

Benefits Briefs

FALL 2011

Important news and updates from your benefits professional

MyPOMCO – New Name. New Look. Same Great Online Benefits Access.

Recently POMCO Group conducted a survey on visitors to our online benefits website. The purpose of the survey was to gather information that would help us update and revise the site. Based upon those results we have made some changes to the website formerly know as BENEFITsoft.

BENEFITsoft is now MyPOMCO and along with the new name, there is a new look. The site has been updated to include a simpler navigation and to make finding the desired information easier. While there have been many changes to the look and feel, the access to benefit plan information remains the same. MyPOMCO will still provide the following information:

- Covered services under benefit plan
- Physicians and hospitals within the POMCO Group network
- Explanation of Benefits (EOB) statements
- Claim forms
- Email notifications on paid claims
- Temporary member identification cards
- Health and wellness website access

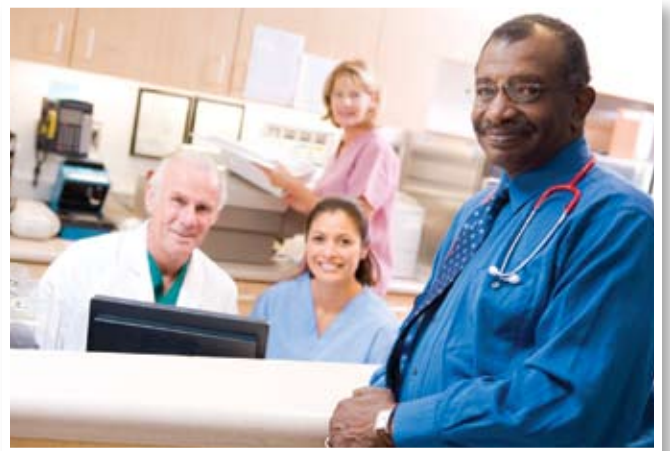
To view the updated site visit www.MyPOMCO.com. Please feel free to contact us directly with any suggestions or feedback you may have.

The Time May Be Right for Accountable Care Organizations

As we move further along the Health Care Reform Law (PPACA) timeline, much attention is being directed at provisions that created Accountable Care Organizations (ACOs). Since Health and Human Services (HHS) has issued final ACO regulations, we thought it might be helpful to consider how they might impact health benefit plans in the future.

HHS anticipates that this approach will result in fewer unnecessary services, fewer provider errors and ultimately, fewer costly Medicare hospital admissions. Groups of hospitals and providers are expected to join together to improve patient outcomes and participate with Medicare in any financial savings.

Many hospitals and provider groups are currently working together to form ACOs by 1/1/2012. While the interim final regulations, issued 3/31/11, have created a scenario where Medicare reimbursements will be substantially reduced by 1/1/2014, it's hard to understand how providers, mostly hospitals, will survive without participating in the ACO Shared Savings Program. It is also possible that after advancing the capital required to form an ACO, providers that experience some success may market their product directly to area employers. Some may form partnerships with insurers, but because 75% of ACO ownership must be provider based, others may consider offering partially self-funded plans by partnering with a qualified TPA. Only time will tell if this trend materializes.



A Flashback to Managed Care

If you're a veteran of the benefits administration industry, the ACO concept may remind you of HMOs that emerged from managed health care in the late 80s. Except for small pockets of the country, HMOs have failed as a delivery mechanism. Times are different today. Quality TPAs have long been active in health and chronic disease management. Participants are aware of the benefits of wellness and accustomed to plans that reward healthy behavior. Most private sector employers have finally realized that costs can be controlled by reducing claims and helping employees achieve a healthy lifestyle. These conditions may make this the perfect time for the ACO business model to succeed, if managed correctly. If an ACO can offer the lowest cost care in town, the need for PPOs may no longer exist and the ease of establishing a partially self-funded plan could cause it to become the most cost effective delivery mechanism. Time will tell.

Q&A

Bringing you answers to tough questions

Should FSAs be Freed From the 'Use-It or Lose-It' Rule?

While FSAs are still one of the most popular benefits offered by employers, having to exhaust the funds in these accounts at the end of every plan year to avoid losing them continues to be a big deterrent.

To remedy this, Senators Ben Cardin (D-Md) and Mike Enzi (R-Wyo) have introduced a bill (S. 1404) that would allow consumers to withdraw and pay taxes on any funds remaining in their Flexible Spending Account (FSA) at the end of each plan year. In addition to bipartisan support in the Senate, the bill has support on both sides of the aisle in the House.

This approach would help participants when out-of-pocket health care costs don't match their estimates for the year, since the 'Use-It or Lose-It' rule requires that any unused balance be forfeited to the employer. While Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs) provide for rollover to the next plan year, many argue that eliminating this restriction would help more workers because FSAs are so much more common than the other consumer directed options.

