



Value Based Health Plan Design

More and more employers and health insurers are exploring the implementation of value based health designs. After years of shifting costs to employees, many plan designs create financial barriers for employees to properly treat chronic conditions. A value-based approach looks to take down those barriers.

According to **Greg Judd**, cofounder of the Center for Health Value Innovation and long time Lambert & Carney associate, "value-based designs enable employers to make measured and measurable investments in health, which changes the strategic role of benefits decision-makers in their enterprises. By changing leadership's focus to what the employee and the employer gain from the health care budget, and away from treating it as an unproductive expense, benefits executives can lead more effectively with regard to the role of an employer's benefit program."

Value-based health design relies heavily on the analysis of data to identify specific employees that are at risk to become chronically ill, or leave manageable chronic conditions untreated or under-treated. Data used in this process comes from several sources including personal health risk assessments and screenings, prescription drug utilization and general claims data. By implementing a value-based approach, employers look to create a long term impact on medical cost and just as importantly, absenteeism and presenteeism (where the employee is at work but not 100% effective because of ill health).

The Institute of Medicine National Roundtable on Health Care Quality recently estimated that 20-30 percent of all prescriptions, visits, procedures and hospitalizations in the United States fall into the categories of overuse, under-use (including non-use) and misuse of what the best available evidence indicates should be applied to provide quality care.

Some employers have already adopted value-based plan designs, targeting services for certain chronic diseases or patients with select clinical diagnoses such as congestive heart failure, diabetes, asthma, and mental health care with services valuable for those diagnoses. Targeting patients with manageable chronic diseases provides more favorable financial outcomes. For example, Pitney Bowes' program of

| Disease State | Percentage Not Receiving Recommended Care |
|---------------------|---|
| Diabetes | 54.6% |
| Asthma | 46.5% |
| CPOD | 42.0% |
| CHF | 36.1% |
| Hypertension | 35.3% |
| CAD | 32.0% |
| McGlynn, Asch et al | |

lower- copayments for drugs for diabetes, asthma, and high blood pressure, implemented in 2001, has yielded a net savings of \$1 million just over a year later.

In reviewing its claims data, Pitney Bowes found that employees and dependents with undermanaged diabetes, asthma and hypertension incurred more hospital stays and emergency room visits than other employees. Further, many of them were not sticking with the effective treatment regimens their doctors had prescribed. Pitney Bowes' benefits executives concluded that their plan design was 'wasting' shareholder value because employees would acquire effective (and sometimes expensive) medicines, but then not use them properly because of the ongoing copay or deductible costs the plan imposed on them. Result? Neither employees nor the company were better off, and effective medicines went to waste.

Other early adopters to this approach include the City of Asheville, NC and the University of Michigan and Proctor and Gamble. These entities lowered copayments for selected medications. By reducing the financial barriers to these medications and increasing the education of at risk employees, these organizations were able to affect a greater impact on adherence to the use of medication. Therefore the number of emergency room visits and hospital admission rates were reduced. Additionally employees had better absentee rates and lower incidents of presenteeism.

Five years after the Asheville program was implemented, adherence to the targeted prescribed diabetes medications rose, sick time off was halved, and the medical trend was 58% lower than expected. (Continued)

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Fundamental aspects of Value-Based Health Design include:

- Gathering and analyzing appropriate data
- Conducting preventive health screenings and assessments
- Easing access to appropriate care
- Enabling health improvement behavior
- Targeting wellness and prevention

Providing services such as health coaching and employee assistance programs.

Value-Based Health At Work

After evaluating its health care data in 2006, Proctor & Gamble began to offer the following preventive benefits and incentives:

- A \$40 incentive for employees who complete an online health risk appraisal
- An \$80 incentive for completion of weight loss and smoking cessation programs
- A \$160 incentive for completion of a one-to-one personalized condition management program for conditions such as diabetes, congestive heart failure, coronary heart disease, and depression

Some of the early program successes that Proctor & Gamble can report now include:

- 40 percent of eligible employees have completed wellness assessments
- 78 percent of those eligible for condition management have enrolled in a program

- More employees have become compliant with taking prescriptions for their conditions (such as diabetes) while overall medical costs have dropped.

According to Sandra G. Morris, Senior Manager, US Health Benefits Design for Proctor & Gamble, this last item is significant, because an increase in pharmacy costs with a correlated decrease in medical costs, such as hospital stays and emergency room visits, is the sign of a workforce that is responding to the company's program and changing its behavior for the better.

