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OUR NEWS LETTER

Health & Science

Medicare covers less when a hospital stay is an observation, not an admission

By Susan Jaffe September 8

An increasing number of seniors who spend time in the hospital are surprised to learn that they were not "admitted" patients — even though they may have stayed overnight in a hospital bed and received treatment, diagnostic tests and drugs.

Because they were not considered sick enough to require admission but also were not healthy enough to go home, they were kept for observation care, a type of outpatient service. The distinction between inpatient status and outpatient status matters: Seniors must have three consecutive days as admitted patients to qualify for Medicare coverage for follow-up nursing home care, and no amount of observation time counts for that three-day tally. That leaves some observation patients with a tough choice: Pay the nursing home bill themselves — often tens of thousands of dollars — or go home without the care their doctor prescribed and recover as best they can.

Angry seniors have sued Medicare and appealed to Congress to change the rules they say make no sense. Although Medicare officials recently began experimenting with limited exemptions, they have been unable to resolve the problem.

But most observation patients with private health insurance don't face such tough choices. Private insurance policies generally pay for nursing home coverage whether a patient had been admitted or not.

Here's a primer comparing how Medicare and private insurers handle observation care.

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Seniors must have three consecutive days as admitted hospital patients to qualify for Medicare coverage for follow-up nursing home care.

Does observation care coverage vary by insurance policy?

Regardless of what type of insurance they have, patients are kept for observation for the same reason — so that doctors can decide if they need care that can only be provided in the hospital. They may also receive diagnostic tests and, in some cases, treatment.

Medicare and most private insurers consider observation care an outpatient service — like a doctor's visit or a lab test — even though observation patients may spend a night or more in a hospital room.

What does it cost?

Because observation care is provided on an outpatient basis, patients usually have co-payments for doctors' fees and each hospital service. And they have to pay extra for routine drugs that they take at home if the hospital provides them during the observation period. For seniors who do not have a supplemental insurance policy that helps cover these expenses, the bill can be oppressive, according to Terry Berthelot, a senior attorney at the Center for Medicare Advocacy, a public interest law firm based in Connecticut.

Like Medicare beneficiaries, privately insured patients are usually responsible for a share of the cost of each treatment or test they receive when hospitalized for observation.

Those bills can add up, according to a study by the Health Care Cost Institute, a nonprofit, nonpartisan research organization. Privately insured people receiving observation and other outpatient services in the hospital paid about four times as much out of pocket as admitted patients in 2012 — an average of $47 per admitted person compared with $199 for an outpatient.

How do you know if you've been admitted?

Ask your doctor or hospital officials to be sure, because patients in observation care are usually treated in the same units and rooms as admitted patients and might not know that they have not been admitted. Most find out when they get a bill.

Although Medicare does not require that beneficiaries be notified when they are on observation status, at least two states —Maryland and New York — have passed laws compelling hospitals to tell all patients when they are under observation care and, as the Maryland notice warns, "that may increase the patients' out-of-pocket costs for their stay."

"Knowledge is power," said Maryland state Sen. Delores G. Kelley (D-Baltimore County), who introduced the notice legislation last year.

How common is observation care?

The number of Medicare observation patients has shot up 88 percent over the past six years, to 1.8 million in 2012, according to the Medicare Payment Advisory Commission, an independent government agency. Even after accounting for the overall growth in the Medicare population, the commission found that the number of observation stays per 1,000 beneficiaries eligible for Medicare's Part B outpatient services rose 61 percent from 2007 to 2012.

That's more than three times faster than the 18 percent increase among privately insured patients over the same period reported by the Health Care Cost Institute, which analyzed 5.7 billion claims from

employer-sponsored insurance policies covering a representative sample of 40 million beneficiaries younger than 65.

What's the effect on nursing home coverage?

"There is generally no commercial policy requirement that skilled-nursing-facility care can only be covered following a three-day inpatient admission — which is what Medicare requires," said Kathleen Shure, a senior vice president at the Greater New York Hospital Association, which represents 150 hospitals.

