



the BusinessEdge

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INDUSTRY WATCH

Long-Term Care Insurance: A New Executive Perk

No one can argue that healthcare costs have gotten out of control. While more of the burden has fallen on employees, senior-level executives have also felt the pinch. Companies have been focusing on ways to attract and retain skilled executives through compensation packages, and one way has been through a long-term care insurance benefit. Expect this benefit to become as commonplace in the next decade as medical or dental care.

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PRACTICAL MANAGEMENT

Simple Risk Management Saves the Small Business Dream

The desire to succeed, coupled with hard work and innovation are crucial ingredients for the small business owner. But watch out for reality in the form of risk. The inability to manage risks results in a 90 percent failure rate for all new businesses according to the U.S. Small Business Administration. While understanding market trends and changing customer tastes are important, so, too, is the focus on financial and legal risks. There are fundamental ways to manage risks to permit business owners to expend more of their energies on their core competencies.

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When is 3¢ Per Minute Not Really 3¢ Per Minute?: A Primer on Call Rounding Part 1

A business signs a long-term agreement with a long distance carrier expecting to enjoy favorable rates. The agreement

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Words from the Wise

"A good plan implemented today is

better than a perfect plan implemented tomorrow."

- George Patton

will reflect what the rate would be per minute; and so adding up the minutes used per month and multiplying the rate should arrive at the billed amount, right? Wrong. The one element not considered is rounding. Businesses could be charged 10 to 20 percent more as a result of rounding; sometimes the average cost per minute can be higher by as much as 100 percent. It pays to investigate what, if any, rounding methods are used before entering into an agreement.

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INDUSTRY WATCH

Medical Insurance Plans: Challenges and Opportunities for Managing Costs

Employers are shifting a larger share of health costs to their employees; and this has resulted in individuals purchasing high deductible or consumer-driven health plans with or without health savings accounts or health reimbursement accounts. Employees want a greater say in **all** aspects of their medical care. This could lead to reduced utilization of medical services and an overall reduction of costs in the near term. The upside to all this: increased consumer education on the medical care available and what treatment options are most suitable.

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INSIDE TECHNOLOGY

What Every Company Should Know About E-Mail

Beyond the efficiency and effectiveness of e-mail systems for businesses and professional service firms is the additional component of corporate governance. Yes, Sarbanes-Oxley addresses e-mail communications in several sections that impact corporations and CPA firms. Protocols must be in place and clearly articulated to all levels of staff with respect to message archival, retention, supervision, mail-storage management, discovery and litigation support. The solutions that are implemented must consider the unique factors and regulatory frameworks associated with different lines of business and departments.

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TIP OF THE ISSUE

Three Ways to Use Trade Shows to Boost Your Bottom Line

It seems that tradeshow run all year round. Tradeshow, if done correctly, can provide a positive image of a company. The three objectives of being at a tradeshow are to: 1) get noticed; 2) drive traffic; and 3) capture leads. Make sure that you spend your time wisely to achieve these goals.

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INDUSTRY WATCH

Long-Term Care Insurance: A New Executive Perk

By Paul S. Devore, CLU, CFP

{ Editor's note: An expanded version of this article was originally published in the June 2004 issue of *Employee Benefit Plan Review*. }

For years, companies have focused on creating benefit packages that provide financial security to key executives and their families as a means for attracting and retaining skilled executives. Times are changing. A secure financial future is no longer enough. As the baby boomers edge toward their 50s, 60s and beyond, they want to ensure that their healthcare needs are addressed in a way that won't deplete their family's life savings and retirement accounts. Responding to this need, many more companies than ever before are offering long-term care insurance as a key executive perk.

Long-Term Care Definition and Tax Benefits

Long-term care (LTC) plans have been around since the mid-1980s, but grew in popularity in the 1990s, especially after the passage of the [*Health Insurance Portability and Accountability Act of 1996*](#) (HIPAA). LTC is defined in HIPAA as accident and health insurance and is not subject to ERISA guidelines (IRC 7702B(a)(2)). A company is under no obligation to offer LTC to all of its employees. It can decide who participates so it can limit coverage to only specified employees and their dependents.

