

# Benefits Briefs

SPRING 2011

Important news and updates from your benefits professional

## THIS ISSUE:

### Controlling Drug Costs

Are your plan participants doing their part?

### Reform Update

How to transfer plans.

### “Hidden” Paycheck

Doing more to stress the value of your benefit plan.

### Health Care Strategy

Maybe it's time you adopted a long-term perspective.

### Centralized Medical Records

POMCO has partnered with HealthConnections.

### New Ideas for Healthy Consumers and Much More!

## All Network Discounts Are Not Alike!

**R**ecently, my wife and I were looking at the website for a national retailer because she needed a new steam iron to replace one that broke. When we found the iron she wanted, the list price was \$159.99 and it was on sale for \$99.99 – a savings of \$60.00. Then we were given an additional \$10.00 off because of a special one-day discount so we paid only \$89.99. Our receipt (much like an EOB) showed a savings (discount) of \$70.00 – WOW what a deal! Afterwards, we went to the manufacturer's website and found the exact same iron with the same stock number for a retail price of \$99.99. So my real savings was only \$10.00.

The comparison may seem odd, but it illustrates that what really matters is not the percentage of discount promised but how the discount is calculated or defined.

One of the more disturbing examples we've seen recently occurred when we were asked to bid on a new fully insured case. When we asked the broker to share reports showing the network discounts and reviewed the reports, we discovered that any amount not paid by the plan or member was labeled as ineligible, with all ineligible amounts shown as savings on the PPO Savings Report.

While PPO discounts are a part of the ineligible amount, they are not the full amount because the ineligible amount can include duplicate charges, COB, network discounts, ineligible charges,

plan limits and more. In the example we referenced above, the carrier emphasized a 48% savings – the ineligible amount divided into the billed claims amount.

To get a true apples-to-apples comparison, you first must realize that...

- Duplicate charges are not discounts
- Ineligible charges are not discounts
- A cut for usual and customary is not a discount
- A cut for maximum allowable charges is not a discount
- A payment by the primary insured is not a discount

### It's Also Easy to Be Fooled by Re-pricing

Another popular practice is offering to re-price claims through the proposed network's system. In order to evaluate the results, you need to know what network contract was used in the re-pricing model. Most networks have multiple schedules that often vary based on geography. You also need to know if claims are actually being re-priced or if an average discount is just being applied against the claims.

As benefits administration specialists, we're accustomed to helping employer groups analyze and evaluate projected network savings. If you need to re-evaluate your health benefit program or debunk the promise of a provider network discount, count on us for a comparison you can believe in.



# Q&A

Bringing you answers to tough questions

## Should You Have a Health Care Strategy?



Far too many businesses make health care a once a year event that includes requesting proposals, reaching a decision based on cost and then closing their file for 10 months or so before beginning the process again. That's anything but a long-term strategy.

Whether it's a sign of a strengthening recovery or a by-product of reform, it appears that more employers are beginning to abandon their annual-survival mode by establishing realistic goals and a strategy for employee health care. More are tracking the health and productivity of their workers in order to create a 3 to 5 year plan for costs, benefits and wellness.

### Every Group Is Unique

Understanding how your plan is being used and the factors driving costs higher are the first steps to establishing realistic goals. Once you know what's happening, you can begin to pinpoint trends and how they can influence costs and the well-being of your employees in the future. Since every group is unique, it's wise to bring plan participants into the planning process. Consider asking what they need from a health care plan and any future health promotion programs.

With costs rising and member's needs changing daily, adopting a long-term strategy for health care makes as much sense as establishing long-term goals for your business. Think about it - maybe it's time for a long term perspective on health care.

## Industry Approaches

# Can More Be Done to Control Prescription Drug Costs?

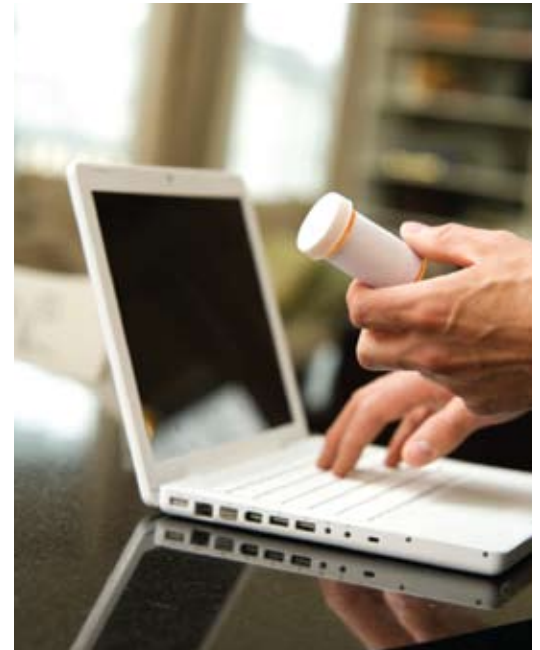
Like every employer group, you're committed to controlling the rising cost of prescription drug benefits. With estimates showing that billions in potential savings still available, chances are that you could be doing more. Here are a few things to consider that might help your plan save money on drug benefits.

