

CSA Benefits

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Feature Story

Maybe It's Time To Review Your Renewal

Renewing a health benefit plan should involve much more than shopping for the lowest rate or a bigger network discount. So even if you just completed your 2007 renewal, it is important to revisit the process that led to your selection. Here are a few steps you might consider:

1. Examine Utilization

Preparing for a renewal should create an opportunity to learn more about how your current plan is being used. Are the needs of your plan participants being met? If your plan is insured and not self-funded, will your carrier provide data on utilization, large claims and use of in-network providers?

2. Analyze Your Claims

Regardless of how your plan is funded, claims tell the story. The total of claims incurred vs. total costs (premiums in an insured plan or the total of administrative costs, claims and stop-loss premiums in a self-funded plan) determines loss ratio. Drilling down into claims information identifies factors contributing to large claims. Answers to these questions help our clients modify their plan designs to achieve higher levels of employee satisfaction and cost control.

3. Empower Your Employees

Offering your employees at least one consumer directed alternative will help them become more effective healthcare consumers. HRAs, HSAs, FSAs and the web based tools associated with these



accounts can help modify behavior and make a positive impact on their future well-being. We offer a variety of consumer directed plan options.

4. Evaluate Your Advisors

We work closely with agents and consultants to make sure our clients have plenty of time to consider new alternatives. Most important – we make all the complex processes associated with their health plan simple. Plan design, claims analysis, provider discounts and wellness are reviewed and integrated into the new health plan without a lot of additional work on the employer's part.

Taking the time to review your renewal should help you confirm that your health plan has been designed and managed to really help your company achieve an important benefit objective – attracting and retaining the finest employees cost effectively.

Q&A

Bringing you answers to tough questions

How can HSAs best be used to cover medical bills in retirement?

According to the Employee Benefit Research Institute, someone who retires today at 65 and lives 20 more years could need \$84,000 to \$164,000 (the latter figure assumes high drug costs) to pay for uncovered medical expenses. It could prove difficult for most consumers to foot their entire healthcare bill in retirement with funds saved in an HSA. But careful planning can help pay for a large portion of the bills.

To maximize an HSA, start young and contribute regularly. Although you're allowed to spend your HSA money on health expenses before retirement, try to cover those costs with other funds. By leaving money in an HSA, you can accumulate interest that will not be taxed later, assuming you ultimately spend the money on qualified medical expenses.

With Congress passing new rules for HSAs, including contribution levels increasing for individuals and families, employers being able to contribute above their employees' contribution levels and a one time tax-free transfer of IRA funds to an HSA, now is a great time to start saving for future medical costs.

Industry Approaches

Small Businesses Take a Run at Wellness Programs

Small businesses are beginning to realize that they too should take a proactive approach to bettering the physical and mental health of their employees.

Health and wellness programs in the workplace can improve morale, improve communication among work groups, decrease absenteeism, increase employee loyalty to an organization, significantly impact a company's bottom line and reduce alcohol and drug use risk factors.

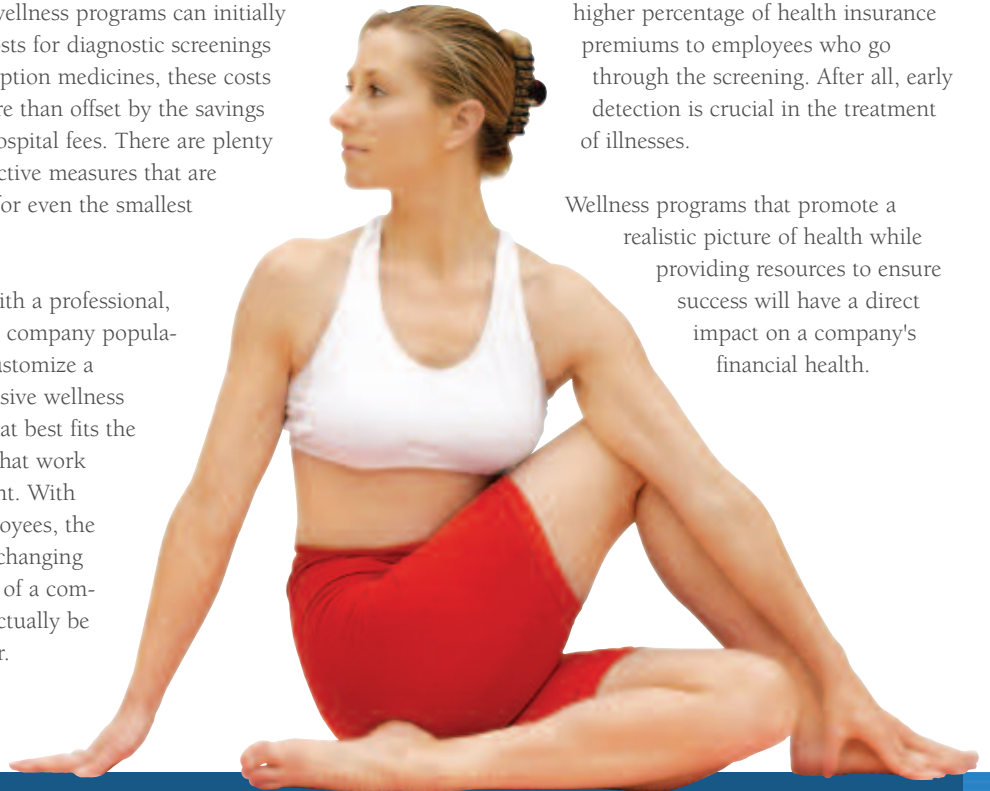
Although wellness programs can initially push up costs for diagnostic screenings and prescription medicines, these costs will be more than offset by the savings in future hospital fees. There are plenty of cost-effective measures that are affordable for even the smallest company.

