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Welcome

I hope that you find these articles of interest. If you have a topic for future discussion, please let me know.

Please call anytime we can answer questions or be of help with your business or personal insurance needs.

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What's New This Month

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Many Employees Remain Unaware Of Lower- Costing Alternatives To Their Existing Medications

Tools Help Consumers Choose Quality Health Care at the Best Price

Avoid Costly and Common Mistakes with an Annual Review of Plan Administration Basics

Once annual enrollment has come and gone, it's a good time to brush up on some basic benefit plan requirements, to avoid some of the common mistakes made in employee benefit plan administration. The following list of potential errors is by no means exhaustive, but represents a sampling of issues to steer clear of:

-- Keep your plan documents up to date and reference them in related plan communications. ERISA requires that all employee benefit plans be maintained pursuant to a written plan document. As the governing document for the plan, it should be reviewed on a regular basis, and amended if necessary, to keep up with new laws and regulations (such as health care reform). Since this will be the most detailed document regarding any given plan, it should be referenced in disclaimer materials included in less formal plan communications (such as annual enrollment materials) as the document that will control in the event of discrepancies, or errors or omissions in these other ancillary communications.

-- Keep SPDs up to date and distribute them to employees. ERISA requires that employees receive a summary plan description (SPD) covering each benefit plan, and specifies the information that must be included in the SPD. Plan vendors may supply booklets or other communications materials to distribute to employees that describe the plan, but these are unlikely to meet the requirements for an SPD. When plan changes result in an SPD needing modification, an employer may distribute a summary of material modifications in the interim before preparing an updated SPD.

-- Include only eligible employees (and dependents) in your plans, as to do otherwise will run contrary to plan documents and represent unnecessary coverage costs for your company. Improperly covering ineligible individuals- contractors, leased employees, former employees, etc.- can be a costly proposition. Similarly, maintaining formerly eligible dependents who, for example, have aged out of the plan, unnecessarily adds to plan costs. Eligibility audits can help to mitigate this problem.

-- Follow plan terms in administrative practices. The plan document governs, and both internal staff and outside administrators must follow the terms of the plan when making eligibility and claims decisions, issuing plan notices, handling appeals, etc.

-- Make sure plan contributions are properly calculated. This includes taking into account the definition of compensation that is in the plan (which may include bonuses, commissions, etc.) and correctly calculating matching and profit sharing contributions.

-- If you allow employees to pay for any benefits on a pretax basis, a cafeteria plan is required. While the term "cafeteria plan" may conjure up images of employees selecting from a menu of benefit choices, a cafeteria plan is, at its most basic level, a premium only plan, and is required to be adopted before employees can pay their health (or dental, vision, etc.) plan premiums with before- tax dollars, or to make before- tax contributions to a health care or dependent care flexible spending account.

-- If employees make salary deferrals to a 401(k) plan, these deferrals must be deposited into the plan trust on a timely basis, as by DOL regulation they become plan assets as soon as they can be reasonably segregated from the employer's general assets.

-- Review your COBRA administrative practices to make sure all individuals qualified to elect COBRA coverage receive the proper notices, for all plans subject to COBRA (the health plan, but also the dental and vision plan, and the health care flexible spending account).

Administrative errors can result in fines and penalties, lawsuits, and employee discontent. An annual plan self-review can avoid these potential costly consequences of common mistakes.

Many Employees Remain Unaware Of Lower- Costing Alternatives To Their Existing Medications

An August 2010 survey sponsored by UnitedHealthcare found that most Americans are concerned with their medication costs, but admit that they don't know how much new prescriptions cost them or if there's a less expensive option available to them.

Consumers being unaware or unfamiliar with generic alternatives and less expensive alternatives means that many are missing a chance to substantially save on their out- of- pocket drug expenses. UnitedHealthcare has estimated that if members with fully insured plans changed to a generic brand or alternative lower- costing option, the result could be a yearly health care savings of over one billion dollars, \$490 million of which would be savings on prescription co- pays.

Other highlights from the study included:

* Thirty percent of those surveyed admitted that they had not taken or skipped a dose of their routine medications due to the high cost of their prescription.

* Sixty percent of those surveyed said that they had concerns regarding the cost of their medications. Of those, almost seventy percent admitted that they often didn't know the cost of their prescription prior to purchasing it.

* Yet, when the respondents were asked if they would be willing to switch to a lower- costing medication if their doctor gave them two medically equivalent medication options, an astounding ninety- four percent answered yes.

