

Benefits Briefs

FALL 2010

Important news and updates from your benefits professional

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Questions and Answers, Helpful Facts, Trends and More!

Wellness: Are You Getting a Return on Investment?

When times get tough and belts get tightened, every discretionary expense is scrutinized several times over. While healthcare benefit plans remain a priority, you can bet that HR directors are scrambling to prove that their company's investment in wellness is being offset, to a growing extent, with increases in productivity. Fortunately, more and more companies striving to keep workers fit and motivated are finding the positive results they are looking for. Strategies like health screenings, fitness and healthier choices in on-premise cafeterias or vending machines are making a positive difference. Not only are an increasing number of workers taking an interest, but their organizations are beginning to see higher productivity with lower annual healthcare cost increases.

More Companies Starting at the Top

What's different this time around, you ask? Our experience shows that companies are finally starting to realize that the right example has to be set at the top. When senior management talks the talk without walking the walk, others just don't take preventive healthcare seriously. One of our clients, a

professional services firm, has found a drop in sick days and increased participation in wellness-related events after senior level executives took the lead by getting actively involved in walking challenges, nutrition lessons and a weight-loss contest.

Creating Affordable Programs

In contrast to big companies known for sponsoring extravagant wellness programs with a variety of incentives, we're helping small and mid-sized businesses find creative ways to promote a healthier work force. When the long-term goals include preventing catastrophic claims and holding the line on health benefit costs, even small programs can make a big difference over time. Group events such as free flu shots, counting steps on a daily basis as part of a month-long walking program, cost-sharing for fitness center use or healthy eating programs can make people healthier and encourage teamwork. Another client credits their success to the short-term focus of their programs. Rather than introducing a walking program that is going to run for six months, they limited their walking program to six weeks. People who were overwhelmed with the challenge of a six-month program see four or six weeks as something they can manage. Add an incentive like a company outing or a Friday afternoon off and you just might have a wellness strategy that is both affordable and effective.



Q&A

Bringing you answers to tough questions

Grandfathering: Can Your Plan Really Afford It?



As we continue to evaluate the interim final regulations issued on grandfathered health plan status, we see little to change our opinion of the grandfathering provisions in the Patient Protection and Affordable Care Act (PPACA). Changes in plan design or a decrease of 5% or more in the employer's contribution level in effect on March 23, 2010 will cause a group health plan to lose its status as a grandfathered plan. As a result, we expect to see a majority of partially self-funded and fully-insured group health plans lose this status in 2011 or 2012.

Initially, even a change from one insurance carrier to another would cause a loss of grandfathered status for a fully-insured group health plan. The Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury are currently discussing circumstances under which a change in carriers, on its own, will not force the plan to relinquish its grandfathered status.

Flexibility in plan design and the availability of claim and utilization information are two of the most popular features of self-funded group health plans. Even if your company's rate of contribution towards the cost of coverage remains unchanged, it would be unusual to begin another plan year without making some changes in design. For this reason alone, grandfathering may be a good thing to lose in the near future.

Industry Approaches

Controlling Costs

We See Opportunities in 2011 and Beyond

Whenever significant change sweeps through our lives, either personal or professional, we are forced to decide how we want to react. Healthcare reform legislation is one such change, and since healthcare benefits administration is our profession, we see enormous opportunities for self-funding and employers willing to take advantage of the many advantages it offers. Here are a few examples:

Analyze Data – When group health plans are fully-insured, carriers are seldom willing to provide relevant data. In a partially self-funded environment, management reports on claims and plan utilization are provided on a consistent basis. This should put you and your advisors in the driver's seat when it comes to understanding where your healthcare dollars are going and why.

Consider New Designs – With access to plan data and predictive modeling technology, we can illustrate how plan design changes will impact your covered group and your overall healthcare spend. Analyzing varying deductibles, co-insurance levels and benefits will help your company make more informed decisions going forward.

Eliminate Waste – With benefits being extended to qualifying dependents up to age 26, there's never been a better time to consider a dependent eligibility verification audit. At an average per dependent cost of \$2,500 per year, an organization with 200 employees could easily save \$50,000 in one year, not to mention future claims you may avoid.

Commit to Wellness – The healthcare reform bill offers grants to small employers that establish wellness programs and evidence-based preventive medicine strategies. Even if your company is not eligible for a grant, there's never been a better time to create a wellness program everyone can benefit from.