**1. Take a look at plan design** – Working with the right formulary and setting your copayment levels appropriately is key to how members will utilize lower cost brand name and generic drugs. Our advice would be to keep things as simple as possible since statistics show that far too many adults with prescription drug coverage are not familiar with their copayment amounts.

**2. Member behavior** – Decisions on plan design and copayment levels will have a significant impact on member behavior. While people are always sensitive to price, it is hard to break habits. If significant changes in benefit design are being made, education will go a long way in directing people to lower cost alternatives.

**3. Choice and flexibility** – Giving plan participants choices has been shown to keep costs down and satisfaction levels up. This can be done by keeping uniform differentials between copayment tiers and by offering convenient features like home delivery for those who require maintenance drugs.

**4. Technology and communication** – A prescription drug benefit is only as good as the information provided to plan participants and



providers. Your plan needs to have easy-to-understand cost-sharing structures and EOBs. Physicians can help reduce errors with electronic transmission of prescriptions and electronic access to the patient's medication history.

Underutilization of generics, inefficient delivery and failure to adhere to prescribed directions cost our health care system billions each year. To review your prescription drug benefits and determine if you're currently doing everything possible to encourage efficient, appropriate utilization, give us a call today.



## TRENDS *Latest Happenings In Today's World*

### Breathing the Benefits

Since the 1990s, the levels of many pollutants present in the air we breathe have fallen.

- Ground-level ozone has decreased by 14%
- Particulates under 2.5 microns are down by 19%
- Particulates 2.5 to 10 microns have decreased by 31%

- Lead is down by 78%
- Nitrogen Dioxide has decreased by 35%
- Carbon monoxide has decreased 68%
- Sulfur dioxide is down by 59%

Some, including carbon monoxide, lead and nitrogen dioxide have fallen below federal standards that protect human health and the environment.

### Exercise Still the Best Medicine

More than 3,200 people at risk for Type 2 Diabetes were observed and those who developed an exercise schedule drastically reduced their risk of developing the disease. The same participants were evaluated 10 years later, and those who maintained a healthy lifestyle including physical activity continued to decrease their risk for Type 2 Diabetes by 34%.

# POMCO Group – A Health Care Reform Partner

Over the course of 2010 and 2011 POMCO has worked to help clients understand and comply with the Patient Protection and Affordable Care Act (PPACA). The information below outlines the steps POMCO Group has taken to assist clients in understanding and complying with the PPACA:

## Understanding the PPACA

The POMCO Group Compliance team has worked diligently to understand the legislation, seek clarifications from the Department of Labor, and identify industry precedent for PPACA compliance. These efforts enabled POMCO to assist clients from a consultative perspective and communicate the steps believed necessary to comply with the federal legislation.

In 2010, POMCO Group created Health Care Educator, a blog to share information and address client questions about PPACA. The blog also serves as an effective communication vehicle for sharing legislation clarifications released by the United States Department of Labor and the Department of Health and Human Services among other governmental entities.

## Documenting Health Plan Compliance

In preparing for the compliance effective date, POMCO Group provided clients with health plan amendments that reflect the federally required plan changes as understood at that moment in time. These amendments are posted to POMCO Group's client and member website, BENEFITSoft.com, to help communicate the plan changes to members.

In addition to providing plan amendments, the federal government requires health plans to send various notices to employees and health plan participants. To assist with this distribution, POMCO Group provided client contacts with applicable notice templates and timelines, and was available to provide contracted services for mailed distribution.

## Administration Changes for Health Plan Compliance

The PPACA requires health plans to provide coverage for dependents until they reach 26 years of age (Age 26). In certain circumstances, plans are only required to offer dependent coverage to Age 26 if the dependent does not have other employer-sponsored coverage available (i.e. grandfathered health plans). To accommodate these new eligibility rules, POMCO Group developed additional enrollment system fields and enhanced reporting capabilities to identify dependents that meet these new eligibility requirements. POMCO Group also developed the Age 26 Affidavit and verification process to determine if the dependent has other employer-sponsored health coverage available.

The PPACA requires health plans to offer an external appeals process (applicable to non-grandfathered plans only at this time). POMCO Group has identified multiple Independent Review Organizations that will review and make determinations on submitted appeals. POMCO Group has established a workflow and member communication tools that outline the action steps and required timeframes for appeal submission.

POMCO Group will continue in its efforts to understand and communicate information about the PPACA and federal legislation. For questions regarding the PPACA, or to provide feedback, please contact your account manager.

## Do Your Employees See Their "Hidden" Paycheck?

In a recent poll of employers and HR executives, fewer than 20% of employers thought their employees had a good understanding of the benefits they are receiving. Nearly 5% are convinced their employees know nothing at all about their benefits. It naturally follows that if employees fail to understand their benefits, they probably have no idea how much these benefits are worth as a part of their total compensation.

