

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).

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.

Welcome to Our Newsletter!

Were you aware that some employers use voluntary benefits as an employee retention tool? Did you know disability coverage is among the most popular of voluntary coverages? If your company is thinking about adding voluntary coverage to your group benefits, please contact our Benefits Department at 317-844-7759 for more information.

TOBIAS
INSURANCE GROUP, INC.

Tobias Insurance Group, Inc.
9247 North Meridian Street, Suite 300
P.O. Box 90380
Indianapolis, IN 46290

Phone: (317) 844-7759
Fax: (317) 844-9910
Website: <http://www.tobias.com>



Cost-Containment Strategies Needed for the Few Employees with the Highest Health Care Spending

Conventional wisdom has it that 20% of health plan participants run up 80% of health plan costs. Now, an analysis of health plan expenditures paints an even starker picture, concluding that 4% of participants account for nearly half of health plan costs.

The analysis of health plan expenditures from Watson Wyatt Worldwide found—

- 4% of participants with serious health conditions—chronic or catastrophic conditions—account for 49% of health care costs. These individuals average more than \$10,000 in annual health care spending.
- 24% of participants—who Watson Wyatt characterized as being in the early stages of chronic conditions or having acute health episodes—account for 40% of spending. These individuals average \$1,500-\$9,999 in health care costs.
- The remaining 72% of participants—who are relatively healthy—account for only 11% of health care costs, and have less than \$1,500 in annual health care spending.

These statistics send a clear message that disease and case management programs are crucial elements in any plan's overall cost management strategy. While much attention has focused recently on consumer-directed health care and the financial incentives these programs use to encourage employees to be smart health care consumers, such incentives are unlikely to make much of a dent in the 49% of spending by the 4%-of-participants group. These individuals need large amounts of health care, thus it becomes critical that such care is appropriately managed. Possible strategies include disease management programs, case management programs and centers of excellence.

Disease management programs focus on a particular condition, usually a chronic one such as asthma, diabetes or hypertension. The program offers care monitoring and coordination, along with patient education and care strategies. The end goal is to enable the patient to manage the condition in a way that enhances quality of life and day-to-day functioning, while providing appropriate care, avoiding complications, reducing hospitalizations and, hopefully, containing costs.

Case management programs usually focus on individuals who have suffered a catastrophic injury or have life-threatening—and sometime multiple—conditions (such as cancer, stroke or head trauma). As with disease management, care is coordinated, usually through a case management nurse with extensive knowledge of the condition. However, a catastrophic case manager also acts as a liaison between the patient and the health care professionals (in catastrophic cases, there usually are many) involved in the patient's care, coordinating the different health care resources and treatment plans that may be involved. Such attention minimizes redundancies and the risks of counterproductive and contra-indicated treatments, and enhances a patient's and family's understanding of the health care received. Again, contained costs are among the hoped-for goals.

Centers of excellence are health care facilities that have been determined to provide high quality, cost-effective care in one or more specialty areas. Directing individuals to these facilities when

appropriate (for example, a cancer patient to hospital that has been identified as an oncology center of excellence) can aid in cost management, especially if the center is a provider in the plan's network.

Financial incentives and consumer-directed initiatives hold great promise for helping the large majority of employees become better health consumers. For the few who have the most spending, however, strategies that focus on managing the needed care likely will be more effective tools.

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

continued on page 2

Misconceptions About Disability Occurrence and Disability Insurance Result in Low Coverage Rates

Although rates for disability insurance coverage are low—fewer employees have the coverage than medical, life, dental or even vision insurance. Yet, the chances of one becoming disabled at some time in a working career are surprisingly high: one estimate finds a one in three chance that an individual will suffer a serious disability between the ages of 35 and 65. The odds may be even higher. Today’s longer life spans mean longer working careers, and advances in medical technologies and disease therapies—such as some cancer therapies—may successfully treat an illness but temporarily disable an individual from working during treatment.

In a recent study, Unintended Exposure: The Surprising “Big Gamble” Employees Take Every Day, the Hartford undertook to determine why disability coverage statistics seem so out of sync with two realities—the odds of becoming disabled and the impact that a disability of almost any duration can have on one’s income. The study found that individuals not only are underestimating their chances of becoming disabled; they’re also overestimating the alternative income sources available to them in the event of a disability.