"This just generally negatively affects Medicare recipients," Bob Armstrong, vice president of elder care services for St. Mary's Health System in Lewiston, Maine, said at the Senate Special Committee on Aging's hearing on observation care in July. "The [private] insurance payers don't have the same limitations in their contracts with us; they just require that the person need the skilled care."

The cost difference can be huge: In some parts of the country, a person without insurance coverage might pay more than $10,000 for a month in a nursing home. When insurance covers the bill, the out-of-pocket costs for consumers might be little or even none, depending on the type of plan.

For Cigna's 12 million members, "admission to a skilled nursing facility may occur at any time, whether hospitalization is inpatient or observation, and depends solely on the needs of the patient," said company spokesman Mark Slitt.

Aetna's 19.5 million commercial health plan members are eligible for nursing home coverage based on medical necessity, said spokeswoman Cynthia Michener.

Even most Medicare Advantage plans, the private insurance policies that are sold as an alternative to traditional Medicare and that are subsidized by the federal government, don't require members to have a three-day hospital admission in order to receive nursing home coverage. This year, 95 percent of the 2,526 plans available have waived that requirement, according to an analysis for Kaiser Health News by Avalere Health, a health research firm.

Is Medicare considering any changes?

Medicare is conducting pilot projects at hospitals across the country to find out what happens if it follows the example of private insurers and exempts seniors from the three-day requirement. If the experiments lead to better care and lower costs, officials say they may expand the exemption to more Medicare patients.

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Regulators struggle with Obamacare's narrow networks problem

BY PHILIP KLEIN | SEPTEMBER 8, 2014

President Obama's healthcare law has provided an economic case study on the tradeoffs between cost and access.

Though insurance premiums soared for many Americans in 2014 — especially for young and healthy individuals — because of the regulations imposed by the law, those increases weren't as high as they could have been. One reason is that insurers responded to the regulations with narrower networks.

Insurers throughout the country offering coverage through the new health insurance exchanges drove a hard bargain with medical providers, and thus many of those providers chose not to participate. The end result was that Americans who obtained coverage through the healthcare law often found that they didn't have much choice when it came to doctors or hospitals. Those who averted "rate shock," in other words, often found themselves exposed to "access shock."

Lawmakers and regulators have been taking measures to try to address the problem going into the 2015 benefit year, but it is not clear whether the moves will actually improve the consumer experience.

California has been ground zero for fights over narrow networks. Early on, controversy erupted in the state when it became clear that Cedars-Sinai Medical Center, one of the nation's premier hospitals, would not be included in any exchange plans, and UCLA Medical Center, another top facility, would only be included in a few networks.

The backlash against narrow network plans has triggered a wave of consumer lawsuits against insurance companies in California. Regulators are investigating the narrow network problem, and last month the state legislature passed a bill aimed at addressing the issue. But the Los Angeles Times noted that "Anthem and other insurers largely stuck with that narrow-network strategy for 2015 plans in Covered California and outside the exchange."

New Hampshire regulators have touted progress on this front. For 2014 the state only had one insurance company, Anthem, whose network included just 16 of the state's 26 acute care hospitals. But in 2015 the state expects to have five insurers participate in the exchanges, and each of the 26 hospitals is expected to be carried by at least two networks.

State regulators have yet to announce final rates for 2015, however, and what could happen is that insurers will offer more access for more money. People who are willing to pay for more expensive insurance will have access to broader networks, but people who seek cheaper plans would be more limited in their choice of doctors.

The Centers for Medicare & Medicaid Services proposed rules for 2015 that would require insurers to submit a list of providers, which CMS would evaluate to make sure consumers are offered "reasonable access." CMS also identified "essential community providers" that offer medical care predominantly to low-income individuals. In 2014, participating plans were required to include 20 percent of those

providers in their networks. The new rules would boost that to 30 percent in 2015. But these moves are mostly symbolic. The problem is, if the administration pushes too hard on access, it would inevitably lead to higher premiums — and the White House is eager to avoid such headlines heading into midterm elections.

