Forget Cost, And Focus On Value: Value-Based Insurance Design. VBID is a new way to look at the benefits you provide to your benes — and how you provide them. Find out how this pioneering benefit design works. (Page 26)

Watch Your MA Plans’ Pay — Congress Is Sharpening Its Axe. Why you need to brace yourself for huge pay cuts in the next federal budget cycle, and what you can do to prepare. (Page 27)

Make Sure Your Providers Are Using Basic Modifiers Correctly. Are providers tripping up when it comes to using common modifiers when coding claims? Check out what one carrier is doing to scrutinize modifier usage. (Page 28)

How To Cope When Your Benes Aren’t Paying Their Deductibles. What you can do to get HDHP benes to pay their deductibles and prevent these potentially mutually beneficial plans from going down the tubes. (Page 30)

New Plans And Products:
- Try These New Incentives To Keep Your Benes Healthy (Page 31)
- Check Out Your Brand-New Competitor In The Market (Page 31)

Industry Notes:
- Will Democrats Cut Your Payments? (Page 31)
- New Rules Make HSAs More Attractive To Your Benes (Page 31)
- Why Your Female Benes Pay More (Page 32)
Frivolous use of medical services contributes to your ever-rising costs, and it’s the result of charging everyone the same price for services, regardless of the actual benefit to the patients. Here’s one way to curb the costs and focus on what’s best for your benes.

It is “estimated that only 15 to 25 percent of medical services are supported by credible evidence of clinical effectiveness,” according to Ha Tu and Paul Ginsburg of Center for Studying Health System Change (HSC). How can you be sure that your benes aren’t using expensive medical services that aren’t the best treatments for their conditions? One answer is value-based insurance design (VBID), an emerging way to control health-care costs and at the same time focus on consumer-driven health care for benes with chronic illnesses, such as diabetes, heart disease and asthma.

How Does VBID Work?

The objective of VBID is to encourage patients’ use of the most clinically beneficial medical services for their chronic illnesses and discourage the use of the least-effective services by adjusting patients’ out-of-pocket (OOP) costs, according to the University of Michigan’s Center for Value-Based Insurance Design. In short, the emphasis is based on the value of the services, not the cost or actual quality of the services.

For example: Patients with a history of heart attacks would have little to no OOP cost for using statins, because they provide the greatest benefit to patients who have suffered heart attacks in the past, suggests HSC.

How To Implement VBID

“There are a range of ways VBID programs can be implemented, ranging from moving high-value prescription medications to lower tiers in the formulary to contracting with a vendor such as ActiveHealth Management to help target copay reductions to specific patients,” says Michael Chernew, professor of health-care policy at Harvard University and author of “Value-Based Insurance Design,” a paper published in Health Affairs on Jan. 30.

Even though VBID is a new approach, it can work with the health-care system and plan-design processes that exist today, asserts Lonny Reisman, MD, CEO of ActiveHealth Management.

ActiveHealth uses clinical decision-support technology called the CareEngine System. The CareEngine uses the individual’s profile, “which is gathered from existing health-care sources such as claims, EMRs, PHRs, etc.,” says Reisman. “CareEngine then identifies the essential treatments and services for a member, and existing health-care administrators are notified of the appropriate plan design changes,” he explains.

This process creates a specialized design plan based on the individual’s needs.

Barriers Can Make Integration Slow

As with any innovation in plan design, there are barriers that hinder successful implementation of VBID. One of these barriers is the very fact that so few medical services in America have research-based evidence for their effectiveness, says HSC’s Alwyn Cassill.

“There is a lack of evidence for many things that are done with medical care in America,” Cassill says.

One of the examples she gives is the constant advent of new technologies that are used in the health-care system, often without research proving their effectiveness and efficiency. These new technologies all add to the cost of health care, Cassill asserts.

“In our health care system, technology equals high medical costs, and we don’t have anything that diffuses the technology,” she says.