LTC plans have attractive tax benefits for the employer and employee because —

- Premiums paid on policies are fully tax-deductible to a C-Corporation for employees and stockholders (IRC 162).
- Pass-through entities and sole-proprietorships receive a full tax deduction for non-owners, and a 100 percent or a partial deduction for owners, depending on their age and premium amount.
- Premiums paid by the company are not considered taxable income to the executive receiving the benefit. [(IRC 7702B(d)(4)]
- LTC benefits are tax-free (up to \$230/day in 2004). [(IRC 7702B(d)(4)]
- Where the policy contains a "refund of premium" feature, the insured's beneficiary can receive all premiums paid into the policy as a tax-free benefit at the death of the insured [(IRC 7702B(b)(2)(c)]. This is an added benefit for stockholder/employees because the premiums were originally deductible — fully or partially — by the company.

How LTC Works

LTC can be offered by companies with one employee or thousands of employees. Premiums are based on the age of employees and the level of coverage. Before introducing a LTC plan to employees, employers must decide who will receive the coverage (all employees or a selected number), and determine whether premiums would be entirely employer paid; or employers pay for base coverage with employees paying for optional coverage.

Companies typically have a great deal of flexibility when deciding on plan objectives; eligibility requirements; types of policies used; optional policy benefits and riders; coverage amounts and durations; and guarantees and payment options.

The lowest premium does not necessarily mean the lowest cost. When determining the appropriate coverage, each prospective LTC policy's provisions and benefits must be carefully evaluated and compared. Initial low-cost policies could end up costing the most if they do not adequately cover or address the multitude of long-term health options and costs.

Basic plans cover care in nursing homes, assisted living facilities, and in-home care and hospice care. In some cases, the policyholder must purchase a "home health care" (HHC) feature as a separate rider. HHC allows benefits for care provided in the care receiver's home instead of in a nursing home or other facility. Some policies will pay benefits to a family member or friend who provides care, while others will pay only licensed caregivers. In-home delivered meals and housecleaning services often are also included in the basic plan.

Important Factors to Know About LTC Policies

LTC policies are typically "guaranteed renewable." With this clause, as long as premiums are paid when due, the insurance company cannot refuse to maintain the policy in force. They can, however, increase rates; sometimes after a brief guarantee period. The company may be forced to choose between paying the higher premium and losing the policy.

Most LTC policies specify how many basic daily living activities must be lost before triggering benefit payments and classifying the loss as needing "hands on assistance" or "standby assistance."

Policies are structured as *indemnity* or *reimbursement* models. In its pure form, the *indemnity* policy pays a specified daily benefit irrespective of costs actually incurred, while the *reimbursement* model pays only the actual qualified costs or a percentage of costs.

Elimination — or waiting — periods are spelled out in LTC policies. These are essentially deductible features where no benefits are paid before a specified period expires. Typical waiting periods are 30 to 90 days. This means the employee must pay the first month to three months of long-term care before the benefits take affect. The shorter the waiting period, the higher the policy cost. There are differences between policies on how the elimination period is measured; some being more generous than others.

Unlike most LTC policies purchased by individuals, *executive benefit policies* purchased through a business are customarily paid within 10 years, and sometimes even with one single premium. Besides the larger tax deduction for the shorter premium period, the policy is truly "paid" and the carrier cannot increase premiums. Thus, an extra measure of price safety exists.

A variety of optional riders can be purchased with the LTC policy. A common rider provides cost of living increases, which come in different formats. The increases typically rise a set percentage each year, increasing either on a simple or compound basis up to a multiple of the base policy. Coverage can also include the parents of employees. This is an especially desirable feature since many workers are in the "sandwich" generation, taking care of children and their aging parents.

Expect LTC to become as common an employee benefit as medical or dental care within the next decade. Unless medical and long-term care costs suddenly stop skyrocketing, all of us will soon be seeking practical ways to manage these costs with the least impact on our financial stability.