ESC: Guidelines Offer Recipe for Ripe Old Age

Published: Sep 4, 2014 By Ed Susman , Contributing Writer, MedPage Today

Action Points

Note that this study was published as an abstract and presented at a conference. These data and conclusions should be considered to be preliminary until published in a peer-reviewed journal.

BARCELONA -- If you want to live to be 100 years old, the best advice is follow guidelines from major cardiology groups: Eat the right stuff, exercise, and avoid tobacco and excessive alcohol, researchers reported here.

In a study of 118 centenarians in Spain, Manuel Martinez-Selles D'Oliviera-Soares, MD, assistant professor of cardiology at the Hospital General Universitario Gregorio Maranon, Madrid, reported that most of the individuals considered their health status as very good -- with 45% rating their health status at least an 8 on a 10-point scale.

"Most of the centenarians that we studied were physically active during their lifetime and continued to exercise after they were 65 years of age," Martinez-Selles said in a press conference at the annual congress of the European Society of Cardiology.

"Their use of tobacco and alcohol was very, very low," he said. "These centenarians appear to follow the advice in the European Society of Cardiology lifestyle guidelines."

He said he was surprised at how high the elderly subjects rated their health. "At my hospital we had 18 centenarians and there was one woman who scored her heath as a 9 out of 10, even though she was wheelchair bound. She was comfortable but had severe physical limitations. We asked her again because we thought she misunderstood the question. But she repeated the same number. She said she could see and enjoy her children and grandchildren."

Martinez-Selles reported that 77% of the centenarians in the study lived at home; the others resided at nursing homes. "Here in Spain we like to keep our grandparents in the home with us," he said.

The researchers identified subjects using a registry of patients treated at nine Spanish centers over a 2-year period from April 2011 through March 2013. The average age of the participants was 101.5 years, and the individuals ranged in age from 100 to 110 years. Martinez-Selles told *MedPage Today* that 28 of the subjects were men and 90 were women.

He said 91% of the men in the study who underwent tests had electrocardiogram alterations, as did 66% of the women. "Some abnormalities in echocardiography are associated with the ability to walk and with mortality," Martinez-Selles said, "This effect should be taken into account in the development of possible strategies to prevent or mitigate it."

He said that most of the centenarians "had strong hearts" with left ventricular ejection fractions of 60%. However, he found that about 20% of these patients had atrial fibrillation. Additionally, left ventricular dilatation was observed in 14% of the patients, and that was associated with the ability to walk 6 meters. Aortic regurgitation was observed in 49% of the patients, and that condition was associated with mortality, Martinez-Selles said. Patients were followed for at least 6 months.

Eva Swahn, MD, professor of cardiology at the University of Linkoping, Sweden, told *MedPage Today*, "The 100-year-olds are the survivors. They are the ones who have good genes, and they have lived a very good life with a healthy lifestyle. So if you want to be 100 years old, choose your parents carefully, but if you can't choose your parents at least live as healthy as you can."

Swahn said that examples of individuals who are overweight and use tobacco into their 90s -- such as the late British Prime Minister Winston Churchill who died at age 90 -- "are true outliers. Forget about them as examples."

Martinez-Selles noted in his press conference report that "our results add to our knowledge of cardiac anatomy and function in centenarians and, thus, help us to better understand the process of aging and exceptional longevity. Centenarians have increased in numbers in recent years, and it is becoming more common to see them in clinical practice."

Questions surround premium increases

by Brent Harrison | Sep 10, 2014

Although premiums from plans sold through the Affordable Care Act's health insurance exchanges are set to increase an average 7.5% next year, some industry experts believe the jump may be less surprising than people think.