Another hindrance is the burden on human resource departments, as Cassill, Chernew and Reisman all agree. Differentiating plans based on each individual condition adds a new level of complexity for human resources, Cassill notes.

continued on following page
Focus On The Rewards

All barriers aside, VBID can pose many benefits to both your chronically ill benes as well as your main customers, the employers who offer insurance plans to their workers. Introducing VBID programs can result in better worker productivity and higher employee contributions to premiums, Chernew points out. And at the same time, employers can ensure that their chronically ill workers are maintaining their health and quality of life.

“The greatest benefit of using VBID is the ability to give employers the flexibility to address cost concerns without generating adverse clinical consequences,” Chernew says.

Lower copays for highly beneficial treatments also lessen the financial burden for your benes, while helping them make the best choices for treatment for their conditions. Requiring little to no copays for medications that will improve your benes’ health will eventually lower their overall health-care costs, says Reisman.

But employers need to take advantage of the VBID programs. And so far, it’s not an overwhelming choice for plan design.

“We’re not seeing a lot of innovation going on in the employers’ side,” says Cassill. “Insurers’ real customers are the employers; they are the drivers.”

continued on page 29
Make Sure Your Providers Are Using Basic Modifiers Correctly

One carrier is scrutinizing providers’ use of common modifiers in an effort to root out claims it’s paying in error. Your plan may want to follow suit.

Cahaba GBA imposed a new set of “audit trail” edits starting March 1. They look to see if providers are following basic compliance on a number of billing and coding issues, including:

• **Use of LC/LD/RC modifiers for coronary procedures.** If a provider bills for a coronary procedure without one of these coronary artery modifiers, you may deny the claim. “RC” stands for right coronary artery, “LC” stands for left circumflex artery, and “LD” stands for left anterior descending coronary artery.

• **Use of LT/RT modifiers for cataract surgery codes.** Providers need to use these modifiers to identify which eye the surgeon operated on, Cahaba warns.

• **Use of the QX/QZ modifiers for CRNA.** If a certified registered nurse anesthetist served as the assistant anesthetist during surgery, the provider needs to apply the QX (with medical direction) or QZ (without medical direction) modifiers to let you know if the CRNA had a doctor’s supervision. If an anesthetist supervised the CRNA, the provider should also attach the QY (one CRNA) or QK (two to four CNRAs) modifiers to the anesthetist’s claim.

• **Name of facility.** Providers are forgetting to attach the name and address of the facility where they rendered services.

• **The billing and rendering providers must be in the same group.** On some recent claims, providers have attached a provider number that’s not associated with the group number on the claim, Cahaba complains.

• **Unspecified procedure codes.** If the provider uses a miscellaneous procedure code, such as J3490, the biller needs to include a description of the services the physician rendered, or you can deny the claim, Cahaba warns.

The Medicare carriers in New York and New Jersey don’t seem to have edits like Cahaba’s yet, notes Jim McNally, third-party coding specialist with Health Care Consultant Services in Flushing, NY. “It wouldn’t surprise me if other carriers had these edits,” notes Cindy Parman, co-owner of Coding Strategies in Powder Springs, GA. “Most of them look like common-sense issues.”

Cahaba’s new edits are good news for providers, McNally adds. “The more specific the edit/denial is, the better it is for the physician,” he explains. These edits will give coders a specific explanation of what information they left out, instead of a standard “information is missing or invalid” message. Providers do sometimes forget to apply basic modifiers such as the CNRA, left/right or artery ones, McNally notes. “That is why I stress the use of modifiers in educational presentations.”
(MedPAC) study that suggests Congress look into alleged overpayments to Medicare managed-care plans. The implication of overpayments could lead Congress to respond with across-the-board cuts.

This move could happen even though several industry experts caution that the MedPAC data may be outdated. “The report is not taking into consideration the MA cuts legislated last year,” says Jane Galvin, director of regulatory affairs for the Blue Cross and Blue Shield Association in Washington, DC. The MedPAC numbers, which come from 2006 data, don’t reflect the $6.5 billion in MA cuts that Congress mandated under the 2005 Deficit Reduction Act, which phases in this year.