About the Author

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Simple Risk Management Saves the Small Business Dream

By Brad Forsythe

Few forces in nature can match the zeal of an entrepreneur. The early days of a new enterprise are filled with boundless energy and faith that the entrepreneur's dream will soon become reality. Then reality arrives. Risk is the reality.

Unmanaged or poorly managed risks are why the vast majority of small businesses fail. According to the [U.S. Small Business Administration](#) figures, approximately 550,000 small US businesses will disappear each year, resulting in a huge and tragic loss of private capital and personal dreams. This means up to a 90 percent failure rate of all new businesses. Although there are a variety of causes, the easiest one to prevent and the least expensive to implement is a proactive risk management program.

Small businesses must be innovative in order to prosper. Innovation is difficult. Brilliant visions of new products or services rarely arrive serendipitously. Effective businesses use a disciplined process of careful, constant observation; focusing on changes in customer behavior that reveal new opportunities for entrepreneurs who can spot the changes, define the new "need" and fill it quickly. Focus. Focus. Focus.

But every business bumps into trouble, and this disciplined, innovative focus is nearly impossible to maintain when risk erupts and seriously threatens the company. Trouble puts limits on focus and progress. The entrepreneur's best resources must abandon their real jobs and become firefighters. Of course, the entrepreneur can't make money or innovate while fighting fires.

Managing Risk for Minimizing the Downside

The most successful companies avoid firefighting by managing risk. Proactive risk management is critical to the success of a small business. Small businesses must identify ways to reduce financial and legal risks; reduce costs of risk insurance; and deal more effectively with employees, clients and vendors – all of whom expose a business to risk. A recent study by the Marshall School of Business at the University of Southern California showed that "crisis prepared" companies suffered 57 percent fewer emergencies and enjoyed up to 100 percent higher return on assets (ROA) when compared to "crisis-prone" companies; proof that you make more money by avoiding firefighting.

Every business faces risk. But being "risky" is a choice. Well-managed small businesses use professional risk management like a bulletproof vest: preventing most risks from occurring and minimizing the danger of risks they can't prevent. With fewer and smaller fires to fight, businesses remain focused on innovation and improved customer relationships. Because risks are managed, they also enjoy lower insurance premiums, smaller legal costs and better banking relationships.

Many companies are confused by the seemingly immense complexity of risk and the broad array of subject matter expertise needed to deal with it. *Analysis paralysis*: the bugaboo of companies that overanalyze and overplan and may cause them instead to mistakenly shrink from engaging and managing risk. They don't realize that America's small businesses have become world-class masters in the management of complex issues. They handle many complex issues every day by wrapping a professional business process around complexity; a process that is simple, measurable, trainable, and profitable and works over the long term. This process involves the business owner finding tested, common sense business process models, and tailoring them to the unique needs of his or her company.

Companies That Manage Risk Well

There are two hallmarks of well-managed companies. First, their owners understand that managing risk is an ongoing process, just like sales or marketing. Second, their owners understand that risk management isn't

part of their job. They delegate risk management tasks to an effective employee or partner; perhaps their administrative VP or controller.

Effective risk management isn't brain surgery. While every company has its own unique risks, most risks are universal because they are linked to people – clients, suppliers, employees and financial stakeholders (e.g., banks or venture capitalists). These people are highly responsive to risk management strategy and tactics. Most risks can be managed with paper — usually in the form of contracts — and simple business processes.

The risk manager obtains model contracts from trusted resource books, other companies or an attorney, and edits them to fit the unique needs of a small business. Model contracts and templates, among other resources, can be a lifesaver to the person in charge of risk management. It should cost little to have an attorney review the edits and add the finishing touches. Once a year, the risk manager verifies that the contracts are working as expected and updates them as necessary.

Client risks usually come down to getting paid and limiting client-related liability to tolerable levels. These risks can be easily managed through a well-written sales contract. Most clients will accept a sales contract if it is reasonable and shows sincere respect for their needs. Most client objections can be overcome and a smooth process can be ensured by establishing a fallback position prior to the negotiation.