Indiana is supposed to see the largest projected rate increase at 15.4% based on preliminary data from PricewaterhouseCoopers' Health Research Institute. Despite their expected increases being the highest in the United States, Susan Rider National Media Chair for the National Association of Health Underwriters and Account Executive/Human Capital Consultant at Gregory & Appel Insurance in Indiana, explained clients have been advised to expect the spike.

"I think that from a group perspective we already advised our clients last year when they did their renewals to budget at least 15 to 20%. So it should not be much of a surprise," said Rider.

Individual coverages should not be blindsided by the increases either.

She continued, "The other thing a lot of those folks needed was a different formulary list based on the medications that they need. That's one reason why they went outside. So they are also anticipating an increase."

In Iowa, projected at an 11.5% increase according to PWC, it appears there is more variety in the effects of premium rates.

"David Lind does a study here in Iowa that is about to come out in the press this week and in that he is projecting about a 6.9% increase in the Iowa employer based coverage. So I would say we're looking at closer to a 7% increase," explained Jesse Patton, President of the Iowa Association of Health Underwriters. "I have about 25 renewals for December and they are ranging from -35% to a 44% increase, but the majority of them are 2% or below that. Probably half of the renewals are actually a negative."

Questions have been raised about the validity of the statistics published in the recent PWC study, most notably in North Carolina where an earlier version of the report showed a 10.8% increase, but has now been updated to 7.7%.

Support for ObamaCare continues to fall

By Sarah Ferris - 09/09/14

Public approval of ObamaCare continued to sink this summer, issuing the latest warning for vulnerable Democrats who will face voters this fall after backing the law.

Just 35 percent of voters now support the Affordable Care Act, down 3 percentage points from May, according to a monthly poll by the Kaiser Health Foundation released on Tuesday. Support for the healthcare overhaul law once stood at 50 percent, just weeks after it was signed in 2010.

The percentage of voters who are dissatisfied with the law is also slipping as a larger share of respondents said they didn't have an opinion. A total of 47 percent of voters said they feel negatively about the law, down from an all-time negativity rating high of 53 percent in July.

Healthcare remains one of the most important issues in midterm elections, ranking only behind the economy and jobs as voters' top issue. Still, four years after its passage, nearly 60 percent of voters said they have not felt any direct impact of the law, according to the poll.

The Affordable Care Act faced a series of setbacks this summer, including a barrage of criticism against HealthCare.gov and a hacker who successfully breached the site last week. Federal appeals courts also released a pair of contradictory rulings on the law involving insurance subsidies in states without their own marketplaces.

Political advertising on healthcare has been a key ingredient in candidates' midterm strategies. Just over half of voters reported seeing an ad related to the healthcare law in the last month, the majority of which were negative. In the 11 states with competitive Senate races, 71 percent of voters said they saw ads related to the law, according to the Kaiser poll.

Sen. Mark Pryor (D-Ark.), the vulnerable incumbent in Arkansas, is one of few Democrats to campaign on healthcare reform this year. He released an ad last month to highlight the ways that the law could have helped him fight his own battle against cancer. But he did not mention the name of the law during the 30-second ad.

Political groups had poured about $450 million into anti-ObamaCare ads as of May 2014, according a nonpartisan analysis this summer by Kantar Media CMAG.

When asked whether ObamaCare should be a campaign issue this fall, voters were nearly equally split, with 47 percent arguing that the debate should continue, while 48 percent said they are "tired of hearing" about it.

Early tax planning may be needed because of the Affordable Care Act

By Michelle Singletary Columnist August 26

Having gone through tax season not that long ago, you may not want to face any issues related to your tax situation until next year.

But some of you may need to do some tax planning now nonetheless. It has to do with the Affordable Care Act.

So here's the deal. If you bought insurance through a federally run or state-run health insurance exchange, also known as the health-care marketplace, you may have received financial help with the monthly payments. This premium tax credit helps offset the cost of your insurance and is intended to make premiums more affordable.

