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Americans Worry about Access to Care if Universal Health Insurance is Passed

Source: Health Insurance Underwriter Magazine

In a recent survey of 1,000 American consumers, more than half (55%) believe that if universal health insurance coverage is passed by Congress, it will not ensure equal access to care because of capacity constraints, particularly in hospital emergency rooms according to a report recently released by PricewaterhouseCoopers (PwCs). A significant number of people, however, would be open to the idea of shared doctor appointments, online physician consultations, worksite clinics and other alternative ways of receiving medical care.

PwC's research reveals that universal coverage could swamp the health system unless simultaneous steps are taken to create innovative, new care delivery models that will expand access to care without adding costs to the system. Research conclusions and survey findings are in a new PwCs' Health Research Institute (HRI) paper titled "Jammed Access: Widening the Front Door to Health Care."

Americans, in general, not just the uninsured, are increasingly using costly hospital emergency rooms as the first point of entry into the health system, according to the PwC's report. Per capita visits to hospital emergency departments already are at an all-time high, reflected in overcrowded emergency rooms, ambulance diversions and long waits. The reasons are varied and include shortage of physicians, lack of access to specialists, Medicaid reimbursement disincentives, high costs for the under-insured, poor coordination among practitioners, growing consumer demand and inefficiencies throughout the system all of which have created jammed access points. The survey also found:

- Patients covered by Medicaid use hospital emergency rooms at twice the rate of the uninsured even though the uninsured are most often blamed. Forty-four percent of Medicaid respondents visited an emergency room in the past year compared to 20% of uninsured respondents.
- More than half of people who went to a hospital emergency department in the past year said they went for a reason other than an emergency, for example, their doctor's office was closed or they couldn't get an appointment in an acceptable time.
- Hospital emergency rooms have become holding tanks for mental health patients because of a shortage of mental health providers and beds. The average length of stay in an emergency department for patients in need of mental health services is double that of other patients.
- One in four consumers and one-third of Medicaid patients said it takes more than 30 days to see a doctor. One in 10 said they've had to wait three months or longer.

PwCs' analysis found an inverse relationship between insurance status and emergency department usage. States with high uninsured populations generally have lower emergency room utilization than states with lower uninsured populations. For example, Massachusetts, which has one of the lowest rates of uninsured residents (3%) , has one of the highest per-capita utilization rates of hospital emergency rooms in the country. In addition, Massachusetts has the highest number of physicians per capita but has been plagued by a severe physician shortage since introducing near-universal coverage in 2006.

PwC's research shows that Americans are willing to participate in alternative ways to access health care—many of which bring access to the patient. Some of these solutions are in use today and include:

- Electronic interaction with providers and payers: half of consumers surveyed said they'd be willing to seek health care through the Internet or other computer technology as a substitute for a face-to-face, non-emergency visit. Of those, email consultations were the preferred method of interaction (76%), followed by telehealth, questions/answer fee-based consults and an online forum/chat room monitored by a doctor.
- Retail and worksite clinics for patients: Of consumers surveyed, 37% said they'd be likely to use a worksite clinic, and 36% would use a retail health clinic. Ten percent of large employers surveyed in PwCs' 2009 Annual Employer Barometer Survey said they are now providing worksite clinics, up from one percent in 2008.

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Employee Cost-Sharing Up in Prescription Drug Plans

Source: SHRM

More U.S. employers are using employee cost sharing in their prescription drug programs, according to Buck Consultants' *Prescription Drug Benefit Survey*, completed in July 2009.

Cost sharing is part of a consumer-directed approach that encourages plan participants to consider price when selecting among drugs that might be similar in terms of outcomes but vary greatly in cost, such as an over-the-counter medication vs. a prescription drug, generic vs. brand-name drugs, or a heavily advertised new entry vs. a lower-priced but similarly effective alternative that actress Sally Field isn't pitching on prime time.

The survey reveals that 76 percent of respondents use employee cost sharing as a utilization management tool, up substantially from 51 percent in 2008. The most common target cost-sharing range is 11 percent to 20 percent of claim costs (used by 39 percent of respondents).

