

The Benefit

Spring 2009



BOARD OF DIRECTORS

Jo Lester, President
Group Resources, Inc. 2100 Ross, #900
Dallas, TX 75201
214/922-8880; 214/922-9802 fax
jlester@groupresources.com

Robyn Jacobson, Vice President
Entrust, Inc. PO Box 441588
Houston, TX 77244-1588
281/368-7878; 281/368-7828 fax
rjacobson@entrustinc.com

Joanie Verinder, Secretary/Treasurer
Group & Pension Administrators
Park Central 8, 12770 Merit Dr., 2nd Floor
Dallas, TX 75251 972/744-2528;
972/238-8924 fax joaniev@gpatpa.com

Sheryl Bonner, Director
Boon-Chapman PO Box 9201
Austin, TX 78766
512/233-7182; 512/459-1552 fax
sbonner@boonchapman.com

Sam Francis, Director
JI Specialty Services, Inc. 10535 Boyer Blvd.,
#100 Austin, TX 78758
512/427-2302; 512/427-2304 fax
sam.francis@jicompanies.com

Jay McIlraith, Director
IMS PO Box 15688
Amarillo, TX 79105
806/373-5944; 806/373-3121 fax
jaym@imsm.net

Jim Reid, Director
Verity National Group 11467 Huebner Rd.,
#300 San Antonio, TX 78230
210/442-4642; 210/442-4664 fax
jreid@veritynational.com

David Smith, Director
Smith Administrators 3800 Sandshell Dr., #260
Fort Worth, TX 76137
817/867-2582; 817/335-9734 fax
dsmith@smithadmin.com

Clint Wilson, Director
HealthFirst TPA 509 N Sam Houston Pkwy E.,
#500 Houston, TX 77060 281/999-9470
281/999-9518 fax gcwilson@hftpa.com

Fred Newman, Vendor Advisor
Interface EAP 10370 Richmond Ave., #1100
Houston, TX 77042
713/781-3364; 713/784-0425 fax
fnewman@ieap.com

John Farnsley, Vendor Advisor
HealthSmart Preferred Care
2002 W Loop 289, #103 Lubbock, TX 79453
806/473-2542; 806/473-2525 fax
jfarnsley@healthsmart.net

Burnie Burner, Legal Counsel
Mitchell Williams Long Burner
106 E. Sixth Street, #300 Austin, TX 78701
512/480-5100; 512/322-0301 fax
bburner@mws gw.com

Bob Kamm, Lobbyist
The Law Offices of Robert Kamm
1304 Guadalupe Austin, TX 78701
512/477-2008; 512/477-2029 fax
bob@robertkamm.com

Laura Firestone CPA, Exec Director
PO Box 380236 Duncanville, TX 75138-
0236 972/572-1551; 972/709-0611 fax
admin@tpbaa.com www.tpbaa.com

A Message From The President

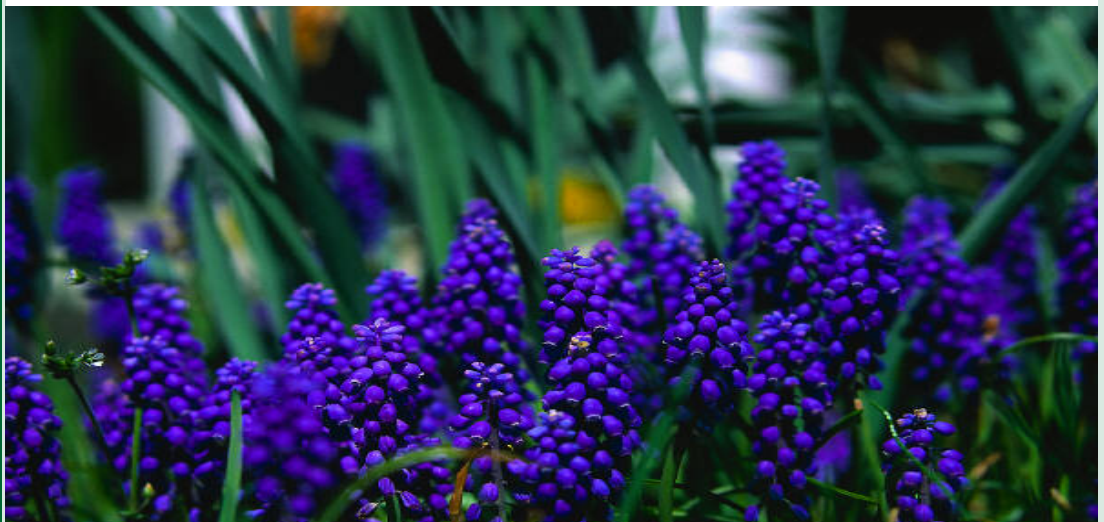
TABA's 6th Annual Legislative Day was a big success. Thanks, as always, go to Sam Francis and Bob Kamm for getting the speakers and content for the meeting pulled together. The Legislative presence at this year's conference was great. We received knowledgeable input from Representative John Smithee, Representative Carl Isett and Representative Craig Eiland. TABA is fast becoming a recognized name in Austin. And, another special thank you to our Legislative Day Sponsors: **HCC Life Insurance Company, Interface EAP, MaxorPlus, National Care Network and WellDyneRx.** Their support is greatly appreciated!

The Legislative Committee and Bob Kamm are proceeding to work on TABA's bill which includes looking for sponsors in both the House and Senate. Harvey Kronberg provided insight into Texas politics during lunch. The political face of Texas is changing and we all will be impacted. If you missed this meeting, you need to get involved. There is proposed legislation that you need to be aware of. We are always looking for additional members to serve on the Legislative Committee. Please volunteer!

Our next event will be the TPA College of Knowledge presented by Glenn McLellan. We have lowered our registration fees in the hope that every TPA will be able to send multiple attendees. Put May 18-19 on your calendar now! More information is included in this newsletter on pages 4 and 5.

I would also like to encourage you to become a PAC contributor. TABA's board members delivered checks and visited with multiple members of the Texas Legislature during the off year. It is extremely important to get involved in the political process. We need to keep our story out there and to do that we need everyone to become a part of the process. It's amazing how communicating a little knowledge can make a big difference!