In the aftermath of healthcare reform, employers are looking for answers and employees are concerned and confused. Instead of focusing on the negatives, we can provide the information and direction you need to take advantage of new opportunities.



TRENDS *Latest Happenings In Today's World*

Competition Among ERs

In order to decrease the wait time in their emergency room, some hospitals are taking an unusual approach: advertising. With the number of ER visits increasing, using online billboards or text messaging to broadcast how long waits are in a given hospital could dramatically

improve patient satisfaction by letting patients know where the shortest wait times are. It might also be a sign of increased competition in urban areas.

Deductibles to Rise

Based on a recent survey by PricewaterhouseCoopers L.L.P., the costs for employer-offered healthcare could increase by between 8% and 9%

next year. Increased use of high-deductible health plans is one reason cited. Of the 700 employers surveyed, approximately 40% say they are willing to increase employee contributions and deductibles to cope with expected cost increases.

Lunchtime Now Snack Time?

It started as a fad to save money, but today, consumers choose to fill up on





BENEFIT BEAT

Keeping An Eye on What's Happening

Self-Funding: No Longer Just for Big Companies

Whether its the fact that a few healthcare reform measures will not apply to self-funded group health plans on January 1st or the recent availability of new, user-friendly stop loss products in the marketplace, the fact is we are experiencing renewed interest in self-funding, especially by smaller groups.

While specific plan parameters tend to vary based on market conditions, small group self-funding is usually available to employers with as few as 50 plan participants. To learn more about partial self-funding for smaller groups, give us a call or talk to your agent today.

Contribute the Same Amount Each Month

With a number of top-rated stop loss carriers offering innovative products, these partially self-funded plans are able to establish unit costs for single, two-person and family coverage and fix these costs for the contract year. Other than adjustments for changes in enrollment, the employer contributes an equal amount to their claims fund each month. If cumulative claims exceed the funding requirement, stop loss coverage protects the plan. When claims are lower than expected, the plan retains the savings.

Fully-Insured Policy



Partially Self-Funded Plan



Creating the Potential for Savings

Two of the best features of these partially self-funded plans are ease of operation and the opportunity for savings. As our existing clients know, when it comes to the plan's operation, there is little difference between small group self-funding and a traditional fully-insured plan with a fixed monthly premium. By contributing an equal amount to your claims fund each month, you create an opportunity for savings that can result if claims are lower than expected.



Health Wise

Doctor Visit Admissions Fall



Some say the tough economy is forcing many Americans to delay elective procedures, while others cite the growth of high-deductible health plans and continued high unemployment as reasons for fewer doctor visits and hospital admissions. Whatever the reason, the facts do show that visits to primary care physicians and specialists have fallen more than 7% from a year ago. Reports from Thomson Reuters also show that hospital admissions fell more than 2% since spring of last year.

The COBRA subsidy, in which the federal government covered 65% of the cost of coverage for those who elected to continue their employer-sponsored coverage after leaving their job, only covered the unemployed for 15 months. Many unemployed Americans have hit that 15-month limit and dropped their COBRA coverage, which certainly could be a factor influencing this trend.

We have seen similar cutbacks during recessionary periods in the past, but there is no doubt that weak activity and high unemployment have continued on for a longer period than we have been accustomed to in past recessions. Some experts are speculating that continued weak demand could eventually create so much downward pressure on healthcare costs that insurance premiums actually begin to drop. Now that would be news!

snack-sized fast food items as often as three times a day. A Snack Wrap from McDonald's here, a KFC snacker mini chicken sandwich there... all with diminished prices that are easier on a wallet and faster on busy schedules. One other perceived benefit is that by eating quick meals promoted as snacks, the "guilt factor" associated with unhealthy fast food is being eliminated or at least reduced.

Social Networking and Employee Behavior

Today, nearly 10% of top companies are using social networking sites to establish two-way dialogue to influence and listen to employees. This manner of communicating with employees establishes a personal connection and inspires employee involvement. In addition to helping to engage employees, social media can bring your company's mission and values to the forefront.