Individuals surveyed had the following insurance coverages:

- Medical—held by 85 %
- Life—72 %
- Dental—69 %
- Defined contribution (e.g., 401(k), 403(b) plan)—50 %
- Vision—47 %
- Short-term disability—42 %
- Long-term disability—34 %
- Pension/profit sharing—32 %
- Health savings accounts/flexible spending accounts—19 %

The study asserted several reasons for so few having disability coverage:

- People have misconceptions about the circumstances that lead to disability. For example, those surveyed thought that accidents, injuries or poisonings were the leading causes of both short-term disabilities (74 %) and long-term disabilities (35 %). People, therefore, may feel they can avoid becoming disabled by being careful and leading safe lives. However, the actual leading causes of short-term disability

are pregnancy (21 %) and musculoskeletal/back problems (19 %); accidents/injuries/poisonings account for only 13 %. The actual leading cause of long-term disability is musculoskeletal/back problems (24 %), followed by circulatory system problems (13 %) and nervous system disorders (11 %); accidents/injuries/poisonings tie with cancer as accounting for 10 % of disabilities.

- People may be expecting income during a disability from unrealistic sources. Employees surveyed expected income from the following sources; this data is juxtaposed with the actual sources from which those in the survey who had actually experienced a disability in the past five years had received income:

Income Source	Expected	Actual
Disability Insurance	49 %	37 %
Unemployment Comp.	27 %	6 %
Social Security	23 %	6 %
Medical Insurance	21 %	0 %
Workers’ Comp.	18 %	12 %

- Another misconception about disability insurance concerns its cost. Close to half—42 %—of those surveyed, who had no short-term or long-term disability insurance coverage, gave as their reason the cost of disability insurance being too high. And, these individuals estimated the annual cost of coverage to be about five times higher than it actually would be.

Both employers and employees would be better off if disability insurance coverage rates were more in line with the realities of an actual disability occurrence. Employees without disability coverage may come to work when they shouldn’t (known as “presenteeism”), or may fail to return from a disability because no one is managing the return-to-work process, resulting in lower productivity and running up an employer’s cost of doing business. Offering disability insurance coverage to employees—whether on a voluntary, employee-pay-all basis or with some employer contribution to the premium cost—helps address these issues, along with helping employees meet their income needs during times when they are not able to work to their full potential.

continued from page 2...Cost-Containment Strategies Needed for the Few Employees with the Highest Health Care Spending

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).

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.

Should You Offer Incentives to Keep Your Employees Thin?

The growing problem of obesity is taking its toll in the workplace. Obese employees tend to be less productive and use more sick days because of health issues related to their obesity. It goes without saying that covering the medical needs for obese employees increases already skyrocketing group healthcare coverage costs.

In an effort to combat the problem, employers have turned to a Pavlovian solution to spur overweight employees to lose weight. They are using incentives such as cash bonuses, vacations, and paid days off from work to reward employees who fight the battle of the bulge. It may seem like an extremely expensive bell to ring, but when you compare the cost of the incentives to the amount of money lost because of poor productivity, it doesn't seem so extreme. According to the Centers for Disease Control, obesity is costing American business \$56 billion in lost productivity resulting from disability, illness and death. It is no wonder companies are pushing the envelope in search of a solution.

If you are considering offering this type of program, start by walking a mile in your obese employees' shoes. Overweight people, contrary to popular myth, are not jolly about their condition. They are already sensitized to what people are saying about them, so make sure your program doesn't stigmatize them any further. The program focus should be on progress, no matter how small. And of course, there should be no retribution for employees who fall off the bandwagon.

The program also needs to be grounded in something more substantial than the immediate gratification of a reward. It should encourage overall healthy living and wellness, not just shedding pounds.

America on the Move is a national campaign whose goal is to convince employers to get involved in their employees' eating and exercise habits. It works with employers to offer a 15-week program that encourages employees to work up to walking 10,000 steps each day. They also offer some other suggestions for implementing an effective obesity prevention program:

- Ask on-site cafeterias and vending machine providers to ensure that 60 to 80 percent of food choices are healthy options.
- Make exercise an attractive option: Put a sign near the elevators that asks, "Have you thought about taking the stairs?" Make stairwells attractive with paint or piped-in music.
- Consider sponsoring on-site Weight Watchers meetings.
- Encourage more use of on-site fitness centers. Sponsor a "Newcomers to Fitness Day" to encourage those who are new or reluctant to exercise.

According to the group, implementing these guidelines will result in a 32 percent decrease in sick leave, a 55 percent reduction in healthcare costs and a 50 percent increase in productivity.

INSURANCE GROUP, INC.
9247 North Meridian Street, Suite 300
P.O. Box 90380
Indianapolis, IN 46290

TOBIVS