Jo Lester
TABA 2009 President



Business Associates Beware: The American Recovery and Reinvestment Act's Expansion of HIPAA's Privacy and Security Rules

Contributed by Barbra Rabinowitz, Berry, Odom & Rabinowitz, LLP

The recent enactment of the American Recovery and Reinvestment Act of 2009 (the "Act") has not only had a significant impact on third party administrators with respect to the COBRA subsidy and the required COBRA notices that stem from the subsidy, but also with respect to the expanded HIPAA privacy and security rules. More specifically, among other things, the Act imposes upon business associates (such as third party administrators) the obligation to comply with certain of the privacy and security rules under HIPAA and subjects business associates to the civil and criminal penalties for violating those rules in the same manner as they apply to covered entities. Many of these new obligations take effect on February 17, 2010. A brief summary of some of the more pertinent highlights of the broadened application of HIPAA's privacy and security rules is set forth below.

Direct Application of Certain Privacy and Security Rules to Business Associates

As we are all very much aware, business associates are already required to comply with certain privacy and security standards pursuant to the business associate contract they have with a covered entity. Under current law, the covered entity (such as the health plan) is required to identify all of its business associates and enter into applicable business associate agreements. In other words, the burden is on the covered entity. The Act makes business associates directly responsible for compliance with many of the privacy and security rules. Under the Act, it is as much the business associate's burden to have business associate agreements in place as it is the covered entity. A business associate must also comply with certain of the HIPAA security standards as if it were a covered entity, such as developing written policies and procedures, training its employees on protecting certain protected health information ("PHI"), appointing a security official, and implementing physical, technical and administrative safeguards.

Notification Requirements Upon Breach

Currently, HIPAA does not mandate that a covered entity notify affected individuals of a security breach involving PHI; rather, a covered entity is only required to mitigate the potential damage resulting from an unauthorized disclosure. The Act imposes significant notification requirements upon business associates (and covered entities) if and when a breach of unsecured PHI is discovered. Specifically, in the event a business associate discovers a security breach of PHI, it must notify the covered entity of such breach, and the covered entity must notify affected individuals directly in a timely manner (that is, no later than sixty days following the discovery of the breach). Notification must be in the form of a letter or email (if requested by the individual). In addition, if the breach involves the data of more than 500 individuals in a given area, then a "prominent media outlet" in the area must be notified, as well as the U. S. Department of Health and Human Services ("HHS"). The reported breach of this magnitude will be posted on the HHS website for public viewing.

Electronic Health Records

The Act imposes new accounting requirements with respect to PHI disclosures made through an electronic health record. The Act defines an "electronic health record" as an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff. The Act grants an individual the right to receive an accounting of PHI disclosures made through an electronic health record, during the previous three years, by a covered entity (or its business associate) even if the disclosures are necessary to carry out treatment, payment or healthcare operations. (Note that, currently, a covered entity is not required to track its disclosures of PHI if the PHI is used in connection with treatment, payment or healthcare operations.) Regulations implementing this new requirement must be promulgated by the HHS, but this requirement does not take effect until at least January 1, 2011 (with respect to electronic records acquired by a covered entity after January 1, 2009) and maybe as late as January 1, 2014 (with respect to electronic health records held by a covered entity as of January 1, 2009).

Minimum Necessary Standard

HHS has been directed to provide guidance on what constitutes "minimum necessary" regarding the use, disclosure or request of PHI. Until such guidance is provided (no later than August 17, 2010), the Act provides that covered entities (and business associates) should, if possible, limit their use and disclosure of PHI to that contained in a limited data set.

Other Individual Rights

Other individual rights provided by the Act include the right of an individual to prohibit a health care provider from sharing PHI with his or her health plan if such healthcare provider has been paid out-of-pocket in full. In addition, if a covered entity uses or maintains an electronic health record that contains PHI, an individual can request a copy of his/her record in electronic format

Continued on page 3

Business Associates Beware: The American Recovery and Reinvestment Act's Expansion of HIPAA's Privacy and Security Rules

Contributed by *Barbra Rabinowitz, Berry, Odom & Rabinowitz, LLP*

Continued from page 2

and/or direct it to be sent to another designated person or entity. Furthermore, within the next three years, HHS is required to promulgate regulations that would afford individuals affected by a HIPAA violation with the right to receive a percentage of any civil monetary penalty or monetary settlement collected in connection with such violation.

Civil Penalties and Enforcement Provisions

Effective immediately (that is, for violations occurring after February 17, 2009), the Act has dramatically increased the civil penalty scheme under HIPAA. The imposition of civil penalties is based upon the nature of the violation. If the violation is due to "reasonable cause," the Act increases the civil penalty amounts to \$1,000 per violation (up to \$100,000 per year), for each type of violation. If the violation is due to "willful neglect," the maximum penalty can range from \$10,000 (up to \$250,000 per year) to \$50,000 (up to \$1.5 million per year), depending upon whether the violation is corrected properly.

Furthermore, the Act authorizes individual state attorney generals to bring a civil HIPAA enforcement action against those covered entities or business associates who violate the HIPAA privacy and security rules and can seek damages in connection with such violations.

Finally, HHS will be required to conduct periodic audits to ensure that both covered entities and business associates are complying with the new rules.

Effective Date

Most of the new provisions become effective February 17, 2010. However, there are some provisions that have various effective dates.

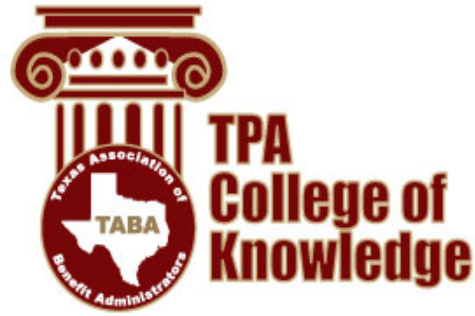
Impact of the Law

The Act imposes significant changes to the HIPAA privacy and security rules and requires covered entities and business associates (including third party administrators) to carefully review these provisions and take appropriate and quick action. Clearly, business associates (including third party administrators) will need to work quickly to comply with the new provisions by, among other things, entering into business associate agreements, adopting and/or revising HIPAA policies and procedures, appointing a security official, conducting a security gap analysis, revising record retention policies, and providing requisite training to their respective workforce. Of course, the covered entity-health plans which the third party administrator services will most likely also be looking to its third party administrator for guidance on complying with the new provisions imposed by the Act.

