

# Benefit Insights

## ***Small and Large Health Plans Alike Must Comply with HIPAA Security Rule***

As part of the Health Insurance Portability and Accountability Act (HIPAA), the HIPAA security regulation focuses on protecting the health information of individuals that is in electronic form, such as that contained in e-mails or on CD-ROMs, networks or the Internet. The HIPAA security rule requires covered entities to take steps to safeguard such electronic protected health information (e-PHI). "Covered entities" are defined as health care clearinghouses, health care providers and health plans—which includes, of course, employer-sponsored health plans.

Though the final security regulation was issued in 2003, health plans were given some time to take the necessary measures to come into compliance. For most plans, compliance was required by April 20, 2005. However, small plans—defined as those with annual receipts of \$5 million or less, as measured by premiums paid for fully insured plans and claims paid for self-insured plans—were given an extra year, with a compliance date of April 20, 2006. Regardless of these deadlines, the continually changing nature of electronic technologies means that compliance with the security regulation will be an ongoing effort for employers.

The general requirements of the security rule state that a covered entity must—

1. Ensure the confidentiality, integrity and availability of all e-PHI that it creates, receives, maintains or transmits.
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of e-PHI.
3. Protect against any reasonably anticipated uses or disclosures of e-PHI that are not permitted or required.
4. Ensure compliance with the security rule by its workforce.

The rule includes specifications for administrative, physical and technical safeguards. The administrative section requires implementation of policies and procedures designed to prevent, detect, contain and correct security violations. A risk analysis is required, along with assignment of responsibility to an identified individual for development and implementation of the required policies and procedures. Other standards in the administrative section cover workforce security, information access management, security awareness and training, and plans for dealing with security violations and emergencies (such as system failures).

The physical safeguards section includes standards that ensure authorized access to e-PHI, while deterring improper access or unauthorized disclosure, modification or destruction. Standards address access to, along with the control and security of, facilities and workstations, in addition to the hardware and electronic media that contain e-PHI.

The technical safeguards section requires implementation of policies and procedures that maintain access control for the systems that contain e-PHI (for example, user IDs, emergency access provisions, automatic log offs, and encryption and decryption). This section also includes standards for transmission security, data integrity, user authentication and audit controls.

The security rule also contains provisions for business associate contracts, amendment of group health plan documents to incorporate security measures, and documentation of security procedures (and the time period for which such documentation must be maintained).

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## **Research Confirms Promise of Consumer-Driven Health Plans**

Though consumer-driven health care plans (CDHPs) are becoming more widespread, many employers are taking a wait-and-see approach toward implementation. In a survey conducted in late 2005 by the International Society of Certified Employee Benefit Specialists and Aon Consulting, about one-third of employers that had not yet implemented a CDHP said they thought the consumer-driven concept was too new and wanted to wait and see other employers' results before going forward.

Companies taking this approach might be interested in the results of a study by McKinsey & Company, a management consulting firm, of consumer-driven health plan participants. Though other studies of CDHP experience have been done, this one was unique in that it examined plans in which the CDHP was the only health benefit offering. The employer plans in the survey were "full-replacement" plans, i.e., when implemented, they replaced previous health plan offerings, rather than being one option from among many. By focusing on full-replacement plans, the study sought to eliminate any adverse selection bias.

According to the results, CDHPs are "delivering on their promise to increase consumer engagement and reduce utilization." The responses of the CDHP participants indicated that they made more careful, value-conscious health care utilization decisions, and that they had a heightened level of engagement in their overall health and wellness.

Five key findings emerged from the study, according to the published report:

- CDHP participants appear to be more value-conscious. For example, although they were twice as likely to report not seeking care for conditions they perceived as less serious, they were no more likely than traditional plan participants to put off treatment for what they thought were serious conditions. Those who had sought treatment (non-pharmaceutical) in the past year were three times more likely to have selected a less intensive (and less expensive) set-

ting, such as an urgent care center rather than an emergency room.

- CDHP participants were as likely or more likely to receive preventive care, and were 20% more willing to take part in company-sponsored wellness programs. They also were more likely than participants in a traditional health plan to say they pursued preventive treatment—such as an annual physical—because it was important for their long-term health or because it would save them money in the long run; traditional plan participants more frequently said they had annual physicals because these services were covered by their health plan.
- Companies in the study reported lower health care costs, even when including costs that had been shifted to employees. Part of the reason for this may be that individuals with chronic conditions who were in a CDHP were 20% more likely than those with traditional insurance to say that they carefully followed their treatment regimens. Also, CDHP participants were nearly twice as likely to discuss less expensive treatment alternatives with their doctor or pharmacist.
- Less than half of CDHP participants said they were as satisfied with their current plan as they had been with their previous plan, a result that did not vary by health status but which did vary widely among companies, suggesting that how a company helps employees transition from traditional to consumer-driven care—and its attendant decision-making responsibilities—is critical to success.
- CDHP participants seem to be more open to their new plans when they perceive factors other than cost-shifting as driving a company's decision to make the switch to a consumer-driven plan.

Research such as this can contribute to the decision-making process as an employer considers adding—or switching to—a CDHP.

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The security rule adopts a somewhat flexible approach, permitting covered entities to take into account their size and capabilities, along with cost, in implementing the required security measures. Also, while some of the steps outlined to maintain compliance are required, others are characterized as "addressable," which means that each

organization can evaluate how to best achieve implementation of the standard. That said, any organization that is subject to the security rule must take steps to implement and maintain adequate security of e-PHI. And, as noted above, this includes large and small employers alike that sponsor health care plans.