Conclusion

Value-Based Health Design is an emerging area of opportunity for our clients and their employees. This is particularly true for those that are self insured. Fully insured plans are currently limited by the designs offered by the insurance companies and the resources they commit to these programs. A number of organizations are creating useful tools to harness the potential savings. In the near future, we anticipate market forces will compel carriers to react and create plans that are more integrated with the Value-Based Design approach. However, even in the current fully insured environment there are steps an employer can take to bring greater "value" to their employee benefit programs.

Lambert & Carney Benefits Group, LLC is in a position to help our clients create a program that works best for their needs.

Life Insurance Conversion vs. Portability

When an employee covered under a group life insurance plan leaves employment, they typically have an ability to continue insurance on their own. Most group term insurance policies will have a conversion provision attached to them while some are eligible for portability. The specific provisions of a policy will vary from carrier to carrier so just use this article as a general guide.

Conversion and portability provisions differ significantly in their approach to continuing coverage. Under the conversion approach a departing employee can purchase a whole life insurance policy from the carrier without being subject to evidence of insurability. This type of policy may be kept in force for a person's entire life and pays a benefit upon death. Premiums are fixed throughout the life of the policy. The premiums for whole life policies are higher than premiums for term insurance policies. Premiums are generally higher than other whole life products that the carrier may sell since coverage is guaranteed.

In addition, the whole life policies build cash values and include a cash surrender value. This means that as the built-in value of the policy increases, you have an asset from which you can borrow money from. Further, if you surrender the policy, you can receive cash or continue your coverage without additional premium payment. Your amount of continued

coverage would be based on how much your cash surrender value could buy.

In some instances the conversion right may be for a universal life insurance policy not whole life. This type of policy combines the low-cost protection of term insurance with a savings feature. Premiums are put into an account that is invested. Each month the cost of insurance is deducted from the account. The account builds cash value from which you can take loans and provides flexibility in premium payment. A premium payment can be skipped if there is adequate money in the account to pay the cost. However, if premiums are not paid on a regular basis, the insurance may not last throughout your lifetime.

When a plan offers a portability provision, the employee is typically able to continue the policy through a term insurance product. It is more commonly found in supplemental life coverage. This type of policy provides protection for a specified period of time. The premiums charged are lower than whole life policies; however, no cash value is built up from which you can take loans or receive a cash refund if you surrender the policy. Premiums are typically set in five-year age bands so that they will increase as you get older. Like many term policies the cost of the premium may be prohibitive as an individual gets older. Coverage that has been "ported" may also be subject to limitations not found in a conversion benefit,

such as benefit reductions do to age, military service exclusions and more.

Activating a portability feature may be a good alternative for an employee who is looking to bridge a need between times of employment.

Healthy individuals are usually able to find less expensive life insurance policies when they buy an individual contract. This is due to the fact that their coverage is subject to evidence of insurability. However, if you are an employee that has a medical condition conversion or portability may be the only means of continuing protection after employment.

One last word about these conversion provisions, if you are an employer who is experience rated, you should be aware that the election of a conversion right could impact your experience. A carrier will typically establish a reserve for any converted policy to protect against future loss.

Long Term Disability

Adding Long Term Disability coverage is an inexpensive way to add breadth to your benefits package and something your employees need. In the following we will explore what you need to know and why you should consider adding LTD insurance to your employee benefits package.

With the most recent data showing that nearly 1 in every 7 Americans will become disabled before the age of 65 many Americans are looking for a way to protect their family and assets against an extended loss of income. But, how???

Here are the basics of what you need to know.

Experiencing an extended loss of earnings can devastate a families "nest egg" potentially causing liquidation of retirement savings and in the most extreme cases loss of home. Savvy Employers know that offering Long Term Disability to their employees can have extremely positive effects for both their company and their employees well being. Companies purchasing LTD insurance or offering voluntary LTD insurance give their employees at least an opportunity to take advantage of the significant savings that can be realized through group purchasing.

Why are many Employers offering LTD insurance?

- Many LTD insurance carriers take an active role in engaging your employees through rehabilitation offerings. Helping to return your employees faster than if no disability plan is in place.
- Return to work incentives and training including partial disability payments and residual disability. Everything geared around trying to get your employees back to you as safely and effectively as possible.
- LTD insurance is a relatively inexpensive way for Employers to bolster their benefits offering. Helping

you to attract and retain the talent you need to run your business. As Medical contributions continue to be shared by the Employer and Employee many Employers use LTD plans as a price stable way to give back to their employees and ease the blow of increased contributions for medical.