Most supplier risk objectives boil down to getting what you pay for and shifting liability away from your company. Again, a well-written contract and preset fallback positions make this effort faster and easier than you might expect.

Employee risks are managed by contracts called the "nons" — *nondisclosure* of important information; *noncompete* against your company; and *nonrecruitment* of your employees by those who leave your company. Just the act of deploying these contracts is a powerful deterrent to trouble.

Banks require entrepreneurs to sign a personal guarantee before receiving a substantial loan or credit line. This guarantee places their personal wealth, and often their home, at risk if they default on the loan. This is often an entrepreneur's greatest risk and can be a frightening experience. But guarantees are only contracts and bankers are only human. Guarantees are usually negotiable; and there are many steps entrepreneurs can take to reduce this financial risk.

Forecasting cash flow is another major financial risk that is also best handled with a piece of paper. A cash budget is a simple forecasting tool, especially suited to entrepreneurs who dislike the complexities of accounting. It is easy to use and can save your company from reaching the end of the line.

Clients, bankers and insurance companies will reward your efforts at risk management; the less risk they face, the more they can help you. The recommended steps in risk reduction can be implemented quickly, cheaply and with surprising ease. They might cut your total risk in half and save your company when big trouble comes to visit.

About the Author

Brad Forsythe is founder of Best Practices Advisor, LLC located in Cincinnati, Ohio, which teaches risk management for companies with less than 500 employees. He is also the author of Bulletproof Your Business – Cutting Risk for Small Business Owners and Managers. Brad can be reached at brad@bestpracticeadvisors.com. Readers can also visit his web site at www.bradforsythe.com.

Part 1

By Yosef Rabinowitz

In exchange for guaranteed low rates, many businesses sign a term agreement with their long distance carrier. The contract specifically states what the rate per minute will be, and indeed, each call is calculated based on that rate. In a perfect world, your carrier would tally up all of your minutes for the month and multiply by the contracted rate to arrive at your bill. In many cases, though, at the bottom line, the average cost per minute comes out higher than what's clearly written in the contract; sometimes by as much as 100 percent. How do phone carriers pull this off legally and within the framework of their contract with you? The method is *call rounding*.

A Penny Here; A Penny There

As a general rule, the various types of rounding combined will add about 10 percent to 20 percent to your bill overall. If your average call is longer than five minutes, read no further. Rounding will have very little impact. But if the bulk of your calls are very short (i.e. under one minute), watch out! You might be getting ripped off. After reading this article, you'll understand how rounding affects the cost of a phone call. The next time you negotiate a contract for long distance service, you'll know what to insist on.

There are several ways that a carrier can manipulate the cost of a call. Most are subtle and the results are based on convenient mathematics (convenient for the carrier, that is). They include time rounding, call-length minimums, decimal rounding and cost minimums. In many cases, they can easily turn a monthly bill of \$25,000 into \$30,000 or more.

Example #1

For our purposes, we'll use a rate of 3 cents per minute and nearest-penny rounding unless stated otherwise.

The most well-known form of rounding is six-second versus full-minute. A 36-second call will cost 2 cents with six-second rounding and 3 cents with full-minute rounding. On average, full-minute rounding will add 10 percent to 15 percent to the real cost. Here are some examples:

Six-Second Rounding			Full-Minute Rounding	
Length	Raw	Rounded	Rounded	Rounded
Of Call	Cost	Cost	Minutes	Cost
0.6	\$ 0.018	\$ 0.02	1	\$ 0.03
1.5	\$ 0.045	\$ 0.05	2	\$ 0.06
2.1	\$ 0.063	\$ 0.06	3	\$ 0.09
3.4	\$ 0.102	\$ 0.10	4	\$ 0.12
4.5	\$ 0.135	\$ 0.14	5	\$ 0.15
6.9	\$ 0.207	\$ 0.21	7	\$ 0.21
19.0		\$ 0.58		\$ 0.66
			Increase	14%

Multiplied over a full month of calls, this difference can add up to hundreds, or even thousands of dollars.