"This year, plan sponsors are clearly focused on controlling costs in response to budget cuts," says Michael Jacobs, a principal and national clinical practice leader at Buck Consultants.

Controlling Plan Expenses

More than 140 U.S. based organizations participated in the survey, representing a broad range of industries and employer size. "While the cost of prescription drug coverage varies widely, 30%, or the largest group, said pharmacy benefits represent between 11% and 15% of total health care costs," says Jacobs. "This is down from last year's survey, when the largest group indicated their drug benefits made up between 16% and 20% of total health care costs. This may be the result of many expensive brand medications moving off-patent and being replaced by lower-cost generics.

Broad-Based Approaches

According to survey respondents, the most important clinical management steps they are taking to control pharmacy benefit costs are broader based than prescription drug coverage. These include care management, disease management and low-cost generic pricing programs offered by retail pharmacy chains.

"Our survey revealed a disconnect with using low-cost generic pricing as a cost management tool," says Jacobs. "While 73% of respondents cited are taking advantage of low-cost generic pricing offered by retail pharmacy chains as a high priority, only 26% require their mail service provider to match these low-cost retail generic prices."

Specialty Drugs

Employers are increasing their effort in managing specialty medications—complex drugs that are often injected or infused. According to the survey, 59% of respondents have included adherence to clinical guidelines as part of their specialty drug management programs.

"Employers are also more actively managing these specialty drugs to control cost," Jacobs notes.

The top priorities in managing specialty drug therapies are:

- Adherence to clinical guidelines
- Clinical management
- Coordination with case managers
- Centralized distribution

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Wellness At Work For You

Size and Scope of Wellness Incentives Grow Larger

Almost two out of three U.S. companies offer programs to keep employees healthy, and 66 percent of those offering programs use incentives, with a healthy number showing a return on investment (ROI) of greater than $1 for each dollar spent.

The findings are part of a survey, now in its third year, that tracks how much U.S. employers pay in incentives, what activities they incentivize, and how success and ROI are measured. The report, How Employers Use Incentives to Keep Employees Healthy: Perks, Programs and Peers, was conducted by Health2 Resources, a firm providing health care trend research.

"During tough economic times, employees who take control of their health and are more engaged and active in their own health are valuable assets," says Katherine H. Capps, President of Health2 Resources. "We are not talking about $5 here or there. We are talking about serious investment into productivity, made by employers with as few as 200 employees, for as much as $1,400 a year per employee. Employers are taking control of health care costs by creating smart, effective new strategies to keep employees healthy and to keep employees at work."

Among the key findings:

- The value of incentives is up, averaging $329 in 2009 and ranging from $1 per pound for weight loss to annual premium reductions valued at more than $1,500. The most commonly used incentive is premium reductions, followed by merchandise/tokens and gift cards.
- More offer cash and gift cards to spouses and family members to keep them healthy. More than half the companies surveyed offer health and wellness or disease management programs to spouses and a third extend the programs to other family members.
- Confidential health history questionnaires are an important starting point for worksite wellness and disease management. Two out of three U.S. employers– large, mid-size, and small-offer a health risk assessment to employees, and nearly three out of four of those offer incentives to take it, ranging up to $300 annually, with about 10 to 15% exceeding $300.
- Smoking cessation programs are the most popular health and wellness program offered. More than half of employers surveyed, 53%, offering smoking cessation to employees, but weight management and physical activity programs are not far behind.
- Diabetes programs are the most popular disease management programs, 92 percent offer diabetes programs, making them the most common disease management program offered in 2009.
- Company size matters but doesn't dictate value of incentives. Among large employers, a bigger percentage offers programs and incentives when compared to small and mid-sized companies. But some organizations with as few as 210 employees are offering incentives valued at $1,450 per year to keep employees healthy, well above the average.
- Results count, and employers are counting. The percentage of U.S. companies measuring ROI wellness programs has increased sharply over the years, from 14% in 2007 to 73% in 2009.

Some 83% of those who have measured say the programs return better than 1:1 on their investment. In growing numbers, employers are rewarding goal achievement during and after health and wellness program completion.

