost alternatives (e.g., higher co-pays on name brand drugs than on generic drugs). Plans also often "carve out" some benefits (e.g., experimental procedures) that the insurance will not pay for or will pay for at a lesser rate. Legal mandates in many states, however, limit the extent to which benefits can be eliminated.

Claim costs can vary widely as a result of factors beyond the control of the contract holder. Both the level of charges and the utilization of services are significantly affected by geographic area. The age, sex, relative health, and dependent status of the covered group also obviously have an effect.

Typical Costs

How do retention and claim costs components influence health insurance premiums? Here are some typical monthly premiums for an individual employee for two different sized groups, with the different elements of the premium broken out. The benefits provided are for full major medical, including prescription drugs. There is a $500 deductible and a 20% coinsurance on the first $5,000 of expenses after the deductible.

Table 2

TYPICAL MONTHLY COSTS
Per Individual Employee

	Size of Group	
Expense Category	100 lives	1,000 lives
Claim Costs	$140.12	$140.12
Pooling Charge	3.50	.70
Network Access Fee	2.75	2.75
Case Management Charge	2.25	2.25
Claim Administration Charges	7.01	7.01
Case Charges	6.30	4.30
Commissions	4.20	1.40
Interest	-2.80	-2.80
Profit	7.00	5.00
Total Monthly Premium	$170.33	$160.73

Conclusion

Many employers with health insurance contracts know the level of their claim costs, and all know their monthly premiums. Most insurers are willing to provide additional information on exactly what the retention costs cover. Knowing how retention costs break down can give an employer useful information that can be used to pursue lower premiums and reduce total benefit costs.

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Self-Funded Costs

M&R's Self-Funded Administration Cost Survey found that administration fees charged to employers for health care coverage varied widely but were generally lower in self-funded plans that covered larger groups of participants. The survey, conducted by M&R's Milwaukee office, asked for fees for six sample groups in an indemnity arrangement and the same six groups in a preferred provider organization (PPO).

The highest first-year per employee per month (PEPM) fee for standard administration services in 1998 was reported at $28.13 for a group with an indemnity plan and 250 employees. The lowest first-year PEPM fee for an indemnity plan was reported at $10.57 for a group with 15,000 employees.

For a PPO plan, the first-year PEPM fee for standard administration services ranged from a high of $26.35 for a group with 250 employees to a low of $13.57 for a group with 15,000 employees.

The following table shows the range of first-year PEPM fees reported by the nine major insurance companies and third-party administrators participating in the survey for standard administration services (by major category) for a PPO plan covering 1,000 employees.

First Year Self-Funded Administration PEPM Fees

PPO Plan 1,000 Employees
Effective January 1, 1998

Administration Services	High	Low
Ongoing Administration	$13.20	$6.84
Health Cost Management	4.14	.54
Marketing Expenses	6.90	0.00
Network Access Fees	5.34	1.65

The fees by major category varied significantly in surveyed companies. Because a participating company that had the lowest fee in one category might have the highest fee in another category, the total fees represent the best indication of the cost to an employer group.

Renewal year PEPM fees tended to be somewhat higher than first-year fees. On average, the renewal-year fees appeared to be 5% to 10% greater than first-year fees.

The survey also reviewed service standards for claim handling accuracy, claim financial accuracy, and claim turnaround time. Claim handling accuracy ranged from 95% to 99%, while claim financial accuracy standards ranged from 98% to 99%. Claim handling accuracy represents the percentage of claims on which all coding was correct; claim financial accuracy represents the percentage of claims on which all coding affecting the amount of payment was correct. The claim turnaround time ranged from 80% to 90% of claims processed within 10 working days.