The Desire For Information

The survey clearly showed that most Americans purchasing prescription drugs have an interest in learning more about their options, especially lower- costing options. There are several ways that employers can help their employees to more comprehensively understand how much their medications are costing them and discover ways to reduce their out- of- pocket prescription drug spending without compromising the medicinal effectiveness of their medications.

1. Employers might develop communications tailored to providing plan participants information about saving options, recognizing alternative lower- costing medications to their existing expensive medications, and advice and support on how to pursue other options. This can be in the form of a phone call, email, newsletter, or such.

2. A co- pay tier system can be very helpful in communicating the differences in value between drugs. The more fiscally and clinically advantageous medications should be placed on the lowest tier. These are the medications that have little, if any, co- payment. Meanwhile, the more expensive medications with higher co- payments should be placed on higher tiers. Plan members will be able to clearly see the difference in how much they pay for their existing

medication and how much they could be saving with an equally effective lower- costing option. Seeing the difference in such a comprehensive manner can motivate the employee to consider trying a lower- costing medication option.

3. Pharmacists can be given specific messaging on what lower- costing and effective options are available to plan participants. As an employee goes to his/ her pharmacy to fill a prescription, the pharmacist will see what alternatives are available at a lower- cost and be able to convey this information to the individual. If the employee feels that a lower- costing medication is desirable, then the pharmacist can contact the doctor that prescribed the medication to approve the change or, in some cases, make the change then and there.

4. A pill splitting or half- tablet program can reduce employee co- pay on medications by fifty percent. However, a physician must state on the prescription that the pills are to be halved or split.

Tools Help Consumers Choose Quality Health Care at the Best Price

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The cost control promise of consumer- directed health plans depends on plan members making medically appropriate, yet cost- conscious, decisions when seeking health care services. Though resources to enable this kind of decision making have been lacking, some tools are being developed that help consumers to find and choose quality providers, and compare costs before receiving services.

As stated in a release from the Employee Benefit Research Institute in conjunction with its 2008 EBRI Consumer Engagement in Health Care Survey, the premise of consumer- directed health plans is that by transferring more costs to plan members, they will become more savvy health care consumers, and have more incentive to take better care of themselves. In support of this, the survey found that consumer- directed health plan members ranked high in cost- conscious behaviors, including seeking information on the cost and quality of doctors from sources other than their health plan, considering cost information when making health care decisions, and asking a doctor to recommend a less costly prescription drug.

But just where can consumers find cost and quality information on doctors, hospitals and other health care providers to enable informed health care consumerism?

For health care provider quality information, the Department of Health and Human Services' hospital compare tool ([http:// hospitalcompare.hhs.gov/](http://hospitalcompare.hhs.gov/)) allows users to choose up to three hospitals, and then provides data on patient satisfaction, outcome and process of care measures and other quality data. Users can also input a medical condition and the results will be specific to that medical condition. The Leapfrog Group website ([http:// www.leapfroggroup.org/ cp](http://www.leapfroggroup.org/cp)) enables hospital comparisons on overall patient safety and the safety of selected procedures.

For information on the cost of specific health care services, the firm change:healthcare ([http:// www.changehealthcare.com/](http://www.changehealthcare.com/)) issues a quarterly Healthcare Transparency Index that analyzes medical claims to determine opportunities for cost savings in different medical categories. The index, for example, looks at the cost of prescription drugs in different pharmacies to isolate opportunities for savings that consumers could take advantage of by shopping around when filling their prescriptions.

According to the 2010 index, prescription drugs are the health care services category that offers the highest opportunity for savings, followed by dental, psychotherapy, primary care physician office visits, physical therapy and chiropractic care. Both generic and brand- name prices varied by dispensing pharmacy. For example, a user of Abilify, a brand- name drug to treat depression, could save nearly \$2,500 a year by making a pharmacy change; for omeprazole, a generic for Prilosec (to treat acid reflux), a pharmacy switch could mean close to \$900 in annual savings. Switching from one name pharmacy to another was not the only way for a consumer to save money on prescription drugs, because within pharmacy chains, costs could vary widely location to location, with Wal- Mart, Target, CVS and Walgreen topping the list of pharmacy chains with the largest cost discrepancies for a one- month supply.

Consumers need and deserve more information than has been traditionally available about health care providers and services, including the costs of various treatment options, results of patient experience surveys, and data on quality. The Consumer- Purchaser Disclosure Project, an employer/ consumer/ labor organization collaboration, suggests that such information should be provided through simple printed materials, including comparison charts and worksheets, as well as through interactive computer programs. These types of tools will help consumers choose the right health care, at the right price. Only then will consumer- directed health plans live up to their cost- savings potential.

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