Hidden Trap

While you can typically determine if you have six-second rounding just by looking at the call lengths (i.e., 2.1

or 2:06 versus 3), some carriers display the fractions of minutes but bill in full-minute increments. The best way to check is to find a call, for example, that is 1.5, 2.6 or 3.4 minutes and verify the math.

Example #2

Even with six-second rounding, many carriers (including the major companies) secretly raise the cost of a call by billing a minimum amount of time (i.e. 18, 30 or 60 seconds). A company with a lot of short calls can easily get taken for a ride with this alone:

18-Second Minimum				30-Second Minimum			Minute Minimum	
Length of Call	Billed Mins.	Raw Cost	Amount Billed	Billed Mins.	Raw Cost	Amount Billed	Billed Mins.	Amount Billed
0.1	0.3	\$ 0.009	\$ 0.01	0.5	\$ 0.015	\$ 0.02	1.0	\$ 0.03
0.2	0.3	\$ 0.009	\$ 0.01	0.5	\$ 0.015	\$ 0.02	1.0	\$ 0.03
0.3	0.3	\$ 0.009	\$ 0.01	0.5	\$ 0.015	\$ 0.02	1.0	\$ 0.03
0.4	0.4	\$ 0.012	\$ 0.01	0.5	\$ 0.015	\$ 0.02	1.0	\$ 0.03
0.5	0.5	\$ 0.015	\$ 0.02	0.5	\$ 0.015	\$ 0.02	1.0	\$ 0.03
0.6	0.6	\$ 0.018	\$ 0.02	0.6	\$ 0.018	\$ 0.02	1.0	\$ 0.03
0.7	0.7	\$ 0.021	\$ 0.02	0.7	\$ 0.021	\$ 0.02	1.0	\$ 0.03
0.8	0.8	\$ 0.024	\$ 0.02	0.8	\$ 0.024	\$ 0.02	1.0	\$ 0.03
0.9	0.9	\$ 0.027	\$ 0.03	0.9	\$ 0.027	\$ 0.03	1.0	\$ 0.03
4.5			\$ 0.15			\$ 0.19		\$ 0.27
Actual Cost Per Min.			\$ 0.0333			\$ 0.0422		\$ 0.0600

In this scenario, call-length minimums add at least 11 percent and as much as 200 percent to a typical short call. To determine how your company's calls are rounded, look at a page of call detail from a recent bill.

Tips to Consider

Insider Tip #1: When quoting rates, telecom salespeople will refer to these types of rounding as 18/6 ("Eighteen and six"), 30/6 and 60/6 respectively. The first number is the minimum length per call and the last number is the increments thereafter. 6/6 is the best option.

Insider Tip #2: Even the carriers that use 6/6 or 18/6 rounding on domestic calls tend to have at least a 30-second minimum (30/6) on international calls.

As if time rounding wasn't enough, there's more. In Part II, we'll expose how carriers hit you with a double whammy and manipulate the actual cost itself through decimal rounding and cost minimums — all perfectly legal, and all under the radar. We'll also include some tips on how to combat these practices.

About the Author

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INDUSTRY WATCH

Medical Insurance Plans: Challenges and Opportunities for Managing Costs

By Timothy Cahill

The present shift by employers offering, and/or individuals purchasing, high deductible, or consumer-driven health plans, either with or without the new Health Savings Accounts or Health Reimbursement Accounts, has created a renewed — and mainly positive — interest in the health insurance marketplace. And for good reason. The primary goal of the High Deductible Health Plans (HDHP) and Consumer-Driven Health Plans (CDHP), versus the more traditional health insurance products, is to directly engage the consumer in *all* of the decision making aspects of their medical care; from selection to utilization, and ideally to the actual cost. This, of course, is accomplished through a more significant personal financial incentive defined as first dollar medical claim “risk” up to approximately \$5,000 for an individual and/or \$10,000 for a family. This incentive reflects an effort to rein in our country’s runaway healthcare costs. If this experimental model is successful, the end result will be a sustainable growth economy via more affordable healthcare coverage for all. We all have a vested stake in seeing this succeed.