This document is not intended to be legal advice regarding any specific situation, nor does it encompass all provisions regarding the HIPAA privacy and security standards under the Act.



TABA Presents the 3rd Annual



With Glenn McLellan of McLellan Consulting Services

May 18-19, 2009

Renaissance Hotel

900 East Lookout Drive

Richardson, Texas 75082

972-367-2000 phone

972-367-1600 fax

This one and a half day seminar is designed to provide TPA managers with the strategies, information and tools to function more effectively in today's competitive market. The seminar agenda, location, timing and pricing has been developed to facilitate multiple attendees from TPAs located around the country. There will be nine educational sessions as well as exhibitor and sponsor opportunities. TABA is pursuing continuing education credits for all of the sessions.

Agenda

Monday, May 18, 2009

11:00-4:00 Registration

1:00-2:30 Session I: Trends and Tribulations...A Fast-Paced Review of Pressures Facing the Self-Funded Industry and Critical Success Factors for TPAs.

2:30-2:45 Break

2:45-3:45 Session II: Effective TPA Trend Management Programs...Delivering Return on Investments and Value to Self-Funded Employers

3:45-5:00 Session III: PPOs...Preferred Provider Organizations or Pretty Poor Offerings? Strategies for Evaluating, Managing and Replacing Provider Networks

5:30-6:30 Reception with Exhibitors/Sponsors

Tuesday, May 19, 2009

7:30-12:00 Registration

7:45-8:30 Continental Breakfast with Exhibitors

8:30-9:45 Session IV

Care Management Hot Topics...Integrating Wellness, Prevention, Coaching and Disease Management in to the TPA Portfolio of Services

Continued on page 5

9:45-10:45 Session V: Under the Microscope...Effectively Managing Catastrophic Claims
 10:45-11:00 Break
 11:00-12:00 Session VI: Protecting the Plan Sponsor...Forward Thinking Benefit Design and Programs to Mitigate Plan Liability
 12:00-1:15 Lunch
 1:15-2:30 Session VII: Managing the Litany of Carve Out Opportunities...PBM, Specialty Rx, Radiology, Dialysis, Oncology
 2:30-3:15 Session VIII: Building the Account Service Culture within a TPA Organization...Strategies for Training, Accountability and Proactivity
 3:15-3:30 Break
 3:30-5:00 Session IX: Use of Metrics and Benchmarks in Managing TPAs/Update on Current TPA Benchmarks

Please make your hotel reservations directly with the Renaissance Hotel at 800-264-0359 and indicate that you will be attending the TABA meeting to receive the preferred room rate of \$129 single/double. Reservations must be made by April 27, 2009 to receive the guaranteed room rate as long as there is availability. If the room block is sold out prior to the cutoff date, the next best rate will be offered. The hotel is located at 900 East Lookout Drive, Richardson, TX 75082. Discounted parking rates will apply. We will honor member rates for companies who join the association. For exhibitor/sponsor information, contact Glenn McLellan at 860-604-0410 or email admin@tpbaa.com.

	Member Fees*			Non-Member Fees*		
	1/2-Day	1 Day	1-1/2-Days	1/2-Day	1 Day	1-1/2-Days
	Monday	Tuesday	Monday/Tuesday	Monday	Tuesday	Monday/Tuesday
Initial Reg	\$225	\$385	\$495	\$375	\$535	\$645
Second Reg	\$175	\$285	\$395	\$350	\$510	\$620
Additional Reg	\$ 75	\$185	\$295	\$250	\$410	\$520

*After 05/08/09 Add \$50 To Fees

PLEASE PRINT THE FOLLOWING:

Name _____
 Company _____
 Address _____
 City/State/Zip _____
 Phone _____ Fax _____ Email _____
 Additional Registrant Name(s) and Email(s):

Member Registration \$ _____
 Non Member Registration \$ _____
 Additional Registrants (#____) \$ _____
 TOTAL \$ _____

Method of Payment: ___ Check ___ MC ___ VISA ___ AMEX
 Card Number _____ Exp Date _____ VAL Code _____
 Cardholder Name _____
 Cardholder Billing Address _____
 Signature _____

Please make checks payable to Texas Association of Benefit Administrators. Meeting registration cancellations received in writing prior to May 8, 2009 will receive a refund less a \$25 administrative processing fee. Return forms with payment to TABA, PO Box 380236, Duncanville, TX 75138-0236 or fax credit card payments to 972-709-0611. For meeting inquiries, call 972-572-1551 or email admin@tpbaa.com.

The Lobbyist's Corner: *Legislative Update*

Bob Kamm, TABA Lobbyist

I. Hospital billing practices

TABA's main legislative priority is the passage of a bill that will improve hospital billing practices as it relates to timely payment of claims. TABA has identified some of the key issues as:

1. Need to amend chapter 324 of the Texas Health and Safety Code to create standardized hospital billing practices in an effort to create greater transparency and enable faster, more accurate payment for services rendered.
2. This is not just a self insurance issue. Billing issues impact self-funded plans and fully insured plans alike, especially those that use the same PPOs.
3. An itemized bill should be provided automatically at a defined dollar threshold and upon request (within 10 days) for smaller bills.
4. An itemized bill may not be enough; additional information may still be required because every patient's care is unique.
5. Require interim billing in instances of a hospital stay longer than 15 days; interim billing should be provided within 10 days of request.
6. Reimbursement of any overpayment made to hospital must be made by the hospital within 45 days of notice of overpayment and request for reimbursement; fair is fair; a desire for prompt payment should be matched by prompt reimbursement.
7. Limit timeframe for when claim can be made against the Plan or TPA for payment of disallowed discount; 180 days to make a demand; do not allow a look back greater than six months.
8. Require any third party bill collectors hired by hospital to meet all requirements of the law applicable to their hospital clients before sending a demand for payment.
9. Consider a private cause of action against hospital for failure to follow standardized billing practices; at a minimum, make sure that an enforcement mechanism exists.

