

Dispelling the Discount Myth

In This Issue...

There is a common misperception that national carriers provide deeper discounts than proprietary PPO networks. When presented with a discount report from a national carrier, the discounts do seem impressive, but when comparing discounts between a national carrier and a PPO network, it is important to analyze all of the components carefully and take a close look at what is reported as a discount and the calculation methodology used. Here are some questions to ask:

What is reported as a discount?

Often times, national carriers report metrics such as duplicate billings, ineligible charges, and plan design elements (i.e., employee deductibles and out-of-pocket and co-insurance amounts), which can be an overstatement.

How are the inpatient hospital discounts calculated?

You may have heard that national carriers can provide much larger discounts on services such as inpatient hospitalizations. In some cases, the largest discount is only applicable if the patient admission is less than a certain length of stay, such as three days. If the patient is in the hospital longer than three days, the total discount available can be much less and would be applied to the entire hospital stay.

What data was used to report the discounts?

The savings may appear greater if, for example, the claims data includes a low volume of claims, with two or three large discounts representing a significant portion of the overall savings. In this scenario, the net discounts will appear higher.

Consider this example when comparing discount percentages of a PPO network to a national carrier:

PPO Network		National Carrier	
Submitted Charges	\$200,000	Submitted Charges	\$200,000
Actual Discounts	\$75,000	Ineligible Charges	\$30,000
Percentage Discount	37.5%	Deductible/OOP	\$20,000
		Eligible Charges	\$150,000
		Actual Discounts	\$75,000
		Percentage Discount	50.0%

In this example, the actual network discounts are exactly the same. Assuming the plan design elements are equivalent, the ineligible charges, deductible and out-of-pocket would be the same, resulting in the same net payment. The plan does not save more money with the national carrier, but it appears it is getting a much larger discount.

Mandatory Eligibility Data Sharing With Medicare

Compliance Deadline Extended

The new mandatory eligibility data sharing with Medicare, as required under The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. No. 110-173), requires employers, TPAs and insurers of group health plans to share eligibility information with CMS to assist Medicare in determining primary versus secondary payer responsibility for Medicare beneficiaries.

The guidance released from the Centers for Medicare & Medicaid Services (CMS) in early August, stated it was effective on January 1, 2009. CMS has the regulatory authority to delay implementation and has chosen to do so. On September 5, CMS released its new timeline for implementation by 10/1/09 to some groups, based on the type of plan and if they previously were reporting under voluntary data sharing agreements.

The purpose of the eligibility sharing is for CMS to collect various data elements from the applicable reporting entities for purposes of implementing the mandatory MSP reporting requirements. This information will be used to ensure that

Medicare makes payment in the proper order and/or takes necessary recovery actions.

“MSP” refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary. Under the law, Medicare is a secondary payer to Group Health Plans (GHPs) for certain beneficiaries, including:

- those who are age 65 or older and working with coverage under an employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- those who are age 65 or older and with coverage under a working spouse’s employer-sponsored and/or contributed to GHP, for an employer with 20 or more employees (the working spouse can be any age) (or if it is a multi-employer plan where at least one employer has 20 or more full or part-time employees);
- those who have End Stage Renal Disease (ESRD) and are covered by a GHP on any basis (Medicare is secondary for a 30-month coordination period.); or
- those who are disabled and have coverage under their own or a family member’s GHP for an employer with 100 or more full or part-time (or if it is a multi-employer where at least one employer has 100 or more full or part-time employees.)

The first step in implementation is for the reporting entity to register with CMS, which will begin in April 2009. Each registrant will work with CMS through a web portal, first submitting test information with a Medicare COB contractor. A TPA will then send a file electronically through the web portal quarterly and it will be checked against a CMS database.

Resources

DOL web site:

<http://www.cms.hhs.gov/MandatoryInsRep/>

Society of Professional Benefit Plan Administrators



Mental Health Parity Passes Congress and Signed into Law

October 20, 2008

As many of us watched the deepening economic crisis unfold and applauded or decried the recent Congressional "Bailout Bill," we may not have noticed the important mental health parity provisions snuck into HR 1424 as part of the financial bailout package. The mental health parity provisions of the bill have important implications for employers and are effective January 1, 2010, for calendar year plans and as early as November 1, 2009, for other plans.

The mental health parity provisions require greater mental health and substance abuse parity rules for group health plans. A group health plan cannot impose more restrictive requirements for deductibles, co-payments, or treatment limitations for mental health or substance abuse coverage than for other medical benefits. Specifically, the rule states that the limitations on mental health and substance abuse may not be "more restrictive than the predominant" limitations "applied to substantially all medical and surgical benefits." This language is broader than previous versions of the bill and rules; instead of only applying to lifetime maximums, the limits apply to all expenses, network restrictions, and limitations on frequency of visits and coverage.

If your company has 50 or fewer employees, the mental health parity rules do not apply to your plan. If the costs associated with the new legislation meet the threshold levels in the bill, an employer may apply for an exemption to the requirements. It is important to note that a health plan is not required to cover mental health or substance abuse issues, but if it does, it must extend that coverage in the manner the rule describes. As most employers have mental health coverage in their plan, all plan documents must be amended in the next year. This is also likely to have some cost impact on plans, and employers should be prepared for higher renewal expenses in the next year.