Educating the Masses

The level of success of this grand experiment, however, also depends on the consumer becoming educated about the medical care that they need, require or desire. Several entrepreneurial organizations are quickly trying to fill the void for relevant medical information by delivering various medical diagnoses and medical treatment options through integrated decision support tools delivered directly to the consumer.

This new financial incentive on each consumer created by the HDHP and CDHP will make the public more informed about the appropriate insurance needed. As a result, this will finally address the over utilization of medical services in our country, and lower our overall costs in the near term. There are currently too few decision support tools or accessible information sources that consumers can rely on to manage their healthcare costs.

Simply stated: competitive pricing will fill the void as it relates to the purchase of medical care. Unfortunately, due to the nature and complexity of our third-party payer and healthcare delivery system, there is no easy, intuitive way to provide competitive pricing on medical treatment. Even if pricing transparency can be defined and implemented, it will still not be enough.

Under the traditional insurance products, consumers were never interested in the actual price charged or reimbursed to a particular medical provider. Neither did they know or care that the medical provider they chose was reimbursed two to three times that of another similar medical provider also in their network who provided the same treatment across town. The primary reason was that the consumer only paid a relatively small deductible and the rest of the reimbursement was made by the insurance company. Given that scenario, why would the average consumer think twice about pricing? The tendency is to focus more on convenience, reputation and the perception of quality; the last point really being an unknown.

Price Schmice. They’re All the Same Anyway, Right?

As both employers and consumers, we have assumed if similar medical providers are in the network, they charge and are reimbursed the same amount. After all, they deliver the exact same service in the exact same market. This is a wrong assumption to make, and is not even close to reality. The laws of supply and demand, coupled with the need for certain medical providers to be “in the network” in order to have a marketable health care plan, have severely altered this misguided perception. Remember, each provider contract is a negotiation, not an ultimatum. If the insurance company/network needs a provider more than the provider needs the insurance company/network, then the one-price theory starts to break down.

In our present medical marketplace, what do we really know about price? Can all the tools available to the consumer help them make smarter, more cost effective choices on their medical treatment decisions? Are all the tools and resources used by insurance companies to lower their medical claim expenses and medical loss

ratios going to be readily available, or even provided when it is not the insurance carriers' direct risk? The reality is that only a portion of the cost management programs will be provided by the HDHP and associated carrier.

Insurance carriers offer two types of programs to lower their medical claim expenses:

1. Integrated services
2. Non-integrated services

Integrated services. Third-party provider programs, such as HMOs and PPOs and medical management function — like utilization reviews and case management — are used to create economies of scale. Integrated services are built into the cost of the premium; as opposed to the non-integrated services that are generally charged as a percentage of the savings on a claim-by-claim basis. These services are easy to administer and have a direct, positive impact on the medical claims expense because premiums are reduced; and the reduction is greater than for non-integrated services.

Non-integrated services. These are commonplace programs, such as claim-by-claim negotiation; hospital bill review and auditing; fraud and abuse; medical claim recovery; and clinical bill review. Combined, these services represent a thriving market estimated at \$40 to \$50 billion. As it relates to this article, the difference between the two services is how they are delivered, how they are paid for and by whom.

With traditional insurance, both of these services are easily administered, and both services directly impact the health plans' medical claim expense. They indirectly impact the members' cost in a positive manner by theoretically lowering premiums. With an HDHP, the health plan will continue to provide the integrated services, but the non-integrated services become a more difficult undertaking, because the cost of the service and service fees are all shifted to the member, who in the end will derive the direct benefit.

The issue of pricing will create an increasingly larger void as more and more consumers pursue an HDHP for purposes of lowering their annual premiums, in exchange for higher personal medical claim risk. Over the last decade, the insurance carriers have figured out how to use these non-integrated cost management services for their direct claim risk. Now, it is time for the consumer to start doing the same. To address this void, the market needs to be cultivating forward-thinking organizations that are committed to creating unique business models, tools and services designed specifically to deliver these non-integrated cost management services directly to the consumer.