## Specialty Drugs Pose Health Cost Management Challenge

Though increases in prescription drug spending still outpace the overall health care inflation rate, the pharmaceutical spending trend has moderated somewhat. According to the Segal Company's 2006 Health Care Cost Trend Survey, the cost increase for a prescription drug carve-out plan covering active employees and pre-65 retirees is running at 15.2% for retail drugs and 15.5% for mail-order drugs in 2005, and is projected to fall to 13.8% for retail drugs and 14.5% for mail-order drugs in 2006. These levels, according to Segal, are close to those of 1998.

Running counter to this trend is spending for so-called specialty drugs which, according to the same survey, is projected to increase by 21.6% in 2006, a rate significantly higher than that reported for non-specialty retail and mail-order pharmaceuticals. The Pharmaceutical Care Management Association (PCMA), in its publication "An Introduction to Specialty Pharmacy," estimates spending on specialty drugs amounting to \$25 billion to \$35 billion annually.

The cost to an individual patient of a specialty drug regimen will, of course, depend on the particular pharmaceutical; however, this cost will, by comparison, dwarf the cost of non-specialty drug therapy. Estimates of the per patient annual cost for specialty drug treatment range from \$10,000 to upwards of well over \$100,000—or more.

What are specialty drugs and why do they come at such a cost? The term specialty drugs encompasses types of pharmaceuticals that might differ from other prescribed products in their development, in how they are administered to the patient, and in their storage and handling requirements. For example, some specialty drugs are biologics—genetically engineered drugs. Some require administration by injection or infusion, or administration only by a medical professional. Some have special storage, handling and distribution requirements, meaning that they may not be available through the local pharmacy.

Specialty drugs target complex and chronic conditions. Medical conditions for which specialty drug therapy currently is available include cancer, human growth hormone disorders, hemophilia, psoriasis, multiple sclerosis, rheumatoid arthritis, immune disorders, infertility, Crohn's disease, Parkinson's disease, lupus and HIV/AIDS.

Though expensive, a specialty drug—like any appropriately prescribed and properly managed pharmaceutical—can ultimately be a cost-effective part of a patient's therapy if it aids in that patient's recovery or prevents a condition from worsening, alleviates pain, or averts the kinds of medical costs and complications that can result from hospitalization and more intrusive interventions. However, because the cost of specialty drugs is so high, health plans and pharmacy benefit managers have implemented various controls to ensure that the outlays for these medications are well-spent and geared toward achieving the desired outcomes. Support services that commonly are seen in specialty drug management programs include injection training, extensive patient education, 24/7 dispensing services, patient monitoring to assure compliance, and automatic refill reminders.

Pharmaceutical market trends and the ongoing development of an increasing number of specialty drugs indicate that this area of pharmacy will grow, and with it the potential impact on an employer's health care costs. Employers would be well advised to get a handle on how their employee population is utilizing these products, and how their health plan and/or pharmacy benefit manager (PBM) is managing the benefits. Areas to examine include plan design, the plan's or PBM's initiatives to secure discount pricing and dispensing fees, and how the plan or PBM ensures optimal patient compliance with their specialty drug regimen.

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need long-term care services, and over the next 15 years, the number in need is expected to increase by 30%. An aging population and longer life expectancies both contribute to these figures.

Currently, the largest spenders for long-term care are government programs (Medicaid and Medicare, accounting for 64%), but 21% of spending comes from out-of-pocket payments by people receiving long-term care, according to data from the Georgetown University project. This out-of-pocket figure understates the role of—and cost to—families of individuals with long-term care needs, who might provide hours of informal or unpaid care and also incur indirect costs, such as those associated with missing work.

Long-term care insurance can be of great assistance to individuals who find themselves in need of securing long-term care services for themselves or a family member. Policy terms will vary, and those buying coverage typically choose from a number of daily benefit options.

Currently, private insurance accounts for only 10% of the national spending on long-term care, according to the Georgetown University project. However, the data cited above make a strong case for adding long-term care insurance to a voluntary benefits package. By helping employees meet their long-term care needs (or those of a spouse or parent), you can improve employee loyalty and morale, increase productivity, and reduce absenteeism.

## Long-Term Care Insurance Enhances a Voluntary Benefits Package

Voluntary benefits, for which employees pay the entire premium cost but at a discounted group rate, have grown in popularity as the workforce has become increasingly diverse. Among the benefits that can be included in a voluntary benefits menu, long-term care insurance offers coverage that is suitable for a wide range of employees. Though many perceive this coverage as suited only for older individuals, the need for long-term care is not always tied to age. Additionally, a substantially lower premium will apply if the coverage initially is obtained at a younger age.

The fact that long-term care costs continue to rise adds to the reasons to consider the coverage. According to an annual survey on this issue from MetLife Mature Market Institute, long-term care costs have trended higher over the past three years—

- Nursing home care, average rate for a private room:
  - 2005: \$203 per day, \$74,095 per year
  - 2004: \$192 per day, \$70,080 per year
  - 2003: \$181 per day, \$66,065 per year
- Nursing home care, average rate for a semi-private room:
  - 2005: \$176 per day, \$64,240 per year
  - 2004: \$169 per day, \$61,685 per year

—2003: \$158 per day, \$57,670 per year

- Home health aid:
  - 2005: \$19 per hour
  - 2004 and 2003: \$18 per hour

Long-term care can encompass a range of services that provide assistance with the activities of daily living, such as bathing, dressing, eating, toileting and ambulating. According to the MetLife survey, for example, 95% of nursing home residents required assistance with bathing, 87% with dressing, and 51% with eating. Half of nursing home residents required help with five of the activities of daily living, and 24% required help with four of these activities.

According to data from the Georgetown University Long-Term Care Financing Project, about 10 million Americans

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