How does LTD insurance impact your Employees?

- Income protection while disabled.
- Many insurance carriers help your employees migrate through the social security system to qualify for their disability payments raising the average qualification significantly to over 92%.
- Assisting your employees in "stopping the clock" on the time period that their Social Security retirement benefits will be paid on. Ask your L&C representative for more details.
- Providing vocational and rehabilitation services.
- Providing information and best practices on how to get back to work.

Based off the 2007 Lambert & Carney Benefits Group survey, nearly 92% of companies that offer a benefit plan have some type of Long Term Disability protection. Plans vary by benefit percentage and plan max with the majority of Employers offering 50 to 60 percent of earnings coverage to monthly maximums between \$5,000 and \$10,000. Many plans are designed so that the employer funds a core plan that allows employees the opportunity to purchase higher maximums or benefit percentages. In addition, higher compensated Executives often supplement their plans through individual disability plans that when offered to a group qualify for multi life discounts upwards of 30%. For a benchmark analysis of your benefit package or to learn more about LTD insurance simply ask your Lambert & Carney representative.

If you would like a copy of the 2007 Lambert & Carney Benefits Group, LLC Survey go to :
http://www.lcbenefits.com/2007_Survey_file.pdf

Reminder- End of College May Mean End of Coverage

The end of a college year is soon approaching and with it the end of eligibility for a number of students. Although COBRA regulations put the onus on the employee (or their family) to notify you of this pending status change, many employees may have forgotten about this requirement.

If your plan's dependent eligibility requirements expire with graduation, we suggest a brief notice be sent to all of your employees reminding them of this obligation. A brief notice now can avoid a hardship later.

Wellness and HIPAA

The final Health Insurance Portability and Accountability Act (HIPAA) regulations published December 13, 2006, included regulations surrounding wellness programs. These regulations were set to go into place on the first day of a plan year beginning after July 1, 2007. Since there was some confusion surrounding what was required of employers, the Department of Labor released FAB NO. 2008-02, (<http://www.dol.gov/ebsa/regs/fab2008-2.html>). This FAB provides a straight forward checklist that will assist a plan sponsor determine whether a group health plan offers a health promotion or disease prevention program that is required to comply with the final regulations and if the sponsor's plan is in compliance.

Examples of a covered wellness program incorporated in this checklist include:

1. a program that reduces an individual's cost-sharing for complying with a preventive care plan;
2. a diagnostic testing program for health problems;
3. rewards for attending educational classes, following healthy lifestyle recommendations, or meeting certain biometric targets (such as weight, cholesterol, nicotine use, or blood pressure targets).

This checklist further indicates that a plan discriminates based on a health factor if it requires an individual to meet a standard related to a health factor in order to obtain a reward. A reward can be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would otherwise not be provided under the plan.

Wellness programs that do not provide a reward based on a health factor are not deemed discriminatory. For example, an incentive that is conditioned on participation in a health program, rather than achievement of particular health target, generally is

not discriminatory under HIPAA. Incentives that are conditioned on participation (rather than results) include:

1. a program that reimburses the cost for membership in a health center;
2. a program that provides a reward for attending a health education seminar;
3. an incentive to participate in a cholesterol, blood pressure, or other screening program that is paid regardless of outcome;
4. reimbursement for participation in weight loss and smoking cessation programs that is paid regardless of outcome.

If a wellness program does have a reward element, it must meet five standards to meet HIPAA's non-discrimination requirements:

1. the total reward that may be given to an individual cannot exceed 20 percent of the total cost of employee only coverage;
2. the program must be reasonably designed to promote health or prevent disease;
3. the program must allow eligible individuals the opportunity to qualify for the reward at least annually;
4. the program must be available to all similarly-situated individuals. To meet this requirement, the program must allow: (a) a reasonable alternative standard for individuals whose medical conditions would make attaining the standard unreasonably difficult; and (b) a reasonable alternative standard for individuals with medical conditions that would make medically inadvisable attempts to satisfy the basic standard.
5. all plan materials describing the terms of the program must disclose the availability of a reasonable alternative standard or the possibility of waiver of the applicable standard.

Plan sponsors that are currently offering wellness programs to their employee participants should review FAB No. 2008-02, so that they may make any changes necessary to bring the programs into immediate compliance.



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