

# Benefit Insights

## **Quality Gaps, Errors Persist in Health Care Services**

While health care costs continue to rise, problems with the U.S. health care system and patient care persist. Studies show that large numbers of individuals receive inadequate care, or are victims of mistakes that endanger their lives and unnecessarily raise costs.

A recent study from the Rand Corporation that was published in the *New England Journal of Medicine* reported that surveyed individuals who had made at least one visit to a health care provider in the previous two years received only about half—55%—of the recommended care for their conditions. Differences among gender, racial, or socioeconomic groups were small. Furthermore, while having insurance increased one's access to health care, health insurance status was largely unrelated to the quality of care among those with at least minimal access to care.

Medical mistakes can compound this problem. A 2005 study from the Commonwealth Fund found that 34% of U.S. patients with health problems reported experiencing medical mistakes, medication errors, or inaccurate or delayed test results in the course of receiving treatment. This was the highest rate of error among patients from the six countries included in the survey (United States, Australia, Canada, New Zealand, the United Kingdom and Germany). The incidence of reported errors rose with the number of physicians seen.

A study from HealthGrades, a health care ratings organization, examined medical errors and patient safety in the hospital setting. It found that approximately 1.24 million total safety incidents occurred in 40 million hospitalizations it examined from 2002 through 2004. These patient safety incidents were associated with \$9.3 billion in excess costs. Of the 304,702 deaths that occurred among patients who experienced one or more patient safety incidents, 250,246 were potentially preventable.

Add these figures to estimates of the cost of poor quality health care: a report from the National Committee for Quality Assurance (NCQA) concluded that quality gaps that hindered best practices lead to more than 57,000 avoidable deaths, 41 million sick days and \$11 billion in lost productivity each year. Thus, together, health care quality gaps and medical mistakes take a huge human toll, along with grossly running up the nation's health care tab.

The issue of improving the quality of health care is a broad one, potentially implicating health care policymakers and government bodies, along with health insurers and providers, employers and employees. However, more active patient involvement in their individual health care can go a long way toward lowering the risk that medical mistakes will occur. The Agency for Healthcare Research and Quality, a part of the U.S. Department of Health and Human Services, publishes a tip sheet to inform individuals of what they can do to help prevent medical errors. Suggestions cover medication use, hospital stays, communications with health care providers and pharmacists, and the importance of self-education about one's medical issues. The tip sheet and other resources on medical errors and patient safety are available from the agency's Web site at <http://www.ahrq.gov/qual/errorsix.htm>.

Encouraging your employees to make use of these types of resources can be a first step in enhancing quality for your company's health plan.



## **Welcome to Our Newsletter!**

It is with great satisfaction that we bring this newsletter to you. In this issue and in coming months, we will discuss pertinent employee benefit topics which may affect your organization. We sincerely hope that you will find this newsletter informative and please do not hesitate to contact us at [advisor@21stcenturybenefit.com](mailto:advisor@21stcenturybenefit.com) or 781-416-1043 should you have any questions or needs.





## **More Education Is Needed to Get Employees Ready for Consumer-Directed Health Care**

Though employer interest in consumer-directed health care plans may be growing, employee understanding of these plans—and of the health care system and its costs—remains inadequate. If this is the case, employers implementing high deductible health plans and health savings accounts are well advised to include heavy doses of employee education as part of the plan implementation.

A 2006 General Accounting Office (GAO) study found that a “small but growing” share of Americans with private health insurance coverage were in consumer-directed health plans: From January 2005 to January 2006, the number of CDHP-covered individuals increased from approximately 3 million to as many as 5 to 6 million. A separate survey of 585 employers, from the consulting firm Watson Wyatt, found that the number offering a consumer-directed plan (in the form of a high-deductible health plan with some type of reimbursement arrangement) grew from 7% in 2004 to 13% in 2005, and to 29% in 2006.

Despite this growth in consumer-directed plans, most individuals don’t understand the concept, nor do they have the depth of understanding of some key realities of the U.S. health care system—such as its true costs—that is vital for consumer-directed health care to work as intended. The 2006 Consumer Attitudes Survey from Great-West Healthcare found that only 24% of 1,000 individuals surveyed were familiar with the term “consumer-driven health care.” Of those that were, more understood that the concept involved consumer choice than understood that it also entailed consumer responsibility.

The surveyed individuals—who indicated that they were the key decision makers about health insurance in their households—missed the mark in their estimates of the actual cost of health care services, and tended to place responsibility for controlling health care costs on other players in the system rather than on themselves. For example, respondents estimated the average price of a four-day stay in a hospital to be less than \$8,000, about \$12,000 less than its actual aver-

age cost. Two-thirds said that they typically learned the cost of a treatment they had received only when the bill for it arrived, and 11% said that they never find out the cost of their health care services.