“It doesn’t mean the MA payments have gone down to FFS levels,” Galvin conceded. “But they’re not as high as MedPAC may quote them to be.”

Know Your ABCs: What MA Funds’ Reallocation Could Look Like

Lawmakers and advocates are championing MA pay cuts because many of their pet projects could use a funding boost. For example, Congressional mover-and-shaker Rep. Pete Stark (D-CA) suggests that reallocating payments would bolster the struggling State Children’s Health Insurance Program (SCHIP) and permit lawmakers to increase Medicare payments to physicians — an issue that generates annual dogfights between the federal government and providers.

Alternatively, “that $65 billion could be used to expand eligibility for the Qualified Beneficiary Program (QMB), one of the Medicare Savings Programs (MSPs),” argues the Washington, DC-based Medicare Rights Center (MRC).

QMB pays the Part B premium and Medicare deductibles and coinsurance for people with Medicare living below the poverty line, the MRC points out. “QMB is a far better deal than the ‘extra’ benefits available from Medicare Advantage plans — and it doesn’t require people to give up the original Medicare program they trust for a private plan that every year can choose to change its benefits, raise its costs or pull out entirely,” the group says in a statement.

Protect Yourself By Getting The Word Out

Private plans’ biggest fear is that sizable cuts, coming in concert with a projected 2-percent rate hike in 2008, could force them to introduce cost-sharing measures that would cause benes to lose out.

“Millions of seniors and disabled Americans in Medicare could risk losing their current coverage or see their benefits decline should Congress enact changes based on the conclusions of the MedPAC report, or reduce payments based on the CBO report,” says Peter Ashkenaz, spokesman for United Health Group.

Larger insurers with a stake in the decision can try to sway legislators directly, as United is doing. “We’re working closely with members of Congress to insure that millions of beneficiaries will continue to have the comprehensive coverage in the future,” Ashkenaz says.

Another option: If you’re with a smaller insurer that doesn’t have strong lobbying resources, you can get behind the efforts of America’s Health Insurance Plans (AHIP), which is combating MA pay cuts.

“Low-income and minority Medicare beneficiaries who rely on the program could face higher expenses, which may force them to forgo preventive screenings and other needed medical treatments,” says AHIP president and CEO Karen Ignagni in a statement. This possibility raises special concern because studies have shown that 49 percent of MA enrollees in 2004 had annual incomes of less than $20,000 and that 68 percent of minority MA enrollees had incomes below $20,000, she adds.
High-deductible health plans (HDHPs) can mean big savings for your benes, but they can also be a headache for you and health-care providers when your benes don’t pay the deductible. Read on for preventive measures to help solve the problem and ways to ensure that your benes pay up.

**Why Aren’t Your Benes Paying?**

Why aren’t patients paying their deductibles? There are many reasons: One is that employers aren’t setting up health savings accounts (HSAs) for their employees or educating their employees about benefits.

“Employers have a real responsibility here,” says Greg Scandlen, director for consumer-driven health care at the Galen Institute.

By law, HSAs are available to those who enroll in an HDHP, but many don’t open an account, because either the employer doesn’t offer HSAs or employees simply don’t know what’s available to them.

But employees will contribute to their accounts once they open them, says Scandlen. It’s important for the employer to make sure that the employees start the process. Scandlen suggests that employers give $100 to each employee’s account to get it started. Those who have HSAs will contribute approximately $1,200 a year, Scandlen says.

Another important factor in getting employees to open accounts is making sure that they open HSAs at the same time that they enroll in a HDHP, says Scandlen. The longer the HSA is open, the more money members can save for medical expenses. But the problem is that many of your benes don’t know or fully understand their plan, resulting in high deductibles that go unpaid. Again, this falls on the employer to inform the employees.