"Employers are becoming more sophisticated about measuring the return on investment from wellness and disease management programs, and today's economic outlook dictates that these programs bring a positive ROI," says Sean Sullivan, President and CEO of the not-for-profit Institute for Health and Productivity Management.

Insurance Specialists
1750 Scottsville Road, Suite 4
Bowling Green, KY 42104

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Phone: 270-793-0367
Fax: 270-793-0742
E-mail: msweetman@isbgky.com

HHS Issues HIPAA Breach Notification Rule

The U.S. Dept. of Health & Human Services (HHS) issued an interim final rule on August 19, 2009, requiring entities covered by HIPAA to notify individuals when their protected health information is breached.

The **new rule** applies to health care providers and health plans, among other entities. The regulations also require covered entities' business associates, including third-party administrators, to notify the covered entities of breaches at or by business associates.

The rule requires health care providers and other HIPAA covered entities to promptly notify affected individuals following breaches, as well as to notify the HHS secretary and the media for breaches involving 500 or more individuals. Breaches affecting fewer individuals are to be reported to the HHS secretary annually.

The Federal Trade Commission (FTC) on August 17, 2009, issued companion breach notification regulations that apply to vendors of health records and certain others, including third-party service providers, not covered by HIPAA.

"Pretty much anyone in the IT world is a third-party service provider, "according to Jon Neiditz, an attorney and the information management practice leader at Nelson Mullins in Atlanta, in an August 19 webcast. "Health Insurance brokers in almost all cases are business associates," he added. "If you have a wellness program" and access to personal health records for employees , "you may have to deal with "the federal breach notification rules, he said. Neiditz noted that "not all HR breaches would be covered, but many would be."

Entities subject to HHS and FTC regulations and that secure health information as specified by HHS guidance, which will be updated annually do not have to provide notice of a breach. The two permitted methods of securing health information to avoid having to send notice in the event of a breach are encryption and destruction.

Breaches are very costly, with studies showing the resulting losses to be as high as 20 to 40 % of notified customers, Neiditz said. Because breaches are so costly, he expects many entities covered by the rule will decide to rely more on HHS guidance's encryption standards. And he predicted that "the HHS standards are likely to spread to non-HIPAA lines of business."

According to HHS guidance, the encryption process for "data at rest" (data residing in data bases, file systems, flash drives, memory and any other structured storage method) must be consistent with National Institute of Standards & Technology (NIST) "Guide to Storage Encryption Technologies for end User Devices.

"Data in motion" (data that is moving through a network, including wireless transmission, whether by e-mail or structured electronic interchange) must comply as appropriate with NIST Guidelines for the Selection and Use of Transport Layer Security.

If the HIPAA guidance on technologies and methodologies that render PHI unusable isn't followed and there is a breach, the HHS rule requires written or e-mail notice in accordance with the rule's detailed requirements for either. The covered entity must notify each individual whose unsecured protected information has been accessed as a result of the breach within 60 calendar days after discovery of the breach.

A covered entity will be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known to any "workforce member or agent of the covered entity," according to HHS. The department clarified

that when any further use or disclosure of the information is permitted under the HIPAA Privacy Rule, there is no breach because the security and privacy of the information has not been compromised.

More Enforcement Authority

HHS released the rule two days *after* a deadline set by the HITECH Act. Neiditz remarked in passing that there may be a legal challenge since HHS did not meet its deadline. He said there has been relatively little enforcement of HIPAA up to this point, but said that under the new law and rules *effective February 2010* there will be much more enforcement authority under HIPAA, partly as a result of increased penalties for HIPAA violations.

He also emphasized that the HITECH Act allows state attorneys general to bring civil actions against persons who violate HIPAA. State attorneys generally love going after entities that fail to satisfy breach notification requirements, according to Nieditz, who called this change "extraordinarily important." While most states have breach notification rules, the new federal requirements are much likelier to trigger required notices when there is a breach, he commented. And, Neiditz cautioned, breeches as a result of hacking have become more common this year as hackers have become more sophisticated.