As employers, we need to accept the challenges and limitations of our present benefits programs and actively pursue and endorse business partners who can assist in managing these marketplace imperfections to the betterment of our employees' health, attitude and pocketbook. What is a fair price to pay for medical treatment? If you can answer that one, you are way ahead of the pack. It's certainly something to think about.

About the Author

Timothy E. Cahill is the managing director of My Medical Control, LLC, located in Prospect Kentucky. He is a former medical industry executive with over 10 years experience in the design, development, and marketing of non-integrated cost management services that are presently deployed by over 450 insurance companies. He has extensive knowledge in medical claim cost management and present market-based pricing strategies. Tim can be reached at tcahill@mymedicalcontrol.com.

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Just when you thought you couldn't possibly fit anything else on your compliance plate, e-mail management has emerged as a critical regulatory issue.

One of the fundamental regulations laid out by the *Sarbanes-Oxley Act (SOX)* requires businesses to demonstrate effective corporate governance and information management controls. E-mail has undoubtedly become the de facto method of business communication, as well as the most critical source of information for almost every large business; thus making e-mail management a crucial element of *SOX* compliance.

Yes, e-mail management seems like a daunting task, especially when considering the sheer volume of e-mails exchanged among enterprises. Research from the [Radicati Group, Inc.](#) shows that the average corporate e-mail user sends or receives 84 e-mails daily. This is the equivalent of 10 MB of storage per day. This number is expected to rise to 15.8 MB per user, per day by 2008. Although these figures may be overwhelming, e-mail archiving and management are necessary, unavoidable components of complying with *SOX* regulations.

Impact of *Sarbanes-Oxley*

Numerous sections of the *SOX* discuss communications and retention management. For example, [Sections 103\(a\) and 801\(a\)](#) require public companies and registered public accounting firms to maintain audit work papers; documents that form the basis of an audit or review; and all information supporting conclusions for seven years. Clearly, e-mail communications related to audit work papers and financial controls fall into this category. Other sections of *SOX* use broader language. [Section 104\(a\)](#) states that the Public Company Accounting Board has the option to broaden the range of types of records that accounting firms must maintain.

For some firms, saving every e-mail means backing up an entire e-mail system on a daily basis. Many companies already protect themselves from data loss by storing e-mail on a separate storage device, usually a tape library for large systems; and some attempt to extend these systems for compliance purposes. Tape backup systems are entirely inadequate, however, because of the time and expense required to extract e-mail from enormous volumes of undifferentiated backup tape. In most instances, companies that rely on this method are unknowingly violating sections of *SOX* that require them to establish a "timely" method for retrieving and producing this information. As a result, the concept of active e-mail archiving has emerged.

Simply storing millions of e-mail messages on an interactive storage media consumes expensive storage space without providing a solution. Active e-mail archiving involves storing e-mail in an "active" manner so that it is not only readily accessible, but also easily integrated with applications that provide powerful searching and management capabilities. Without active e-mail archiving, trying to find e-mails among a vast archive is the equivalent of trying to find a needle in a haystack. Remember when politicians criticized the amount of time it took the White House to retrieve e-mails during the investigation of the media's naming of a CIA agent? These politicians called it a "delay tactic," but in truth, extracting e-mail from backup storage at the White House—or at any organization—is nearly impossible without the right tools.

So how does a company integrate an effective solution to deal with the e-mail management regulations set forth by *SOX*? Actively archiving e-mails to comply with regulations is not a new concept. The SEC, for example, has long required that financial institutions retain e-mail exchanges. [SEC rule 17 a-4](#) states that financial institutions must preserve all electronic records exclusively in a non-rewritable and non-erasable format. Additional rules require that the SEC be able to review specific communications upon request.

To ensure SEC compliance, financial institutions deploy message management solutions that support their

compliance policies regarding message archival, retention, supervision, mail storage management, discovery and litigation support. Similarly, these types of solutions can be implemented by companies in other industries that are facing *SOX* deadlines. Before a solution can be put in place, however, corporate compliance policies must be established.