“The more employee education, the better it all works out — more people will choose the HSA program,” Scandlen asserts. Employees who don’t know that they have HDHPs are both surprised by and unprepared for their bills, so the bills go unpaid.

Not to put all of the pressure on employers, Scandlen offers another reason for why so many deductibles aren’t being paid: Sometimes, patients are still within their first year of enrollment in an HSA and it’s not fully funded when they receive an expensive medical service. If a patient needs a pricey medical procedure within the first year of his enrollment in an HDHP and HSA, it can be very difficult to come up with the money to pay the deductible if he hasn’t had enough time to accrue significant savings.

Providers also play a role in causing this problem. “Physicians hate talking about money, but they need to get used to it,” Scandlen says. It is important to make sure that patients understand the cost of the services ahead of time so that they know what they will be able to afford.

Scandlen also suggests that providers and carriers partner up to get real-time pricing for medical services. “Way too often, it can take up to six weeks for PPOs to determine charges for a service,” he says. “There’s no real reason why there can’t be real-time pricing.”

Whatever the reason, the deductibles are still going unpaid, and as a result, providers are looking to you to help collect the cash. Should this be your responsibility? Scandlen doesn’t believe so. But how can you make sure that your benes pay when the time comes?

**Aetna** is taking steps to nip the problem in the bud by offering different options to their members enrolled in consumer-directed health plans. One of these options is “automatic payment of benefits from their HRA or HSA directly to the physician,” says Elizabeth Sell of Aetna Business Communications.

“Aetna also provides debit cards to facilitate payment by the member from his HSA or FSA to a physician. We also offer checkbooks with HSAs,” states Sell.

One of the newest innovations is offering credit cards as an option for payments. Aetna has developed the Aetna Healthy Living Visa Credit Card to its members. Some of the exciting features of the card are “competitive interest rates for medical-, health- and wellness-related purchases, a Healthy Lifestyle rewards program offering bonus reward points on health- and wellness-related purchases, and discounts on health-, fitness- and wellness-related items,” Sell says.

All of these options are designed to simplify the payment process for members, making it easier to pay for services as soon as providers bill them and taking the financial pressure off of providers. Proactive planning, innovation and partnership on the part of the employers, the providers and the insurers can ensure a smoother process for HDHPs, experts maintain.
**NEW PLANS AND PRODUCTS**

**Try These New Incentives To Keep Your Benes Healthy**

Can gift cards make your benes wise up and get healthy? Democrats in the Minnesota state Senate think so, according to an article in the *Los Angeles Times*.

These lawmakers are proposing that the state give money for gift cards to nationwide stores such as Target to insured patients who follow their doctor’s orders and improve their bill of health by making changes like quitting smoking.

Paying out $1 million in incentives to patients like diabetics who control their blood sugar and benes who quit smoking will pay off in the long run, says state Senator Linda Berglin. “It’s not a huge amount of money, but I think it’ll have a lot of impact,” said Berglin in the *Times* article. Berglin believes that a patient’s involvement in his care is just as important as a doctor’s involvement, and might respond to incentives.

The proposal targets patients covered by subsidized programs including the MinnesotaCare plan for the working poor, the *Times* reports. The proposed value of the gift cards is $20 each, although lawmakers have not yet established restrictions about what benes could purchase with the gift cards.

**Check Out Your Brand-New Competitor In The Market**

Highmark Inc. and Independence Blue Cross, the two largest health insurers in Pennsylvania, have agreed to merge. The brand-new company will generate an estimated $1 billion in benefits to Pennsylvanians, reports the *Pittsburgh Tribune-Review*.

Such benefits will include savings of $300 million to customers, after the company holds administrative fees flat for two years. Better management of prescription drug costs is expected to save customers in the state an estimated $280 million. The uninsured are also expected to benefit from the merger: The company plans to provide more than $650 million to expand uninsured patients’ access to health care, according to the *Tribune-Review*.

