

Employee Benefit Insights



HRAs Help Introduce Employees to Health Care Consumerism

Discussions of consumer-directed health plans frequently focus on high-deductible health plans coupled with health savings accounts (HSAs). Sometimes overlooked are health reimbursement arrangements (HRAs), employer-funded accounts that can be a solid first step in transitioning to a consumer-directed approach to health care.

In some ways, HRAs work like other kinds of account-type health care plans. Employees can use an HRA to pay for their qualified medical expenses, along with those of a spouse and children. Such expenses could include deductibles, copayment and coinsurance amounts, and any type of expenses that fall under the Internal Revenue Code definition of a qualified medical expense. Funds withdrawn to pay for qualified medical expenses are not taxable to the employee.

From an employer's perspective, one of the great advantages of HRAs is that they have tremendous design flexibility. Unlike health savings accounts, they do not need to be tied to a high-deductible health plan. Their design, however, can complement the company health care plan; for example, if you have had to make changes to your company health plan to make it more affordable—such as increasing deductible or copayment amounts—you can offset the impact of such changes on employees by setting up HRAs and letting employees know that they have access to HRA funds to pay for these increased costs. The employer can also, by plan design, limit the expenses that can be paid for through the HRA (such as only for those increased deductibles or copayments); change or enlarge the scope of reimbursable

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WELCOME...

On February 17, 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act, was signed into law as part of the American Recovery and Reinvestment Act (ARRA). Among other things, the Act extended HIPAA privacy and security requirements to directly regulate business associates of covered entities and included stricter requirements for breach notifications.

To learn more about HITECH please login to your BRB Client Access portal by going to www.BroadReachBenefits.com. Once logged in, type HITECH into the search box. If you need your login information click the "Retrieve your login information" link.

Please be assured that we will continue to treat with utmost care the confidential information entrusted to us and are prepared to comply with the requirements imposed upon business associates by the HITECH Act. As always, let any of our staff know if you have any questions.

—Philip Cohen, BRB President

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expenses year to year; and change the contribution it makes to the plan each year.

For employers unable to sponsor a comprehensive type of medical plan, an HRA can be a way to provide some health care benefit to employees. The cost of the plan would be predictable-whatever amount the employer chooses to contribute to employees' accounts-and could vary year to year. Employees could use their HRA funds to pay for medical expenses, or apply them toward the premium of a health plan they purchase on their own.

As noted above, HRAs are employer-funded accounts; no employee contributions are permitted. However, as with any type of health plan contributions, the contributions an employer makes to an HRA are deductible. Though funding HRAs entails some expense for employers, strategic implementation can sometimes be used to offset these costs to some degree. For example, if the HRA is implemented along with health plan design changes that help control plan costs-such as an increase in deductibles or copayments-the employer can use any premium cost savings to help fund the HRA.

HRAs also have the advantage of helping employees develop more awareness of the cost of health care. Just as when withdrawing funds from any type of savings account, each time employees contemplate using the HRA to pay for a medical expense they're faced with considering whether they're meeting the medical expense in the most cost-effective way possible. Such thinking is an incentive to take the steps necessary to make informed, cost-conscious health care spending decisions. And, since HRA funds carry over year to year (and are not forfeited, such as are unused amounts left in health care flexible spending accounts), employees have additional reasons to be careful about how they spend HRA money. By design, however, an employer can limit the carry-over feature of the HRA and decide whether to make unused funds available for retirees to use.

HRAs offer the opportunity to provide a cost-defined, tax-advantaged health benefit that can help employees become more informed, savvy health care consumers. Of the many options employers have to choose from in providing health benefits to employees, HRAs are an attractive one to consider. 🌊

Fight the Epidemic of Health Care Fraud

In 2007, health care expenditures in the United States hit approximately \$2.6 trillion, according to the Centers for Medicare and Medicaid Services. Estimates put the portion of this outlay that is attributable to health care fraud-

payment for nonexistent, exaggerated, or ineligible services-at anywhere from 3% to 10%, according to the National Health Care Anti-Fraud Association (NHCAA).