Establishing Policies for Compliance

An effective policy must take into account the relevant technology and business factors associated with compliance. For example, simply setting a policy under which every e-mail ever sent or received in the enterprise is stored may not be efficient. Many e-mail messages may not be relevant for compliance, including personal e-mail and spam messages. Within an archive, these messages take up costly storage space and impact the efficiency of the overall e-mail system.

Policies must also take into account the unique factors and regulatory frameworks associated with different lines of business and departments. For example, a company might establish an enterprise-wide policy that any messages exchanged between an entity and a third party will be archived, regardless of content. It is prudent to establish such policies for third parties, such as consulting and accounting firms, because they still have access to and influence information germane to *SOX*.

Only after a comprehensive compliance policy is put in place does it make sense to implement a solution that flexibly supports this policy. This flexibility could include the ability to retain e-mails between specific groups of people—internally or externally—or messages sent to a specific person. For example, a company can customize the solution to archive any e-mails sent to C-level executives. The company may also choose to save e-mails sent between executives and the Board of Directors, while choosing not to archive messages exchanged among junior level individuals (excluding, perhaps, the employees in the finance department).

Of course, retaining e-mails is only useful if you can find the archived messages when needed. Section 105 (b) of *SOX Investigation And Disciplinary Proceedings; Investigations; Use Of Documents*, states that any client of a public accounting firm may be required to produce documents related to audits or investigations. The core concept of an active e-mail archive is to find, organize and produce archived messages. Effective e-mail management solutions also need discovery and litigation tools for quickly and efficiently searching the archive—regardless of volume or size—for pertinent messages. They should also offer the ability to automatically categorize messages according to content or flag messages that contain information under the attorney-client privilege. These features are valuable for refining what does and does not have to be turned over, which can prove to be critical to producing successful litigation and regulatory outcomes.

Effective e-mail management solutions enable companies to take a proactive approach to compliance. Monitoring capabilities allows any message to be flagged for review by company officials, and can even stop delivery of messages based on content. Messages containing certain “danger” words or phrases—such as those related to a public company’s performance—will not be delivered until they are properly reviewed and authorized.

Implementing an e-mail management solution is an enterprise-wide IT decision. E-mail touches every person and department within an organization, and it is becoming more critical to business processes. Developing requirements for any e-mail management solution for *SOX* compliance should involve IT executives, Chief Information Officers, lawyers, outside consultants, the CEO, and, of course, the Chief Compliance Officer.

Everyone in the corporate world knows that *SOX* violations will have drastic consequences for firms and individuals. Fortunately, to comply with the regulation’s information management standards, corporations can look to best practices and software solutions that have already been proven in the field by many organizations in highly regulated vertical industries.

About the Author

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TIP OF THE ISSUE

Three Ways to Use Trade Shows to Boost Your Bottom Line

By Chet Holmes

Many industries are heading into their trade show season and most will be unprepared to make the most of it. Trade shows are an excellent way to impact a company's bottom line, if it's done correctly.

Here are a few secrets to improving your results at a trade show:

Get noticed. The most important thing to do at a trade show is to get noticed. Smart exhibitors or attendees have a plan of attack to get noticed. They use a "theme." Themes can be everyone wearing Hawaiian shirts and leis.

Drive traffic. You need an inducement or "bribe" that attracts buyers to your booth. One company got a 500 percent increase in trade show booth attendance by giving away a trip to Hawaii. These trips can be inexpensive if reservations are made in advance or if you use priceline.com.

Capture leads. The third most important objective at a trade show is to get contact information. Use a simple form attendees can staple their card to (of course have staplers available). The form should contain a multiple choice check-off list to be sure you're getting data.

Another great strategy for having a successful trade show is to team up with other vendors. You should have someone whose only job is to go around and find potential partners with whom you would like to work.

About the Author

Chet Holmes is president of Jordan Productions; an international multimedia firm located in San Rafael, Calif., that helps companies accelerate growth. He's creator of several business building programs including Zero to \$100 Million, Mega Marketing & Sales and Guerrilla Marketing Meets Karate Master. For more information, visit www.chetholmes.com.

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