Representative John Smithee (Abilene), chair of the House Insurance Committee, and Senator Robert Duncan (Lubbock), chair of the Senate State Affairs Committee, each filed bills that attempt to improve the issues above: HB 4183 by Smithee and SB 1747 by Duncan. TABA has been meeting with members of the Texas Hospital Association for the past six months or so but unfortunately little agreement has been reached in resolving the issues. Failure to reach agreement with THA will make the likelihood of passing a bill this session very difficult. Legislators like bills to be "worked out" since passing a bill over opposition is not easy in the 140 day legislative session.

II. Texas Department of Insurance Sunset Legislation

TDI was reviewed by the Sunset Commission during the interim to determine if the agency should continue in existence. In doing its review, the Sunset Commission also looks at ways to improve the operations and oversight of the Department. Two bills have been filed: SB 1007 by Senator Hegar (Katy) and HB 2203 by Representative Isett (Lubbock). Each bill provides for new regulation of PPOs. This part of the bill will be of particular interest in TABA. Additionally, a "sunset" bill usually receives many amendments so TABA will be watching the bill closely. Additionally, Representative Eiland (Galveston) has filed HB223, relating to regulation of the secondary market in certain physician and health care provider discounts. The bill defines "Discount broker as any entity engaged, for monetary or other consideration, in disclosing or transferring a contracted discounted fee of a physician or health care provider."

III. Cost of medical hardware and specialty drugs

Representative Coleman (Houston) has filed HB 3749 that attempts to provide transparency in the billing of implantables and specialty drugs. Often these items are marked up considerably, but the consumer and payor have no way of knowing how much they are inflated. The Committee Substitute to HB 3749 provides in part:

An itemized statement provided as required by this section must: (1) include the unit price charged to the facility by a manufacturer or supplier for: (A) any medical hardware provided by the facility; (B) each device or implant provided by the facility; and (C) any prescription specialty drug or drug protocol dispensed by the facility;

The Committee substitute further provides that On or after September 1, 2009, a contract may not contain a provision that prohibits a facility from disclosing the unit price charged to the facility by a manufacturer or supplier of any medical hardware, device, implant, prescription specialty drug, or drug protocol, or from disclosing other pricing information related to the contract.

The legislative sessions ends June 1, 2009.

Helping TABA’s Legislative Efforts—We have begun a new year and even though we can’t contribute to legislators while the legislature is in session, we still should continue the momentum of contributing to the PAC to be ready after the session is over. We contributed close to \$11,000 to legislators last year and as you know this money helps legislators with campaign costs, as well as costs of being in office that the State does not cover. Legislators are paid \$7200 per year (\$600 per month). Many spend their own money to cover costs that don’t get reimbursed by the State. You and your employers can participate in the legislative process by helping legislators with these costs. We encourage those of you who have not yet made your 2009 contribution to do so today! TABA is definitely making inroads within the legislative arena.

We still need to meet our goals and you can help by following this suggested plan: We are asking each member TPA to commit to contributions in an amount equal to their membership fee. This amount will come from personal contributions from TPA owners and key employees. Corporate contributions are prohibited by Texas law. Many of our member TPAs already contribute in this manner but many do not. We need the support of all members! Also, we would ask that any TPAs not contributing to the level of their membership fee, to solicit an increase in contributions or broaden the base of contributors in their office. A number of the TPAs whose contribution level already exceeds their membership fee have found that its success lies in its ability to attract contributions from a number of their key employees. This has been brought about by a payroll deduction plan that makes contributing much easier. They have found that it is much easier to make a contribution of \$5 a week than to make a one time donation of \$250. The president of each TPA member company convenes a meeting of key employees. In the meeting, the president explains TABA’s legislative goals and why those issues are important to the company and to the industry. Each company establishes an annual company goal based on the number of key employees. If, for example, there are six key employees, the annual goal could be \$1000 with five employees paying in \$100 and the president \$500. Along with the annual goal, a payroll deduction is instituted for this expense. Each key employee will contribute \$8.33 per month; the president, \$41.66 per month. Once in place, the goal is met every year. No golf tournaments, no fancy galas, no auctions – and none of the time and planning those events required. Not very flashy, but it would be dependable, predictable, simple, and hugely successful.

TABA Political Action Committee “TABAPAC” Contribution Form

GOLD \$150 (\$12.50/mo.) **PLATINUM** \$300(\$25/mo.) **RUBY** \$600 (\$50/mo.)
DIAMOND \$1,200 (\$100/mo.) **OTHER** \$_____

Note: Corporate contributions to TABAPAC are prohibited. Individual contributions only!

Name _____ Employer _____
 Occupation _____ Address _____
 City _____ State _____ Zip _____ Telephone (____) _____
 Fax (____) _____ Email _____

Check the appropriate box(s) that apply:

- () I have enclosed a **check** payable to TABAPAC for the selected level.
- () Please **charge** my contribution **Monthly/Quarterly/Annually** in the amount of \$_____ to my credit card:
- () MasterCard () Visa () American Express
- Card Number _____ Exp. Date _____ Sec Code _____
- Cardholder Name _____
- Cardholder Billing Address _____
- Cardholder Signature _____

*This authorization is to remain in force until TABA has received written notification from me of its termination. I authorize TABA to charge my credit card as shown above. I understand that the statement will read “Texas Professional Benefit Administrators Association.” I understand that contributions to TABAPAC are NOT tax deductible. **Mail checks to: TABA, P. O. Box 380236, Duncanville, Texas 75138-0236 OR fax credit card authorizations to 972-709-0611.***

**TABA EXTENDS A SPECIAL
THANK YOU TO OUR
2008-09 TABAPAC
CONTRIBUTORS**



DIAMOND (\$1,200+)