Working with a professional, analyze the company population and customize a comprehensive wellness program that best fits the culture of that work environment. With fewer employees, the process of changing the culture of a company can actually be made easier.

With the support of top management, organize a wellness team to oversee the program. The entire company will feel they have a voice in the creation, promotion, progression and evaluation of their wellness efforts. For genuine improvement, create a simple plan and set simple goals.

Because you can't change what you can't measure, health screenings should be the cornerstone of every wellness plan. Employers can provide incentives for participation, such as offering to pay a higher percentage of health insurance premiums to employees who go through the screening. After all, early detection is crucial in the treatment of illnesses.

Wellness programs that promote a realistic picture of health while providing resources to ensure success will have a direct impact on a company's financial health.



TRENDS Latest Happenings In Today's World

Ignorance Isn't Bliss

According to a new survey from HealthMarkets, more than 70 percent of Americans know little or nothing about the cost of medical services from one doctor to the next. This costly trend is attributed to a lack of information on healthcare and lack of price transparency.

The survey revealed that 73 percent of adults assumed the highest price for a

CT scan of the abdomen would be \$2,000. In actuality, the cost for such a procedure ranged from \$298 to \$2,858. Similar levels of miscalculations were found with knee replacement surgery and a tonsillectomy. Approximately 70 percent of those surveyed said it would be helpful to have online data comparing healthcare providers. If the consumer is expected to manage their own health dollars, they need to have access to better information.



A Real Pain in the...

According to the National Health Interview Survey released by the Center for Disease Control in December of 2006, during the three months prior to the interview, 15 percent of adults had experienced a migraine or severe headache, 15 percent had experienced pain in the neck area, 28 percent had experienced pain in the lower back and 4 percent had experienced pain in the face or jaw area.



BENEFIT BEAT

Keeping An Eye on What's Happening

FMLA Challenges Ahead

Many companies find administering leave benefits under the Family and Medical Leave Act (FMLA) difficult, which is why the Department of Labor is requesting public comments on how to improve the 14-year-old law. Several legal opinions, including the U.S. Supreme Court's 2002 decision in *Ragsdale v. Wolverine World Wide, Inc.*, have already challenged FMLA regulations.

Companies have cited difficulty with record-keeping, tracking use of leave, determining what constitutes a serious health condition, communicating with physicians and coordinating FMLA with workers' compensation, long and short-term disability, state laws and the federal Americans with Disabilities Act.

Wellness Program Nondiscrimination Rules

The Department of Labor, the Internal Revenue Service and the Department of Health and Human Services published their final rules for implementing wellness programs while complying with HIPAA nondiscrimination rules. The agencies treat all programs of health promotion or disease prevention as wellness programs.

Employers may reward workers up to 20 percent of coverage costs for meeting health-related goals in wellness programs. The program must be reasonably designed to promote health and prevent disease. Eligible employees must have the opportunity to qualify for the reward at least once per year. The reward must be available to all similarly situated individuals and provide a reasonable alternative standard for obtaining the reward to any individual who does not satisfy the initial standard. The plan must disclose the terms of the program and the availability of a reasonable alternative standard.