With such a lack of understanding of health care cost issues, it is not surprising that more individuals thought that health insurance companies, hospitals, drug companies, physicians or the government—rather than individuals—have the responsibility for controlling costs. However, the survey did find that some consumers, at least, make a connection between individual behavior and the cost of health care. For example, 66% said that it is fair that smokers pay a higher health insurance premium than nonsmokers, and 37% thought it was fair that obese individuals pay higher health insurance premiums than individuals of average weight.

As these survey findings indicate, for consumer-directed health plan implementation to be effective, an employer needs to address some critical educational issues. These include:

- The true cost of health care treatments and services.
- How rising health insurance costs can impact a company’s overall business.
- How rising health care costs can limit an employer’s ability to provide coverage at current levels and can lead to employees’ out-of-pocket costs increasing.
- How one’s individual lifestyle and personal behaviors can affect health care costs.
- How one’s decisions about health care treatments and services can affect health care costs.

While some might argue how open employees are to these kinds of messages, they are key to making consumer-directed health plans effective. Only when employees make informed decisions about health care treatments and services, and about individual behaviors, can they truly partner with their employer in using consumer-directed health plans to manage health care spending.

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

disorders (11%); accidents/injuries/poisonings tie with cancer as accounting for 10% of disabilities.

- People may be expecting income during a disability from unrealistic sources. Employees surveyed expected

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## Identity Theft Coverage: A Voluntary Benefit That Can Ease Impact of Crime

Victims of identity theft spend much time, effort and money to clean up the mess created by the crime and to restore their credit status. According to data from the Identity Theft Resource Center, in 2004, half of identity theft victims spent more than 100 hours repairing the damage. A Federal Trade Commission survey released in 2003 found that individual identity theft victims lost an average of \$1,180.

When your employee is an identity theft victim, your business can feel some of the impact too. Phone calls to creditors, missed workdays to consult with a lawyer or attend court hearings, and overall distraction caused by worry can cause the employee's productivity to plummet. Because the issue hits home with all of us, co-workers will be interested in the victim's ongoing story, and water cooler and coffee room discussions are likely to further erode productivity. And, if the theft involved personal items such as the employee's health insurance card, the crime can result in unauthorized use of benefits, as well.

Both to help victimized employees, and to minimize the impact that an employee's stolen identity can have on a business, some employers are making identity theft coverage available as an employee benefit, usually as a voluntary (employee-pay-all) benefit. Some insurers sell identity theft coverage as a standalone policy; others offer it as a rider to a homeowner's or renter's policy. Also, some legal services providers' plans include identity theft protection. According to Aon Consulting's "What's Hot and What's Not in Voluntary Benefits," 3% of employers currently offer the coverage, while another 5% said employees were asking that the coverage be added.

Policy features commonly include reimbursement for the types of out-of-pocket expenses that identity theft victims may incur: attorney fees, lost wages, long-distance phone calls, certified postage, and notary fees. Other possible cash benefits include emergency money, restoration of credit lines/limits, and expenses related to a wrongful incarceration (the victim is apprehended for offenses committed by the identity thief while using the stolen identity). The reimbursement benefit will be subject to a maximum that varies depending on the policy.

Beyond coverage of certain expenses, identity theft protection typically will include a variety of services designed to help the victim deal with the crime and to minimize damages. For example, the coverage is likely to provide access to a counselor—variously known as a credit counselor, identity theft restoration specialist or consumer fraud specialist—who is available to assist the victim with the many tasks he or she faces in the aftermath of identity theft, including filing police reports and fraud affidavits and obtaining credit reports. Such counselors also may help the victim develop a step-by-step plan for moving forward. Identity theft coverage also may provide sample charge dispute letters and credit monitoring and alerts.

Common exclusions/limitations of identity theft coverage include dollar caps (a sub-limit within the reimbursement maximum) that apply to lost wages, and non-coverage for losses when the thief is a family member.

Identity theft coverage can be purchased at very reasonable rates, and can represent true value to those who fall prey to identity thieves.

### **continued from page 2...Misconceptions About Disability Occurrence and Disability Insurance Result in Low Coverage Rates**

income from the following sources; this data is juxtaposed with the actual sources from which those in the survey who had actually experienced a disability in the past five years had received income:

<b>Income Source</b>	<b>Expected</b>	<b>Actual</b>
Disability Insurance	49%	37%
Unemployment Comp	27%	6%
Social Security	23%	6%
Medical Insurance	21%	0%
Workers' Comp	18%	12%

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

the annual cost of coverage to be about five times higher than it actually would be.

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

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

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

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

Individuals surveyed had the following insurance coverages:

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

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

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

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