According to the bill's sponsors, the average FSA maintains an unused balance of \$100, amounting to nearly \$400 million in unused funds each year. A companion bill (H.R. 1004) was introduced in the House of Representatives, but has not advanced. If enacted, the provisions of either bill would apply to plan years beginning after December 31, 2012.

Any Company Can Walk for Wellness

With most employers paying at least a third more for employee health benefits than they did just five years ago, it has become obvious that the only way to slow this trend is to keep people healthy so that they stay out of the health care system.

In an effort to get people on a path to better health, more and more organizations are emphasizing the benefits of walking. Ease, convenience and little or no start-up cost make walking a great way to incorporate wellness and fitness into the workday. Here are a few things to think about if walking sounds good to you...

- In contrast to many wellness programs, walking can be voluntary, with support given to those who want to participate.
- You may want to think about holding weekly meetings to encourage participation, boost interest and help identify more ways to build more movement into everyone's day.
- Setting a goal, such as walking 10,000 steps a day, is very realistic when you consider that many people can walk at work, at home and in between.
- Depending on your facilities, people can walk



indoors and out. Hallways or a large training room can provide a viable option when it's cold or rainy outdoors.

- People can walk during their breaks and it just may add energy and clarity to team meetings or small group discussions.

One of the best reasons to consider walking for wellness is that a program can be maintained without spending a lot of money. Progress can be measured, incentives can be added and over time, conditions such as high blood pressure can often be brought under control. As office visits and the use of prescription drugs are reduced, future costly claims may be avoided. And that, after all, is the key to lowering costs.



TRENDS *Latest Happenings In Today's World*

Stop Loss Premiums to Rise

While trends can vary from region to region, some parts of the country are experiencing increases in the cost of stop loss insurance. Higher than normal stop loss claims are the cause for some, while others cite a market reaction to a prolonged period of low pricing as a reason for increasing premiums. Consultants say that competition for carriers can result in pricing below levels that

are actuarially required. When this model continues for a significant time, carriers reach a point where losses begin to accumulate. While some renewal increases are a direct response to higher claims experience, some may be imposed to help carriers return to a profitable level.

McDonald's Feels the Pressure

The food industry has been under a watchful eye as childhood obesity levels



have risen. In April, U.S. regulators proposed guidelines for foods that are marketed

to children; these foods must contain healthy items and limit sodium, sugar, fat and calories. In an effort to fend off more regulation of what foods children consume, McDonald's Corporation plans

Health Care Reform Update

The latest in health and medical news

SIIA to Fight Michigan Tax on Claims

The Self Insurance Institute of America (SIIA) submitted a letter to Michigan Governor Rick Snyder requesting that he veto proposed legislation imposing a 1% tax on medical claims paid by health plans.

The request is based on the fact that the proposed law violates ERISA preemption. In response to Governor Rick Snyder of Michigan, who says the legislation is needed to help balance the state's budget, SIIA said "while our attention has been largely focused at the federal level, we also have to be engaged at the state level. Any

state action that compromises ERISA preemption deserves our serious attention and response."

A similar one percent fee would have gone into effect in Oklahoma in late August, however the Oklahoma Supreme Court ruled it unconstitutional.

Some States Reject Exchange Funds

Earlier this year, when the Department of Health and Human Services appropriated nearly \$250 million to kick-start insurance exchanges in several states, it probably didn't expect some states to decline the offer.

That appears to be the case, as Oklahoma and Kansas have returned money and others, such as South Carolina, are weighing their options. The exchanges are intended to serve as open markets where uninsured individuals and small businesses can find competing insurance plans.

When asked about South Carolina's intentions, its Health and Human Services Director said it would continue to analyze its options, cautioning that many states have a habit of chasing any money that becomes available, rather than pursuing its visions and goals. January 1, 2013 is the deadline for states to submit detailed plans for exchanges. After that date, the U.S. Health and Human Services Department will build

them. Regardless of who runs the exchanges, they have to be operational by 2014.



Government to Foot More of the Reform Bill



The slow economic recovery is expected to reduce the growth rate of health spending as consumers continue to delay out-of-pocket medical expenditures. High unemployment is expected to continue, lowering the number of people covered by employer-sponsored plans and possibly causing some large employers with low-wage workers to stop offering coverage altogether.

In 2010, national health spending grew by a historic low of 3.9% as the federal government paid private insurers less to administer Medicare Advantage plans. Health spending is expected to rise dramatically in 2014, when the larger parts of the health overhaul kick in and the federal government begins to subsidize health coverage for millions of lower earners who obtain coverage through insurance exchanges. Based on data published by a trade journal, *Health Affairs*, spending by federal, state and local governments is expected to account for up to 49% of all health spending in 2020, up from 45% in 2010.

to fill its Happy Meals boxes with apple slices and decrease the portion of french fries. McDonald's will not ditch Ronald McDonald or the toys included in the meal, which President Jan Fields describes by saying, "that's what makes the meal happy."