This is federal law and, as such, is applicable to all health plans including those that are self-funded.

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Innovative Care Management's Healthy Mother Baby Program

Giving birth to a healthy baby can be one of life's most exciting events.

Innovative Care Management (ICM) offers the Healthy Mother Baby program, designed to provide valuable information, tips, reading materials, videos, phone support and peace of mind for expectant mothers.

Early in the pregnancy, a nurse specializing in maternity and newborn care will conduct a telephone interview with the expectant mother to get to know her and better understand

how ICM can best serve her. As the pregnancy progresses, the Healthy Mother Baby nurse will contact the expectant mother on a regular basis to address concerns, questions and continue to evaluate her needs. With approval, the nurse can consult directly with the participant's physician, as appropriate.

Program Features:

- Available to new AND experienced mothers
- Access to a nurse specializing in maternity and newborn care
- Educational packets sent to the participant's home, which include a prenatal care book, brochures and a variety of samples and coupons
- A resource library with additional materials available upon request (at no charge)
- Support and information for high risk pregnancies
- Confidentiality
- Convenient on-line enrollment

To obtain more information, visit www.HealthyMotherBaby.com, call ICM at 1-800-862-3338, or contact your Account Manager at A&I.



Pension Plan Limits 2009

The Internal Revenue Service has announced the annual cost-of-living adjustments applicable to dollar limitations for pension plans and other items for Tax Year 2009. With only one exception, the increase in the cost-of-living index met the statutory thresholds that trigger their adjustment:

Type of Plan	2009	2008
Elective Deferrals: 401(k), 403(b), 402(g)(1)	\$16,500	\$15,500
Elective Deferrals for 457(b) and Special Catch-up Limit: 457(b)(3)	\$16,500 \$33,000	\$15,500 \$31,000
Age 50+ Catch-up: 414(v)(2)(B)(i)	\$5,500	\$5,000
Defined Contribution Limit: 415(c)(1)(A)	\$49,000	\$46,000
Defined Benefit Plan Limit: 415(b)(1)	\$195,000	\$185,000
Annual Compensation Limit: 401(a)(17), 404(1)	\$245,000	\$230,000
Highly Compensated Employee: 414(g)	\$110,000	\$105,000
SIMPLE Retirement Accounts & Age 50+ Catch-up: 408(p)(2)(E), 414(v)(2)(B)(ii)	\$11,500 \$2,500	\$10,500 \$2,500
IRA/Roth IRA Accounts & Age 50+ Catch-up: 219(b), 408(a)(1), 408(A)(c)(2)	\$5,000 \$1,000	\$5,000 \$1,000
Social Security Wage Base	\$106,800	\$102,000

Limitation which remains unchanged

The maximum amount of catch-up contributions that individuals age 50 or over may make in 2009 to SIMPLE 401(k) Plans or SIMPLE Retirement Accounts remains unchanged at \$2,500 (Code section 414(v)(2)(B)(ii)).

Resources

Trucker Huss ERISA and Employee Benefits Attorneys



Employee Update

Promotions

Jessica Holstead to Claims Analyst II

2009 Upcoming Milestone Anniversaries

Bethine Vincent	20 years
Rich Crook	5 years
Debbie Roeters	5 years
Heidi Vass	5 years

Congratulations to you all!



Upcoming Holiday Closures

December 24 & 25	Christmas
January 1	New Years Day
January 19	Martin Luther King Day



A&I Memberships & Affiliations

- ◆ Health Care Administrators Association
- ◆ International Foundation of Employee Benefit Plans
- ◆ Oregon Health Forum
- ◆ Oregon Entrepreneurs Network
- ◆ National/Oregon Association of Health Underwriters
- ◆ Northwest Association of Administrators
- ◆ Self-Insurance Institute of America
- ◆ Society of Professional Benefit Administrators
- ◆ Society for Human Resource Management

Showing Our Support

A&I is pleased to support our community through a commitment to charitable giving and volunteerism. In each newsletter, we will feature one of the many nonprof t organizations we have had the pleasure to work with and support.

Health Bridges International

Founded by Wayne and Lee Centrone, Portland-based Health Bridges International is committed to improving public health by creating medical and social service partnerships between healthcare workers and organizations in the United States and those in developing nations. The organization distributes donated medical equipment and other supplies, and provides support services such as water purification, training and aid. Volunteers from the organization take annual trips to Peru and work in tandem with Peruvian professionals and volunteers delivering a range of services and aid.

A&I Senior Vice President & Trust Administrator Lee Centrone, who currently serves as treasurer on the board of directors, was very involved in the founding of the organization, along with her husband, Dr. Wayne Centrone. They both spend several weeks each year in Peru, and Lee volunteers her time organizing medical and social outreach missions to help those in need.

You can show your support by visiting www.hbint.org to learn more about how to get involved or make a donation.

"We build bridges so that the communities and individuals have the systems in place to take care of themselves."

-Wayne Centrone



Health Bridges International, Inc

Health through Partnerships and Service

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