Prescription Perceptions The Pass-Through Pricing Debate

In response to increased scrutiny, many pharmacy benefit managers (PBMs) now offer pass-through pricing contracts. Pass-through pricing is a retro arrangement in which the PBM charges a defined administration fee. Plan sponsors are billed for the actual amount retail pharmacies charge for drugs and dispensing fees and also receive all of the rebates paid to the PBM by drug manufacturers. While pass-through pricing increases transparency, some important issues arise that need to be considered.

Unlike traditional PBM contracts, pass-through pricing does not offer the rate guarantees for retail pricing and dollar guarantees for manufacturer rebates. Depending on the location of the plan sponsors' covered lives and their demographic make-up, a pass-through pricing contract may not produce retail pricing and rebates as well as a traditionally priced PBM contract. For example, if the plan sponsor is located in a rural area, traditional pricing contracts may be a better deal because PBM retail pharmacy contracts may not offer the deep discounts found in urban areas with more competition. Traditional rebate terms might be better if a plan sponsors' covered lives are young and use their drug benefits for acute care generic drugs and not maintenance brand drugs that generate rebate dollars.

Pass-through pricing contracts can also present claims audit challenges that differ from traditional contracts where the PBM serves as the defined pricing source for retail pharmacy claims and manufacturer rebates. These audits are costly, lengthy and difficult for most plan sponsors to perform. As the industry pushes towards transparency, plan sponsors will have to ask critical questions to PBMs regarding the true value of the plan.

Women were more likely to experience pain in the aforementioned areas than men. Women were twice as likely as men to experience migraines or severe headaches, or pain in the face or jaw.

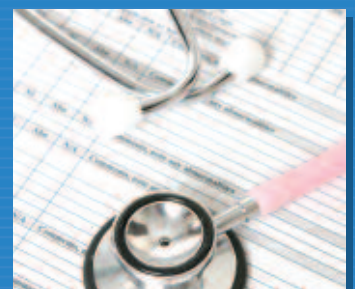
Online Medical Records Sought with Caution

Approximately 65 percent of Americans expressed interest in being able to access their medical information online, accord-

ing to a survey commissioned by the Markle Foundation.

Consumers want access to their medical information to be able to check accuracy, to improve communication with their doctor and to help prevent errors. The vast majority of consumers think that access to their medical records will help them manage their own health better and track the health of their children.

Eighty percent of those polled say they are very concerned about identity theft or fraud. Seventy-five percent of those polled say the government should have a role in establishing rules to protect the privacy and confidentiality of online health information. Sixty-six percent say the government should have a role in establishing rules by which businesses and third parties can access personal health information online.





In The News

Have Your Voice Heard in The Call for Transparency

The Department of Health and Human Services is soliciting support for their study of value-driven healthcare. We ask you to take a minute and sign up as many different supporters as possible. You are not committing a form to anything. It is simply an expression of support for the concept. Go to <http://www.hhs.gov/transparency/employers> and click on "The Role of Employers" followed by "Committing to These Goals" and finally "Sign-up On-line"

The on-line registration asks that the President or CEO's name be listed as the official supporter for the firm, but you or anyone can be listed as the contact person. The Secretary of Health and Human Services office will be dealing with the named contact person to thank you and keep you posted. Don't sit on your hands on this one. Success or failure of solving the problems depends on having as many names of employers and organizations as possible to show the medical community the level of public support.

The government has taken some steps to put medical pricing on a realistic and equal footing. Medicare and some other agencies are starting to make available the actual amounts they are paying to medical entities for specific services. President Bush has asked the insurance carriers who pay the claims in the Federal Employee Health Benefit Plan to

show the actual amounts they are paying for those employees' specific claims.

The goal of pricing transparency is to have the entire health-payer community be open about how much is being paid to whom for what services. TPAs and their clients will be able to make plan designs based this knowledge and avoid the dreaded balance-billing. It should also make estimating costs – and thus stop-loss – easier and more accurate. Laying all the dollars on the table would do away with "discounts" from carriers and eliminate the problem of PPO "late" payments.

The biggest complaints from TPAs and their clients for decades have been outrageously inflated medical charges brought on by the whole mess of carriers claiming to have mega discounts and a host of other PPO discount problems. TPAs simply asked to want to know what is being paid and accepted for specific medical service. Join us in our call for a more just medical pricing system.

(From the Society of Professional Benefit Administrators)

Please Contact Us: This newsletter is not intended as a substitute for personal medical or employee benefits advice. Please consult your physician before making decisions which may impact your personal health. Talk to your benefits administrator before implementing strategies which may impact your organization's employee benefit objectives.



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