- ◇ ENTRUST, INC.
ROLANDO BARRERA
BRIAN DAVIDSON
ROBYN JACOBSON
- ◇ GROUP & PENSION ADMIN
JEFF MCPETERS
JERRY MCPETERS
JOANIE VERINDER
ALL EMPLOYEES OF GPA
- ◇ HEALTHFIRST TPA
LAREA ALBERT
GARY CHAPMAN
CLINT WILSON
ALL EMPLOYEES OF HEALTHFIRST TPA
- ◇ JI COMPANIES
PARKER CHAMBERS
FRANCIS FEY
SAMUEL FRANCIS
BART GRIFFIN
JOSEPH HRBEK
HERMAN JUAREZ
KEVIN MCCORMICK
STANWOOD MOONEY
GREG WOMACK

RUBY (\$600-\$1,199)

- ◇ BENEFIT MGMT ADMINISTRATORS
JAMES BURKHOLDER
- ◇ GROUP RESOURCES
ROBBY KERR
JO LESTER
- ◇ INTERFACE EAP
FRED NEWMAN
- ◇ MUTUAL ASSURANCE ADMINISTRATORS
TODD ARCHER
GREG BROWN
JEFF MORRISON
ERIC WRIGHT
- ◇ SMITH ADMINISTRATORS
DAVID SMITH
- ◇ THE PHIA GROUP LLC
ADAM RUSSO
- ◇ VERITY NATIONAL GROUP
JIM REID

PLATINUM (\$300-\$599)

- ◇ INTERNATIONAL ASSURANCE OF TN
BOB BAISDEN
BRANDON BAISDEN
WALT MCELROY
- ◇ WELLDYNERX
JOE BURGESS

GOLD (\$150-\$299)

- ◇ ALLIANCE UNDERWRITERS
JAMIE ROBERTS
- ◇ BOON-CHAPMAN
SHERYL BONNER
KEVIN CHAMBERS

SILVER (\$1-\$149)

- ◇ AIM ADMINISTRATORS
SCOTT ANDALMAN
- ◇ BARDON INSURANCE GROUP
LARRY VOLPE
- ◇ CAPROCK HEALTHPLANS
LIZ FRANCO
- ◇ CVS/CAREMARK
MICHAEL COLLINS
- ◇ HCC LIFE INSURANCE COMPANY
JOE KIPP
- ◇ HINES & ASSOCIATES
LISA JO JOHNSON
CYNTHIA KLORER
- ◇ IIS
KENNETH WALKER
- ◇ IMS
JAY MCILRAITH
- ◇ MULTIPLAN
DENNIS FISHER
- ◇ NATIONAL CARE NETWORK
BOWIE HOGG
STEVE WAGNER
- ◇ TELADOC
GARY DAIGLE

Making Plan Design Changes and Showing Return on Investment Adds Real Value For Your Clients

Contributed by Marilyn Fooshee, Director Client Relations, Benefit Informatics

Each year, employer group customers want to make changes to their health plan and they turn to you, their TPA, for expert advice and direction. The current economic challenges have necessitated greater changes to plan design to help employers and health plans control costs.

Making plan changes can be as simple as increasing co-payment and deductibles or drilling-down into intricate plan changes that only affect a tiny subgroup within the plan. After these modifications are implemented, you can greatly increase the value of your professional service to employer group clients by showing them a detailed return on investment (ROI) for the plan design changes.

There are several key ingredients needed in preparing a plan design change analysis. Chief among these are claim data and the plan document. But another requirement is the passage of time. We need a good period of time and claim data from this period to analyze utilization by plan members. Six months is a good start and should allow for adequate analysis of the plan from the same period the year before. But a complete year is best when analyzing this data.

The following is a sample plan change analysis performed recently for plan changes implemented last year. The health plan and TPA implemented changes such as:

- Type I expenses no longer paid at 100%. Charges now subject to the plan deductible and coinsurance.
- Eliminated Outpatient Diagnostic X-ray and Lab charges paid at 100% of the first \$100. Expenses now paid subject to plan deductible and coinsurance.
- The annual deductible increased from \$100 per individual/\$200 per family to \$200 per individual/\$400 per family. Deductible combined for in and out of network services.
- Combined in and out of network coinsurance maximum of \$2,000 per covered person changed to an in and out of network per single/family arrangement. New coinsurance maximums \$1,000 per single covered person/\$2,000 per covered family in network and \$5,000 per single covered person/\$10,000 per covered family out of network.
- Out of network providers paid at a 60% plan payment level rather than 80%.

To properly evaluate the results of plan modifications, the exact same plan codes, provider tax identification numbers or benefit types for the plan changes and equal data time frames must be included in the equation. The changes in plan design referenced above led to significant year over year savings for the group. Here are a few highlights:

- Percentage Savings per category:

○ Type 1 Services Plan Change Savings	18%
○ Dx X-Ray & Lab Plan Change Savings	5%
○ Individual deductible savings	44%
○ Family Deductible Savings	45%
○ Out of Pocket Maximum Savings	39%
○ Out of Network Coinsurance Savings	31%

This sample also provides an excellent example of the value of conducting predictive modeling and forecasting before making plan design changes and the potential effects in areas such as retention, employee morale and provider relations. Every TPA can add value to their client relationships by offering proactive consultative services including plan design change analysis. Conducting ROI analysis of these changes can provide concrete proof of the plan change methodology and the value you provide in helping your clients manage their health plans and control costs.

Marilyn Fooshee is the Director of Client Relations for Benefit Informatics. Her responsibilities include coordination of customer interaction with Benefit Informatics clients with a special emphasis on providing enhanced professional services and return on investment. Marilyn has more than 23 years experience in the health insurance industry. mfooshee@benefitinformatics.com

Never Events

Contributed by Adam Russo, Esq., The Phia Group LLC

Undoubtedly you have recently heard about “Never Events” and their anticipated impact on the health claims payer community. Numerous entities are now either denying or contemplating denial of charges for services, supplies, care and treatment that result from medical errors that are clearly identifiable, preventable, and serious in their consequence for patients.