Health care fraud comes in many different shapes and sizes. Perpetrators include patients, providers, as well as individuals or groups with no connection to the health care system.

Organizations such as the NHCAA emphasize that, while the vast majority of doctors, hospitals, therapists, etc., are honest and submit valid billings, most cases of health care fraud do originate with providers. The types of health care fraud seen from providers include:

- Billing for services that were never actually provided to the patient;
- Falsifying a diagnosis;
- Upcoding, or billing for a more expensive service, treatment, or procedure than the one that was actually performed;
- Recoding, or billing for a different treatment or procedure than the one actually provided (for example, the service actually provided is a nose job, which is considered a cosmetic procedure and not covered under the plan; but the provider codes it as a repair to the septum, which would be covered);
- Performing unnecessary tests and/or procedures (e.g., diagnostic tests);
- Unbundling services that are part of one procedure and billing for each separately; and
- Billing for the entire cost of a service when partial payment (such as a copayment) has been collected from the patient.

Patients commit health care fraud by listing and filing claims for ineligible dependents; sharing health plan identification cards;






filing claims for services they never received; altering or forging bills and receipts; and buying and re-selling prescription medications.

Health care fraud can also be perpetrated by individuals or groups posing as providers who, using stolen or “purchased” patient insurance information and provider billing numbers, submit bills for services from a fictional clinic. Or, they may pose as providers in order to obtain other individuals’ legitimate health insurance information, and then use the information for themselves, or even sell it.

While health care fraud adds to costs, it also carries a price tag that is not financial. Patients undergoing unnecessary procedures, testing, or drug therapies face risks to their health. Phony or inflated diagnoses result in inaccurate patient medical records, which can complicate later treatment. Amounts paid on fraudulent claims may result in an insured reaching a dollar-amount or number-of-visits maximum under a policy when seeking coverage for later, legitimate claims.

Industry groups, insurance companies, and state and federal governments have become increasingly proactive in their efforts to prevent, detect, and punish instances of health care fraud. The Health Insurance Portability and Accountability Act (HIPAA) established health care fraud as a federal criminal offense. HIPAA provides for financial penalties as well as imprisonment for up to ten years for health care fraud convictions, with longer sentences if the fraud results in patient injury or death. Many state insurance departments require anti-fraud efforts by the insurers or HMOs that operate in their states. Insurers and HMOs staff dedicated investigative units that use computer technology, patient education, and solid communications with other insurers and law enforcement to battle health care fraud. The NHCAA offers a professional certification-the Accredited Health Care Fraud Investigator-to those that complete a training course.

It is in the best interest of every business and individual to do what it can to prevent health care fraud. Not only does fraud contribute to the overall rate of health care cost increases, it affects your rates at renewal. Talk with your health insurance provider about their anti-fraud efforts, and help your employees become attuned to what they can to avoid becoming an unwitting participant in a health care fraud scheme (e.g., safeguarding their health insurance ID cards and insurance information; being wary of offers for “free” services; examining explanation of benefits (EOB) statements for accuracy).

These efforts, at a grassroots level, do make a difference. 



Communications Are the Most Important Factor in Generating Satisfaction with Benefits

Effective communications can have as much impact on employees’ satisfaction with their benefits as the actual benefits offered or the amount of money a company puts into a benefits plan. This finding, from a study by the Prudential Insurance Company, illustrates one way for companies to contribute toward positive employee morale, even when economic factors necessitate benefits cutbacks or restructuring.

The study looked at a number of variables that affected employees’ perceived value of their benefits. The effectiveness of communications topped the list, followed by a company paying all or most of the cost of benefits and then by a company offering a range of benefits. According to the study, how employees perceive the value of their benefits directly influences how important benefits are to employees when selecting a job or when deciding whether to stay with a current employer. This is because effective communications help employees to not only understand, but also appreciate, the benefits they have or those that are available to them. Thus, the study validates the positive connection between employee benefits and an employer’s recruitment and retention efforts.