## Benefit Statements Can Help

We help many of our clients provide benefit statements to plan participants. They can go a long way towards educating employees and raising awareness to the value of employee benefits, particularly a group health plan. By listing standard benefits such as health benefits or group life, dental and vision care, a benefit statement can help employees find the "hidden" paycheck they may have been missing all along. It just may be a little tool that can go a long way in strengthening loyalty.



## More Enjoy the Benefits of Home Grown Food

The maker of Kerr and Ball-brand mason jars report that the sales of canning equipment have rose by 30% in 2009 and surprisingly, 50% of the people preserving their own home grown produce are under the age of 40. As a result, seed sales are increasing while enthusiasts who are cultivating their harvests are enjoying fresh air and exercise while lowering their food bills.



## Confidence in Health Care Spending

The Consumer Healthcare Sentiment Index reports that in the month of January, the number of Americans more confident in their ability to pay for and access healthcare during the first quarter of 2011 increased by about 3%. This followed a quarter in which those expressing concern over an ability to pay and those likely to postpone elective surgery and fill pre-

scriptions reportedly reached an all-time high. It is assumed that many who wanted to postpone health care expenditures in the 4th quarter of 2010 may have been doing so in order to better handle traditional holiday spending. The Healthcare Sentiment Index, which is part of the larger Thomson Reuters Pulse Healthcare Survey, surveys about 3,000 respondents each month.

# Access Granted: Centralized Medical Records

As part of the Patient Protection and Affordable Care Act (PPACA) regulations, POMCO Group has partnered with HealthConnections, a Regional Health Information Organization (RHIO), giving physicians the ability to electronically share patient medical information securely across different providers in an 11 county region of Central New York (CNY).

The PPACA has mandated that access to a RHIO is offered to employers and all other major payors in Central New York have partnered with a RHIO to provide the medical information that makes up the database. As HealthConnections creates community-based virtual medical records, the immediate benefits to you will include:

**Controlled costs.** For a participation fee of \$110 per in-patient discharge, RHIO gives

physicians access to a centralized medical records database. This database eliminates duplicative tests and procedures and can reduce your overall health care costs.

*Here's an example:*

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On average, an 800-life group can anticipate 40 annual discharges. For an annual fee of \$4400, access to the RHIO will eliminate the need to order duplicates of routine in-patient tests such as CT scans, which average \$340 in Central New York.

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*The elimination of just 13 CT scans annually will cover the cost of the participation fee.*

**Increased level of care.** Providers will have instant access to vital health information for diagnosis and treatment.

**Protection of privacy.** Only authorized medical personnel have access to health information. All access to the RHIO is tracked and can be validated.

**Greater convenience.** Patients will no longer have to request and carry their health reports and results from provider to provider.

POMCO Group recognizes the benefits of participation in the RHIO as a way to help reduce employer health care costs, improve the efficiency of the health care process and give providers access to a wealth of health care information immediately.

As a POMCO Group client, you have automatically been enrolled into the RHIO. If you wish to opt-out of the program, please contact your account manager.

## Top Five Ways to Transfer Plans without Losing PPACA Status

Recently the Department of Labor's Employee Benefits Security Administration ("EBSA") released their newest set of guidelines on the Patient Protection and Affordable Care Act ("PPACA") in the form of "FAQs About Affordable Care Act Implementation Part VI." See <http://www.dol.gov/ebsa/faqs/faq-aca6.html>. The frequently asked questions include various topics surrounding the grandfathered status regulation, including its anti-abuse rules.

Specifically, the regulation's anti-abuse rules require that an employer have a *bona fide employment-based reason* for transferring employees into a health plan different from the one they had on March 23, 2010 (the date of PPACA enactment). While the regulation provided some examples of what constitutes a *bona fide employment-based reason* (e.g. transferring employees from one option to another due to a plant closing would be a *bona fide* reason, whereas, eliminating a plan due to its high cost would not), the guidance remained minimal, leaving employers to rely on "good-faith efforts to comply with a reasonable interpretation of the statutory requirements."

The Part VI FAQs, however, have finally provided additional insight. The following circumstances under which a transfer would not cause a plan to lose its grandfather status now include the following *bona fide* reasons:

- When a benefit package is being eliminated because the issuer is exiting the market;
- When a benefit package is being eliminated because the issuer no longer offers the product to the employer;
- When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package;
- When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or
- When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred.

The EBSA still leaves plenty of room for an employer's good-faith interpretations of the

above. For example, what constitutes "low or declining" participation? What about the definition of "impractical?" The EBSA also provides a disclosure that the foregoing list is not intended to be an exhaustive list, so any number of circumstances may be deemed to satisfy the *bona fide employment-based reason* condition.

And, while calendar year plans did not have the guidance provided in FAQs Part VI when deciding their plan options and benefit changes in time for their January 1st deadline, at least they have them now, and can consider the guidelines when implementing future plan changes.

For more information on health care-related items visit POMCO Group's blog, *Healthcare Educator*, at [blog.pomcogroup.com](http://blog.pomcogroup.com)

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