As the confusion surrounding Never Events has created many unanswered questions, industry leaders are aggressively working to establish the best methodology to handle Never Events. You must determine what Never Events are, which Never Events will be denied, and the procedure for actually denying Never Events – both in drafting unique plan language and handling submissions.

Many employer groups are beginning to ask what their TPA is doing about using plan assets to pay for things that were medical errors, or resulted from medical errors. If a payer wants to exclude these types of charges, the administrator must retain discretionary authority to determine whether an exclusion will apply based upon information presented and ensure that their plan language allows them to do so. Finally, a prudent payer will make it clear that a finding of provider negligence and/or malpractice is not required to apply.

An estimated 98,000 patients die each year due to preventable medical errors. This presents an enormous financial cost. Between 2002 and 2004 the Centers for Medicare and Medicaid Services (CMS) paid more than \$9.3 billion in claims associated with medical errors.

If the self-funded industry and TPAs in particular do nothing, they will lose their clients to the fully insured market. A growing number of insurers such as Aetna, Cigna, and Wellpoint are reacting to Never Events, and in so doing signaling to payers the savings opportunity available to those that react. To prevent potential hostile disputes and litigation, TPAs and Stop-Loss must have complete understanding, coordinating strategy, and cooperation in regards to Never Events.

Determining what constitutes a Never Event varies by the differing procedures of each hospital. Some instances may appear as situations where the surgeon was exceptionally careless, but in reality the hospital was accountable. For example, in many hospitals verifying that all tools and sponges are out of the patient is the responsibility of the hospital-employed surgical nurses. In the case of wrong-patient or wrong-appendage situations, so many duplications of verification exist between surgeons and hospital staff that it would be virtually impossible to nail down whether the hospital or surgeon was responsible.

ERISA Plan fiduciaries must not only protect plan assets, but also be sure that plan beneficiaries receive benefits and payment for what they would logically expect by reading the plan language. If a TPA or Stop-Loss carrier makes the unilateral decision to refuse to pay or reimburse what it arbitrarily believes is a Never Event, the plan beneficiary will get caught in the middle between the hospital demanding payment and the plan refusing payment. Further, in a reimbursement situation where the Stop-Loss carrier refuses to reimburse the plan for claims paid resulting from such Never Events, the benefit plan will end up paying every cent out of its trust.

In order to shield benefit plans from paying claims they are neither responsible for nor can they expect to see any reinsurance for and to keep up with the fully funded market, plan administration must be adjusted. Emphasizing Never Events will ensure that hospitals and eventually all medical providers will not be able to hide or deny when such events occur. They need to apologize to the patient and report to health-quality-tracking authorities. This is a win-win opportunity to show your clients that their plans will no longer be stuck paying for the medical provider mistakes.

It is imperative not to rush into a policy that may quickly become destructive since very few events neatly fit under the term Never Event. Instead, TPAs must create cost effective programs to identify these events and new plan language to fight these claims. TPAs & Stop-Loss need to work jointly on this so that we are all on the same page about what is and what is not reimbursable.



Value-Based Insurance Design (VBID) Versus TMAC For Pharmacy Benefits

Contributed by Frederic R. Curtiss, PhD, RPh, CEBS

Much of the parade of consultants recommending “value-based insurance design” for pharmacy benefits is sponsored by the brand-name pharmaceutical industry. The mantra goes something like this: “high member copayments cause patients to stop taking their drugs.” Or, sometimes the pitch is: “making member copayments \$0 results in better medication adherence and saves you money.” Little wonder that brand-name drug manufacturers have enthusiastically financed this fallacy, particularly when the “value” part of the equation is ignored.

The fact is that about 6 patients can be treated for heartburn (otherwise known as gastroesophageal reflux disease [GERD]) with Prilosec OTC (\$25 per month) for the cost of treating 1 patient with Nexium (\$150 or more per month). Put another way, a therapeutic maximum allowable cost (TMAC) benefit design in which the *defined benefit* is \$25 per month for heartburn would save the payer about 83% in cost avoidance compared with Nexium and other brand name drugs for heartburn such as Prevacid, Aciphex and Protonix.

Rather, the value-based insurance design proponents would have you reduce your pharmacy benefit copayments to \$0 for most brand-name drugs under “umbrellas” such as drugs for diabetes or hypertension. Certainly, we know from experience that making drugs “free” or essentially free with small dollar copayments (e.g., \$2 per month for generic drugs) increases the generic dispensing ratio (GDR) and saves money for drug plan sponsors and for members. However, low copayments for relatively expensive brand-name drugs saves money for plan members but not for drug plan sponsors, a fact that tends to get lost in the clamor.

Value-Based Insurance Design and the Emperor’s New Clothes

In principle, valued-based insurance design (VBID) seems difficult to refute. What is not to like about a promise that beneficiaries will pay lower cost for therapies that have high value and higher cost for therapies with low value? Unfortunately, there is little evidence of what differentiates “high value” from “low value” in most medical interventions — for example, the debate continues this month regarding angioplasty with coronary stenting versus coronary artery bypass graft [CABG] to prevent recurrent ischemic myocardial events. For prescription drugs, the direct cost of the drugs themselves is the best measure of value that we have. However, the VBID salespeople typically do not differentiate *between* the direct cost of 2 drugs for the same indication, but instead attempt to hide actual value analysis in *categories* of drugs for diabetes, hypertension, or other cardiovascular disease such as dyslipidemia.

Between drugs, there is a huge difference in value. Generic Zocor (simvastatin) costs about \$0.50 per day while Lipitor costs about 7 times as much, about \$3.50 per day. As with the heartburn drugs, this means that for the same cost (\$3.50 per day) your pharmacy benefit plan can treat 7 patients with generic Zocor or 1 patient with Lipitor or Crestor. For the heartburn drugs and the drugs for dyslipidemia, these are not small differences, and this is the reason that these low-cost, high-value drugs such as simvastatin, gabapentin, and Prilosec OTC are first-line treatment in step-therapy requirements.