A separate survey from Watson Wyatt Worldwide dramatically shows the impact of benefits communications: Companies with above average benefits but ineffective communications had a 25% employee satisfaction level, while those with below average benefits but effective communications had a 76% employee satisfaction level. Stated another way, it can be better for a company to provide fewer benefits but explain them well, than to provide an expansive-and costly-package of benefits




that employees don't really understand.

Keep the following considerations in mind when assessing your benefits communications:

- Written communications should be in simple and understandable, yet engaging, language. Employees will respond best to communications that they can directly relate to, so use specific examples or modeling tools to help employees select benefits and understand how the benefits can work for them.
- Recognizing that different individuals learn in different ways, use various media at your disposal for your communications. Go beyond written communications to also include emails, meetings/seminars, announcements, posters that highlight images and graphics, interactive web tools, and video conferencing.
- Communicate throughout the year, not only during open enrollment. Use non-enrollment periods to highlight particular features of your benefit plans, perhaps focusing on one each month. This enables you to hone in on benefits or plan features that are particularly useful or unique, and that perhaps get overlooked during the frantic activity of annual enrollment. Such features might include wellness features in the company health plan, modeling tools available through the 401(k) plan, the advantages of pre-tax employee contributions, changing benefits during the year in response to a family status change, etc.
- Help employees understand how the company's benefits offerings are particularly relevant to them. For example, if your company offers voluntary benefits, employees are likely to have broad choices that go well beyond the one-size-fits-all approach to employee benefits. Highlighting the convenience, access and cost-savings features of workplace voluntary benefits can help employees see how advantageous such offerings can be to them.

If the prospect of embarking on a benefits communications campaign seems daunting, a company's benefits provider can be a valuable resource for communications ideas and strategies, along with actual communications materials. Don't hesitate to turn to your benefits providers to see what services are available.

Don't underestimate the value of communications and education as a way to strengthen your company's benefits package. As the research above indicates, dollars spent on communication and education can be as valuable an investment as dollars spent on the benefits themselves. 

Long-Term Care Options Broaden Over Time

In days past, long-term care (LTC) usually meant going to a nursing home for a few months or years, and then dying. This is no longer true.

LTC now covers a variety of custodial (unskilled or semi-skilled) types of care. Although nursing homes are still one of the main pillars of LTC, there are many other options to consider:



- Home health care
- Community-based care
- Assisted Living Facilities
- Adult day care
- Respite care
- Hospice care

In many instances, the care that used to necessitate confinement in a nursing home can now be provided in the home or an assisted living facility. One of the most requested benefits in LTC insurance coverage is the option to stay at home, and/or to keep one's spouse or other family members out of a nursing home, for as long as possible. In today's world, many care facilities are integrated. That is, you can live in a retirement community and receive home health care services; move to the assisted living facility and receive increasing levels of care; and finally enter the nursing home or cognitive impairment facility. All this can often be done within the confines of a single "campus."

Another interesting aspect of LTC is this: many people transit through the various care options and eventually are able to return home or to a less demanding level of care. However, this




presents a problem if Medicaid is your LTC payment source.

In order for Medicaid to pay your LTC bills, you generally need to be in a nursing home or cognitive impairment facility. Most states do not pay for other forms of care. You also have to be nearly destitute. So, if you give away assets or spend them to qualify for Medicaid "aid," and you get well enough to leave a Medicaid-covered facility, what will your plan be? Definitely something to keep in mind!

It's important to have discussions - with your spouse, your aging parents, your adult children - about what LTC really means. A couple of important items for your discussion would be: how you (or they) will pay for this care, and who will make the decisions if you (or they) are not able to do so.

You should also take time to visit the various facilities you might want to live in. If you are considering selling your home and retiring to an integrated retirement/LTC campus, make sure you like all the aspects of the facilities. Many of these facilities require you to pre-pay large sums to ensure you can transition smoothly from one living arrangement to another, so it is important to make an informed decision.

As you can see, LTC now covers a very different set of circumstances than when your great-great uncle or great grandfather went into the nursing home. With a bit of planning, you can continue to live almost a normal lifestyle well past the time you might otherwise have ended up in a nursing home. 

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