MCA Administrators

Administrator

Important news and updates from your benefits professional **Fall 2011**

This Issue

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Maybe it's time to make FSAs even more vital for consumers.

Save with New Generics
Six of the top 15 brand name drugs will go generic in the next 15 months.

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A few states have rejected exchange funds and others are weighing their options.

New Ideas for Healthy Consumers and More!

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.**

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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 from 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

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, their Health and Human Services Director said they would continue to analyze their options, cautioning that many states have a habit of chasing any money that becomes available, rather than pursuing their 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.

regulation of what foods children consume, McDonald's Corporation plans 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.

Did You Know? New Ideas for Healthy Consumers

How to Avoid an After-Labor Day Letdown

Change is always difficult, and this time of year not only are our daily lives changing but nature is as well. People have mixed emotions about this time of year. Some look forward to the colorful leaves, the crisp, cool air, football and holidays with family. Others dread the change because summer vacations have come to an end, school is back in session and pressures on the job can begin to add up as we approach the end of another year. Many had also set a lengthy list of goals they wanted to accomplish before the summer ended. Going back to work can be discouraging to those who did not accomplish everything on their list.

Some adults who get the summer off suffer from "Labor Day Blues." They were given a taste of life without their daily demands and have been reminded of what is truly important. A myriad of individuals suffer from Post Vacation Syndrome (PVS), which is characterized by irritability, anxiety, lack of motivation, difficulty concentrating and a feeling of emptiness that often can linger for a few weeks after returning to work. If these symptoms persist, it may be a sign that we are in the wrong profession or may need a change in work environment. Several individuals feel a very mild form of PVS every Sunday after having the weekend off.

If you feel you are suffering from PVS, try not to make any dramatic changes. Instead, wait a few weeks to see if the feelings diminish. It is important, however, to monitor your feelings to ensure your blues do not cross the line into a state of depression. If your less-than-pleasant mood interferes with sleep, appetite, or daily functions, you should think about seeking some help.

Fewer Antibiotics for Children

Worldwide public health organizations have voiced concern about antibiotic overuse in children. Attempts to discourage the overuse of antibiotics, which can lead to drug-resistance, have been successful. Researchers at the Center for Disease Control and Prevention report that antibiotic prescription rates for children ages 14 and younger dropped 24% between 1994 and 2008.

New Generics Will Save You Money

In the next 15 months, six of the top 10 drugs used by Americans will face generic competition. Nearly 15 million consumers take Lipitor for cholesterol, the anti-clotting drug Plavix and Actos for diabetes. Others include Nexium, Advair, Diskus, Seroquel and Cymbalta, which will go to generic form in July of 2014.

The expiration of these patents represents an unprecedented opportunity for savings since generics are often priced 90% lower than their brand-name counterparts. As an example, those who need Lipitor can expect to see their monthly cost fall to as little as $4 from the $40 they may be spending now. Experience shows that when a generic becomes available, patients change more than 90% of the time. While there are a number of drugs that doctors prefer not to substitute, a transition to a generic is usually complete within six months of a patent expiring.

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 that may impact your personal health. Talk to your benefits administrator before implementing strategies that may impact your organization's employee benefit objectives.

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