Step-therapy edits extend beyond heartburn and dyslipidemia to drugs to treat several indications, such as depression and fibromyalgia. Some useful and reliable evidence comes from a study of a benefit design that required first-line use with generic selective serotonin reuptake inhibitors (SSRIs) such as generic Prozac, generic Paxil, and generic Celexa prior to brand name antidepressants such as Cymbalta and Effexor XR. This step-therapy requirement for antidepressants was found to reduce drug spending by 11% for all antidepressants in a large health plan of 440,000 members,¹ even before the huge cost savings that would have been possible with generic Zoloft that became available after this study was conducted.

Last year at this time, Chernew, Fendrick and colleagues made headlines with an article in *Health Affairs* that was touted by the VBID “salespeople” as evidence that drug plan sponsors needed to rush to lower copayments for certain classes of drugs lest patients stop taking these drugs because of cost.² This article had many flaws, and even 1 of these flaws is enough to discount this “research” as opinion rather than evidence. This so-called “evidence” of the value of value-based insurance design applied to pharmacy benefits had these and other flaws:

- The employer group that lowered copayments was *different* than the employer group that did not lower copayments – a fatal flaw in comparative research.

Continued on page 12

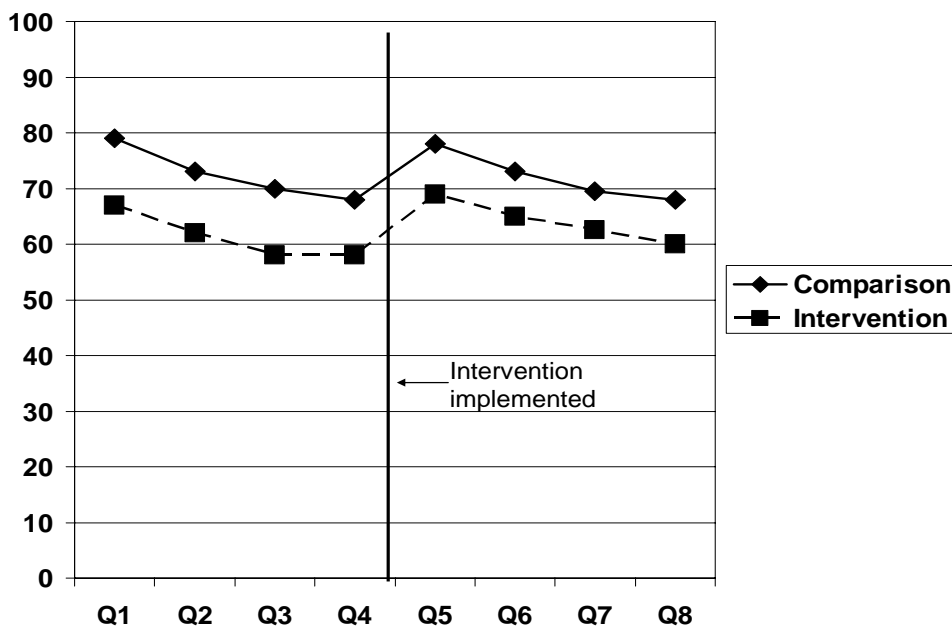
Value-Based Insurance Design (VBID) Versus TMAC For Pharmacy Benefits

Contributed by Frederic R. Curtiss, PhD, RPh, CEBS

Continued from page 11

- The VBID study appears to have little value in the real world of pharmacy benefits management for self-insured employers. While very little information is provided about the 2 employer groups, one can calculate that the 2 groups do not appear to be similar to customary employer-sponsored drug plans. For example, the proportion of non-employee beneficiaries is very small, with an average beneficiary-to-employee ratio of only 1.39 in the intervention group (lowered copayments) and 1.52 in the comparison group that did not change copayment amounts.³
- Amazingly, this report did not describe the intervention, such as the before and after copayment amounts (i.e., benefit design) - we don't know the actual copayment amounts for the 2 groups for generic drugs versus brand drugs.
- The measured outcome was days of drug therapy in a year and there is little, if any, clinical significance to 7 more days of drug therapy in 1 year, even if the study design was appropriate.
- There is no description of how much this VBID intervention to lower copayments actually cost the employer that sponsored the copayment reduction. Therefore, it is not possible to even estimate the return on investment (positive or negative) for the employer (plan sponsor).
- The misleading statistics presentation is better shown in Figure 1 that was created in a critique of the trend analysis over 2 years—the misleading results are more discernible in this figure—a picture tells a thousand words (i.e., there is no meaningful difference between these 2 trend lines, other than perhaps the higher net cost incurred by the plan sponsor in subsidizing the lower copayments in the “intervention” group).

Figure 1. Corrected Graph of Medication Possession Ratio (MPR) for Diabetes Drug Therapy in the 2 Employer Groups



Therapeutic Maximum Allowable Cost (TMAC). TMAC is a more useful method to manage pharmacy benefits, while delivering the same clinical outcomes for beneficiaries, compared with the current pitch from the VBID salespeople to lower drug copayments. Therapeutic maximum allowable cost (TMAC) is a managed care intervention that establishes a defined benefit dollar amount per therapeutic procedure or indication. TMAC can be established for any medical procedure (e.g., joint replacement) or any pharmacological indication (e.g., cholesterol reduction). Heartburn is ideal for TMAC, particularly since there is overwhelming evidence that the proton-pump inhibitors (PPIs) are therapeutically indistinguishable.