Dietary Guidelines: Ignore at Your Own Risk

The 2005 Dietary Guidelines suggested that Americans eat 2.5 cups of vegetables and 2 cups of fruit each day. When we see \$1 menus and a rise in snacking, no wonder only 14% of Americans follow this guideline. The struggle to eat healthier and save money is sure to gain more attention as the government will fight obesity by targeting school programs and the fast food industry.

Healthcare Reform Update "Age 26" Clarification



Last week, the Department of Labor ("DOL") issued guidance on the Patient Protection and Affordable Care Act ("PPACA") in the form of a Q&A. While any

information clarifying the statute and its regulations is helpful, among the most important information provided in this communication was clarification of the "Age 26" coverage mandate. Prior to this, we only had the regulations for guidance, and they required that health plans eliminate dependent child eligibility criteria such as financial dependency, residency with the participant, student status, employment, eligibility for other coverage, or marriage. The regulations specifically stated, "a plan may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant."

The Q&A clarified that a health plan does not fail to satisfy the requirements of PPACA because the plan limits health coverage for children up to age 26 to only those children who are described in section 152(f)(1) of the Internal Revenue Code ("IRC"). This means that for an individual not described in the IRC, such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.

IRC 152(f)(1) defines the term "child" to mean an individual who is: (1) a son, daughter, stepson, or stepdaughter of the taxpayer; or (2) an "eligible foster child" of the taxpayer.

An "eligible foster child" means an individual who is placed with the taxpayer by an authorized placement agency or by judgment decree, or other order of any court of competent jurisdiction. Any adopted children of the taxpayer are treated the same as natural born children.

The late timing of this clarification may not have provided the best news for plans that volunteered to cover adult children aging out of their parents' health plans before the PPACA mandate took effect, as was strongly encouraged by HHS Secretary Sebelius to avoid a gap in coverage for children who graduated from college this past May. Plans that waited to provide this coverage, and are now considering their open-enrollment options under PPACA, will want to consider whether to impose additional eligibility requirements on those children who do not fall under code IRC 152(f)(1). If plans decide to use different categories of dependents, benefit administrators may find that they will need programming changes to track the different dependent eligibilities.

Additionally, plans should consider their enrollment eligibility regarding child dependents in their free-standing dental, vision, and retiree plans, which are exempt from the requirements of PPACA. Plan sponsors could require an altogether different set of eligibility criteria for these exempt plans. Plans need to make these decisions before sending any open-enrollment materials to participants.

For more information on healthcare reform please visit POMCO Group's blog, *Healthcare Educator*, at blog.pomcogroup.com

POMCO Group Contracts with Additional Ambulance Companies

Effective October 1, 2010, POMCO Group has signed agreements with many of the ambulance companies represented by MultiMed Billing Services, Inc. MultiMed provides ambulance billing services to over 100 ambulance companies throughout New York State and in five other states. Today, 42 New York State ambulance companies have signed a participating agreement with POMCO Group. Discussions are ongoing with MultiMed clients that have not yet signed agreements with POMCO Group.

Health Insurance Matching Program

POMCO Group is expanding its efforts to control clients' healthcare claims costs through the implementation of the Health Insurance Matching Program (HIMP). HIMP is a standardized way for health plans to seek reimbursement for health benefits that should have been paid under workers' compensation. HIMP holds great promise of additional savings for self-insured health benefit plans.

In November 2009, health plans' rights to recovery were severely limited by changes to New York State insurance law providing that once a plaintiff settles a case for personal injury, that the insurance company loses subrogation rights to seek recovery of the cost of healthcare services. As a result, workers' compensation plans are one of two avenues where health benefit plans can still subrogate.

The New York State Workers' Compensation Board is mandated to provide a vehicle for health insurers to subrogate against workers' compensation plans. HIMP provides a mechanism for health insurers (and health benefit plans) to seek reimbursement from employers and workers' compensation insurance carriers for medical payments issued on accepted workers' compensation claims.

In November and December, POMCO Group's Client Services team members will reach out to all POMCO Group Health Plan clients with enrollees in New York State in an effort to secure authorization for HIMP participation. As soon as a client authorizes POMCO Group to act as their agent to perform services in partnership with the Workers' Compensation Board, POMCO Group's staff can begin data transfer and HIMP collection services.

POMCO Group is apparently the first third party administrator in New York to provide these services in direct partnership with the New York State Workers' Compensation Board. For more information on HIMP, please contact your account manager.

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