MUTUAL ASSURANCE ADMINISTRATORS, INC.

BenefitWise

Important news and updates from your benefits professionals **Vol. 2012, Issue 02**

What If... the PPACA Mandate is Overturned?

Designed to extend health care protection to millions of Americans who lack coverage, the individual mandate is a central part of the Patient Protection and Affordable Care Act recently debated before the U.S. Supreme Court. While no one can predict the outcome, we thought it might be appropriate to consider a few possible scenarios that could arise.

- If the court finds the mandate requiring most Americans to purchase health care coverage or pay a fee to be constitutional, employers would continue to implement health care reform laws as required. Under this scenario, many expect that employer-sponsored health benefit plans would continue to fade away as more and more employers, especially small business owners, opt to pay penalties and send former plan participants to state-run exchanges.

- If the court finds the individual mandate unconstitutional but not severable from other parts of the PPACA law, they would then need to determine if the law can remain relevant without the mandate.

- A third option is that the Supreme Court could find the individual mandate to be unconstitutional, but severable from the remainder of the PPACA law. Many see this as a real possibility since this was the outcome in the 11th Circuit Court. If this happens, employers could modify their plans while keeping those provisions that have already been implemented.

All Up or All Down

It is probably fair to say that most experts hope that the court either keeps the entire law intact or declares it all unconstitutional, since any compromise would cause continued confusion. If the mandate goes away and requirements such as guaranteed issue and pre-existing condition exclusions remain, costs could skyrocket as people with chronic health concerns enter the marketplace and healthy, young individuals hold off. Limited open enrollment periods and penalties could be adopted to encourage young people to buy health coverage.

Over time, employer-sponsored plans would likely suffer as employers choose to pay penalties and send plan participants to exchanges. If the entire law is found unconstitutional, employers would need to decide if they want to maintain features like extending the maximum age for adult dependents to 26 and eliminating lifetime dollar limits on essential benefits. With the Supreme Court expected to rule in late June, speculation will hopefully be replaced by action, as we continue to help your plan respond to the outcome.

Will ACOs Lower Costs?

An important part of the health care reform law is the promotion of Accountable Care Organizations (ACOs) – programs that enable health care providers to earn financial rewards when they achieve goals for high quality, cost-efficient care.

The Medicare ACO program will begin this year and surveys show more than 150 additional ACOs currently being developed by physician groups, health plans and hospital systems. In contrast to HMOs or PPOs that exploded in the 80's and 90's, ACOs are comprised of providers and not members. When a doctor or physician group joins an ACO, their patients are attributed to that ACO even though they are not restricted from using other providers. The ACO can earn a share of the savings that results from collaborative efforts to deliver cost-efficient care. In the case of Medicare, this means keeping quality high while achieving "lower than predicted" overall costs.

While many see ACOs as nothing more than another attempt to manage care without measurably improving it, others believe the ACO model is based on the right premise – transparency, collaboration and a commitment to eliminating waste. One thing that seems encouraging is that provider interest in ACOs is extremely high. This just might be an indication that those involved are truly dedicated to earning financial rewards by achieving better outcomes and reducing expenditures.

Double Checking A Diagnosis

As health care plans continue to promote wellness and pro-active health awareness, the use of sophisticated imaging technology and pathology becomes even more widespread. Experience shows that many conditions, including certain types of cancers, can be very difficult to diagnose conclusively. While it is very common to choose a treatment plan from the first doctor you consult, taking time for a second opinion and careful consideration of alternative treatments can prove to be very wise.

Malignancies are not the only diagnoses that warrant further examination. Recent studies show that other conditions, such as coronary artery disease and chronic obstructive pulmonary disease, can often be diagnosed incorrectly. If second opinions were requested for every diagnosis, the costs could never be covered. When major surgery or very costly treatment is involved, second opinions are often required.

Seeking A Second Opinion

If you take your scans, images or pathology reports to a physician for a second opinion, which you are always entitled to do, it may help to cover the following points:

- Ask the physician or specialist if he or she has reviewed all the information related to your case.
- Ask if the existing test results are adequate and if an additional test would contribute to a more firm diagnosis.
- Never be afraid to talk about what you are experiencing or ask if there could be another explanation for your symptoms or test results.
- Be sure to ask if the second opinion physician agrees with the original diagnosis as well as the proposed treatment.

If a second opinion fails to confirm a diagnosis, a third opinion may result in a consensus. Even if the second opinion confirms the diagnosis, be sure to ask if the second opinion physician would suggest a different treatment option. Ultimately, you want to be confident that all options have been considered.

Trends Latest Happenings in Today's World

More Addictions in Maternity Wards

According to the American Academy of Pediatrics, doctors are reporting an increase in babies born with addictions to painkillers. These addictions are being identified by monitoring birth weight and sleep patterns. Tremors and other symptoms are being treated with medications to ease withdrawal.

Health Care Spending Slows

While medical goods and services are traditionally viewed as necessities, the difficult economic times seem to have had a dramatic impact on utilization. The Department of Health and Human Services reports that U.S. health care spending grew by 3.9% in 2010. At $2.6 trillion, health care spending continued to represent 17.9% of the U.S. economy, marking the first time in a decade with no increase. Many think the slowdown is mostly due to high unemployment and a growing inability to pay.