Continued on page 13

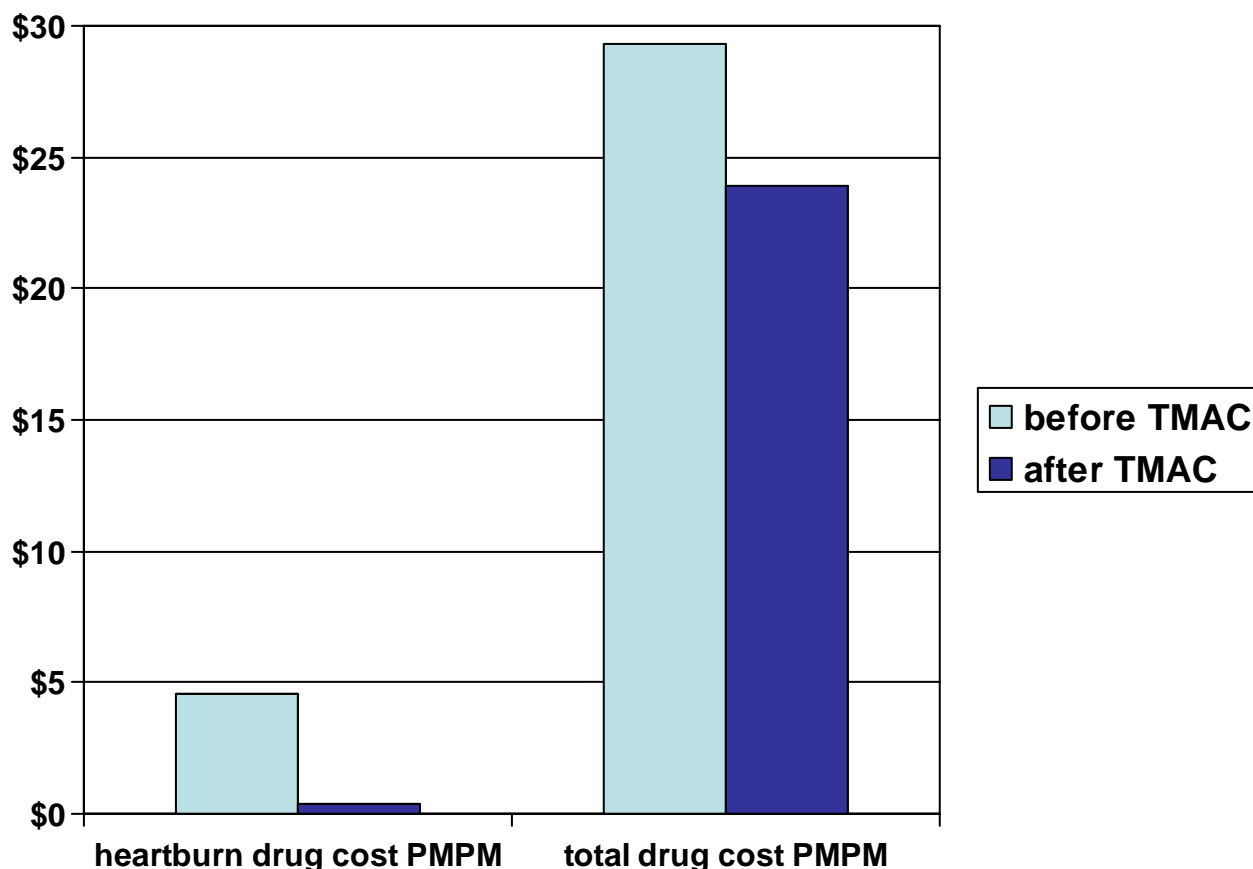
Value-Based Insurance Design (VBID) Versus TMAC For Pharmacy Benefits

Contributed by Frederic R. Curtiss, PhD, RPh, CEBS

Continued from page 12

In this example of actual data from a small, self-insured employer in 2006 compared with 2005, heartburn drug cost per member per month (PMPM) declined by 92% (Figure 2), and because the heartburn drugs such as Nexium accounted for about 16% of total drug benefit spending, total drug costs PMPM dropped by 18%, before accounting for inflation (i.e., adjusting for inflation would increase the magnitude of the cost savings).⁴

Figure 2. Drug Costs Savings from TMAC for Heartburn Drugs



FREDERIC R. CURTISS, PhD, RPh, CEBS, is the only licensed pharmacist certified as an Employee Benefits Specialist. He is the Editor-in-Chief of the Journal of Managed Care Pharmacy (JMCP) and previously provided clinical pharmacy and management services to PBMs, HMOs and other health plans.

DISCLOSURES: The author reports no conflicts of interest related to the subjects or products discussed in this article.

References:

¹ Dunn JD, Cannon HE, Mitchell MP, Curtiss FR. Utilization and drug cost outcomes of a step-therapy edit for generic antidepressants in an HMO in an integrated health system. *J Manag Care Pharm.* 2006;12(4):294-302. Available at: http://www.amcp.org/data/jmcp/research_294-302.pdf.

² Chernew ME, Shah MR, Wegh A, et al. Impact of decreasing copayments on medication adherence within a disease management environment. *Health Aff.* 2008;27(1):103-12.

³ Fairman MA, Curtiss FR. Making the world safe for evidence-based policy: Let's slay the biases in research on value-based insurance design. *J Manag Care Pharm.* 2008;14(2):198-204. Available at: http://www.amcp.org/data/jmcp/JMCPMaga_March%2008_198-204.pdf.

⁴ Curtiss FR. TMAC savings of 90% for heartburn drugs in the United States. *J Manag Care Pharm.* 2006; 12(5):403-05. Available at: http://www.amcp.org/data/jmcp/editorial_subjects_403-405.pdf

SAVE THE DATE!
September 14-15, 2009
Fall Conference & Exhibition
Marriott Plaza Hotel
San Antonio, Texas
MORE INFORMATION COMING SOON!

TABA 2009 Calendar of Events

TABA	SIIA	SPBA
<ul style="list-style-type: none"> • TPA College of Knowledge May 18-19, 2009 Renaissance Hotel Richardson, TX • Board of Directors Meeting May 20, 2009 Group & Pension Administrators Offices Dallas, TX • Fall Conference & Exhibition September 14-15, 2009 Marriott Plaza Hotel San Antonio, TX • Board of Directors Meeting September 16, 2009 Marriott Plaza Hotel San Antonio, TX 	<ul style="list-style-type: none"> • TPA/MGU/Excess Insurer Executive Forum April 14-16, 2009 Newport Beach Marriott Newport Beach, CA • Self-Insured Workers Comp May 18-20, 2009 Westin Hilton Head Hilton Head, SC • 29th Annual National Educational Conference & Expo September 21-24, 2009 Marriott Worldcenter Hotel Orlando, FL 	<ul style="list-style-type: none"> • 2009 Fall Conference October 5-7, 2009 Portland, OR <p style="text-align: center;">For more information on advertising and getting your message out, email us at admin@tpbaa.com.</p>