The new company will work to expand health-care access, lower insurance costs and improve the quality of medical care for Pennsylvanians, said Kenneth R. Melani, CEO of the new insurer and president and CEO of Highmark. Joseph Frick, president and CEO of Independence, will be the new insurer’s president and chief operating officer.

**INDUSTRY NOTES**

**Will Democrats Cut Your Payments?**

Democrats have plans to cut managed-care payments to insurers to increase enrollment in the State Children’s Health Insurance Program (SCHIP), but the Bush administration refuses to play ball.

Insurer concerns were alleviated when Department of Health and Human Services secretary Mike Leavitt asserted that the administration was adamantly against a Democratic plan that would affect payments to insurance providers for the elderly, according to a March 22 *Washington Post* article. Lower payments to insurers would mean that elderly Americans suffer in terms of fewer benefits, increased membership costs and fewer free services such as cancer screenings, according to insurers.

Democrats like Rep. Pete Stark (D-CA) stand firmly behind the plan, asserting that they are only trying to help those truly in need. The government pays 12 percent more for senior citizens enrolled in managed-care plans than for seniors who go through Medicare, according to Rep. Stark.

Industry insiders expect arguments to continue in frequency and intensity in the following months; Democrats plan to renew SCHIP before the end of September, reports the *Post*.

**New Rules Make HSAs More Attractive To Your Benes**

Rules outlined by the Internal Revenue Service may encourage more consumers to consider health savings accounts (HSAs) as an insurance option, according to an article in the *Sun-Sentinel*.

*continued on following page*
Increasing the amount of money plans allow benes to deposit into HSAs, allowing consumers over the age of 55 to put away additional money for medical costs in retirement, and allowing one-time transfers from flexible spending accounts and health reimbursement arrangements into HSAs, are all new provisions set to benefit consumers who choose HSAs as their insurance option.

While younger, healthy consumers benefit from lower insurance costs, HSAs could also benefit consumers in retirement, the *Sun-Sentinel* reports. Because unused money in HSAs rolls over each year, this can be a new way for consumers to save money to cover medical care expenses after they retire, such as Medicare deductibles and long-term care insurance.

Elderly consumers will also be able to use HSAs for services like chiropractic sessions, nursing services, dental care and prescription eye wear, says JoAnn Mills Laing, author of “The Consumer’s Guide to HSAs,” in the *Sun-Sentinel* article.

HSAs shouldn’t take the place of savings plans like 401(k) accounts, because those retirement plans generate more savings for consumers, says Hugh Bromma, chief executive of Entrust Group in Reno, NV. But he does see a benefit to enrolling in both a 401(k) plan and an HSA.

Both 401(k) plans and HSAs are funded with pre-tax dollars and grow tax-free, and HSA withdrawals are not taxed. Retirees would benefit from enrolling in both 401(k) plans and HSAs to maximize savings, says Bromma.

**Why Your Female Benes Pay More**

Women spend much more money on health care under high-deductible health plans (HDHPs) than men, according to a study published in the *Journal of General Internal Medicine* in April, summarized by the *AP/Houston Chronicle*.

The study, which examined data from the 2003 federal Medical Expenditure Panel Survey, found that on average women enrolled in HDHPs spent $700 more than men enrolled in HDHPs, reports the Chronicle. More than half of women with health insurance spent more than $1,050 annually on health-care costs, compared to only one-third of men, according to the study.

The higher costs come from services that only women need: cervical cancer vaccines, mammograms, birth control, Pap tests and prenatal treatments, suggests the study’s lead author, Steffie Woolhandler.

As a result, women covered under HDHPs are unfairly burdened with higher costs merely because they are women, asserts Woolhandler.

Some health-benefits consultants believe this is an unfair assumption, because all HDHPs are not the same in terms of coverage, reports the *Chronicle*. There are many HDHPs that do not require payments for services like vaccinations and preventive care, so they shouldn’t shoulder all of the blame for women’s health-care costs.