Health Care Reform Update

The latest in health and medical news

Essential Health Benefits and Self-Funding

The EHB bulletin, in December of 2011, established the approach that the Department of Health and Human Services intends to take in defining Essential Health Benefits. Their bulletin covered large fully-insured group health plans as well as large and small self-funded group health plans.

Their definition was particularly important to employers with self-funded plans, confirming that regardless of size, self-funded group health plans are not required to offer Essential Health Benefits. The bulletin was not very clear, however, in applying the restrictions on annual and lifetime dollar limits. Since self-funded plans are not subject to state law because of ERISA preemption, it is not clear how EHB will be determined by individual states. We are hopeful that the regulatory agencies will address these concerns more specifically and we will keep you posted as future communications are released.

HHS Issues Exchange Rules for States

On the health care reform law front, this past month saw the release of broad new operating rules for state-run health insurance exchanges. The long-awaited regulations, released by the Department of Health and Human Services, are intended to incorporate the flexibility that state lawmakers will need to establish state and regional insurance exchanges before the January 1, 2014 deadline.

State exchanges are one part of the Patient Protection and Affordable Care Act intended to provide health coverage for Americans who are currently uninsured.

While 33 states have received federal grants to help set up exchanges thus far, many have delayed actions because of the high profile Supreme Court case, oral arguments were recently heard.

While the new rules uphold the January 1, 2013 deadline for state exchanges to meet federal standards, they also allow states to qualify as long as they are able to offer open enrollment by October 1, 2013. States that fail to meet the deadlines will be served by exchanges established by the federal government.

Physicians Struggle to Afford Change

As the U.S. continues to look for more responsible ways of paying for health care, many family practitioners are struggling to remain independent. In fact, the consulting firm Accenture, estimates that in another year, only a third of doctors in all medical specialties will own their own practices, down from about half in 2005. The trend to hospital-owned medical practices continues to increase because the cost of technology and staff needed to achieve quality targets set by payers is huge and growing.

The fact is that while advances like electronic medical records, health coaching and online portals for improved care coordination offer tangible results, few independent medical practices have the resources to fund these enhancements. Still, many physicians determined to maintain control over their practices continue to find ways to upgrade their operations. It will be an interesting trend to watch.

Microchips Replace Injections

If clinical trials continue to produce positive results, millions may someday depend on an implantable microchip to deliver their daily medication. The trials, being conducted by MicroChips, Inc. of Massachusetts, are part of an effort to design wirelessly programmable devices that will deliver medicine more precisely and consistently than conventional injections. The trials are expected to take two more years and if all goes well, these devices could reach the U.S. market late in the decade.

Image Credit: MicroCHIPS, Inc.

Here Come the Hospitalists

In an effort to take pressure off primary care physicians with busy outpatient practices, a new type of physician called hospitalists are treating more and more hospitalized patients. Because their offices are located right in the hospital, these group practitioners can be available to treat hospitalized patients 24/7. Designed to monitor acutely ill patients more closely and respond to situations more efficiently, studies have shown that hospitalist care can yield double-digit reductions in both lengths of stay and in-hospital costs.

Did You Know? New Ideas for Healthy Consumers

Think Twice Before Delaying A Screening

Even though most doctors encourage their patients to have health screenings in a timely manner, we have the final say. If you're good at procrastinating, you may want to consider the following facts.

Half of All Fatal Heart Attacks Show No Prior Symptoms – The American College of Cardiology reports that 50% of the 400,000 Americans who died of heart attacks in 2008 had no prior symptoms of heart disease. Since practicing cardiologists know it's tough to screen patients with no signs of heart disease, they advise the use of common sense. In other words, known risk factors such as smoking, obesity, high blood pressure, elevated "bad" cholesterol and of course, family history, must be recognized as reasons to see a cardiologist and talk about a screening.

50% of Cervical Cancer Patients Have Never Been Screened – The National Institutes of Health estimate that half of women diagnosed with cervical cancer each year have never had a Pap smear, with an additional 10% going without a screening for 5 years prior to their diagnosis. The American Congress of Obstetricians and Gynecologists recommends that women in their 20's have a Pap smear every two years. Thereafter, Pap tests are recommended every 3 years as long as no abnormal results occur.

Only One in 16 Survive Colon Cancer at Stage 4 – If no history of colon cancer is present in your family and no symptoms occur, physicians recommend that you celebrate your 50th birthday with a colonoscopy. If the results are good, with no suspicious polyps, you can go another decade before having another. For those who think early detection doesn't matter, the American Cancer Society reports a 74% survival rate with a Stage 1 diagnosis, but only a 6% survival rate when colon cancer has reached Stage 4.

Concierge Practices Growing

The number of concierge practices in America and the fees associated with this level of 24/7 personalized care appear to be on the rise. These practices typically charge an up-front annual fee that covers an extensive annual physical exam, longer than average same-day or next-day office visits and access to the physician's cell phone number. While fees can vary widely, the typical up-front charges seem to fall in a range of $1,500 to $2,000 per year.

While many concierge patients dread the annual payment, they find the highly personalized care well worth the cost and an approach that makes them much more engaged in their health. Some choose this option as a way of actively managing a serious illness while others simply want the added care and convenience. Since the annual fee does not cover hospital or specialist fees and may not cover all care provided by the concierge physician, health care coverage is still needed.

Please Contact Us: This newsletter is not intended as a substitute for personal medical or employee benefits advice. Please consult your physician before making decisions that may impact your personal health. Talk to your benefits administrator before implementing strategies that may impact your organization's employee benefit objectives.

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