More Hospitals on Sick List

With revenue growing at the slowest rate in two decades, nonprofit hospitals are

under increasing financial pressure. Hospitals have been striving to cut expenses, but are still operating on extremely thin margins, if any. Declining inpatient admissions and cuts in state Medicaid reimbursements make the future extremely challenging. States will continue to dig for Medicaid savings, while the federal Medicare program is introducing cutbacks mandated under health-overhaul law, as well as possible deductions due to the

recent debt ceiling deal. At the same time, hospitals are striving to invest in new facilities and new technologies such as electronic health records.

On-Site Health Clinics

Three in five employees at major companies in the Midwest, including Chicago and the Chicago-area, want their employers to offer on-site medical care services.

According to the Chicago-based Midwest

Business Group on Health, 62 percent of workers are interested in their company offering on-site medical clinics to better manage their health. The Midwest Business Group and a health care consulting firm have formed the National Association of Worksite Health Centers to share best practices and allow members to come together to purchase needed gym equipment.

Health Utilization Management Accreditation

As POMCO Group prepares for the renewal of its Utilization Review Accreditation Commission (URAC) accreditation, the time is right to emphasize the importance of this process and how it can enhance the services we offer. Since most public or private health insurance plans must undergo some form of review to determine the appropriateness of proposed medical care, enrollees are affected by how these reviews are administered. In 1990, URAC introduced standards to ensure that organizations providing Utilization Management (UM) services followed a clinically sound process that respected patients' and providers' rights while giving payors reasonable guidelines. URAC's current UM standards:

- Establish consistency and maintain the highest confidentiality in UM processes
- Serve as the basis for many state laws and regulations and are widely recognized at the state and federal level
- Are applicable to stand-alone UM organizations and functions within health benefits programs such as indemnity insurance, HMOs, PPOs and newer Consumer-Directed Health Care plans.
- Can be adopted by specialty UM companies, such as behavioral health

URAC Health UM Accreditation requires each organization to establish and implement a three-step process to determine if a proposed treatment or service is medically necessary:

- **Initial Clinical Review** – A licensed health professional, such as a nurse, conducts this first, critical step
- **Peer Clinical Review** – A physician qualified to render a clinical opinion about the proposed treatment or service must perform peer clinical review and is the only authorized reviewer to render an adverse determination
- **Appeals Consideration** – Patient or provider initiates the appeal, which is considered by a qualified, board-certified physician in the same specialty not involved in the initial review decision.

POMCO Group has consistently been awarded the URAC accreditation since 1994.

URAC's modular accreditation approach allows a diverse range of health care organizations to apply for accreditation for a wide range of utilization review services. The accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes through benchmarking against nationally recognized standards. The four-phase accreditation process requires 3 to 6 months and successful applicants receive a full 3-year accreditation. Accredited organizations must continue to remain in compliance with the applicable standards throughout the accreditation cycle.

How to Fight Workers' Compensation Fraud

Fraud surrounding workers' compensation is a serious concern. To combat this issue, POMCO Group has partnered with a fraud investigation organization to develop a Special Investigation Unit (SIU) program.

Effective SIUs not only target common employee fraud, but also fraud and abuse in the medical community. For example, POMCO Group's SIU program uses all available and detailed medical treatment history along with the prescribing patterns of physicians to identify abuse. Combined with exclusive access to a wealth of data across claims and employers this equates to an effective management system.

Utilizing cutting-edge technology and experienced staff is key to monitoring each claim on a micro level. Regularly automated reports detailing potential fraud indicators should include items such as unwitnessed accidents, dates of the accident after the employee has received disciplinary action or termination, and injury dates less than 30 days from the date of hire. These should be reviewed by an SIU Coordinator on a weekly basis.

This methodical approach ensures early fraud detection, as well as providing employers with ample time to develop a plan of action concerning the investigation process. At POMCO Group, your SIU Coordinator identifies the applicable claims and closely works with you to create an anti-fraud plan for each case.

Securing an SIU meeting the above criteria will better assist you in managing workers' compensation claims costs. Partnering with TPAs offering this service typically results in generous savings and peace of mind.

To determine how an SIU can benefit your organization please contact your account manager.

POMCO Group Network Update

POMCO Group is pleased to announce the addition of more than 90 ambulance companies throughout New York and Connecticut. Some of the newly signed companies include:

- Mount Kisco Volunteer Ambulance
- Scarsdale Volunteer Ambulance
- Katonah-Bedford Hill Volunteer Ambulance Corp.
- Eastchester Volunteer Ambulance Corp.
- Potsdam Volunteer Rescue Squad
- New Hartford Volunteer Ambulance
- Chester Hose Company Inc.
- Mohegan Tribal Council
- Village of Fayetteville
- Lafayette Fire Department Inc.
- Carthage Area Rescue Squad

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