Once you have coverage through the marketplace, you have to report to the exchange if you've had a life change such as an increase or decrease in household income, or if you've had a baby, gotten married or divorced.

You can find a list of events that can affect your coverage or premium credit by going to HealthCare.gov. On the homepage, click the link for individuals and families. Under the "Take Action" section, click on the link that says, "Report income or life changes."

If you are eligible for the credit, you can choose to get it two ways. You can have all or some of it paid directly to your insurance company to lower the monthly premiums. Or you can wait and claim the credit when filing your tax return.

If you elected to get the credit in advance in any amount, or if you plan to claim the premium tax credit, it is mandatory that you file a federal income tax return.

When people set up health-care accounts, the exchanges estimate the amount of the premium tax credit available based on family size and projected household income. The overall income figure is called modified adjusted gross income or MAGI.

In the income estimate, taxpayers must include salary, tips, net income from any self-employment or business, unemployment, Social Security payments, disability payments (but not Supplemental Security Income) and alimony. You don't have to include child support, veteran's disability payments or worker's compensation.

However, life happens and things change. This is why the Internal Revenue Service is urging taxpayers to report to the exchanges any alterations in their circumstances to avoid getting too much or too little by way of the tax credit.

You can report changes by either going online or calling the marketplace call center at 800-318-2596 (TTY: 855-889-4325). Online you have to log in to your account, click on the link for the existing application and choose "Report a life change," according to instructions from HealthCare.gov.

The health-care exchange will send you a statement showing the amount of your premiums and credit payments by Jan. 31, according to the IRS. This will help you reconcile the advance credit payments made on your behalf with the amount of the actual credit.

The IRS says when you file next year, you'll have to subtract any advance payments you received during 2014 from the amount of the credit calculated on your tax return. If you were eligible for a higher amount of credit than you received, it will result either in a refund (or an increase in one) or a decrease in the taxes you owe.

But people who receive too much of this subsidy may find they have to pay back some or all of the excess. The amounts people have to pay back are capped depending on household income relative to the federal poverty line, according to a spokesman for the IRS. In these cases, repayments range from $300 to $2,500, depending on your income and filing status.

However, if your income for the year was too high (relative to the federal poverty line) to qualify for the credit, you'll have to repay all of the payments that were made on your behalf as an additional income tax liability, according to the IRS.

It's the IRS' responsibility to collect any overage. And the agency has the same authority to get the money as it does with any tax liability or balance due. This includes snatching all or part of refunds to satisfy the debt.

If you have questions about the premium tax credit as it relates to your tax return, the IRS has set up a Web site — at IRS.gov/ACA — to specifically address issues about the health-care law.

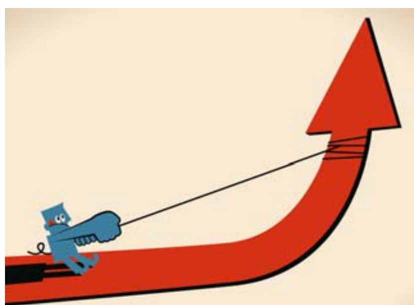
Don't wait.

As soon as there is a change in your situation, contact the exchange. The last thing you want when the next tax season comes around is to have something you consider a windfall turn into a financial misfortune.

Health Costs Inch Up As Obamacare Kicks In

by Jay Hancock September 12, 2014

Partner content from



Whoa! iStockphoto

Doctors and hospitals treated more patients and collected more payments in the spring as millions gained insurance coverage under the health law, new figures from the government show.

But analysts called the second-quarter increases modest and said there is little evidence to suggest that wider coverage and a recovering economy are pushing health spending growth to the painful levels of a decade ago.

Thursday's results from the Census Bureau's survey of service industries join other recent cost indicators that "are quite a bit lower than what the folks at CMS were projecting," said Charles Roehrig, director of the Center for Sustainable Health Spending at the Altarum Institute, a nonprofit research and consulting outfit. "And they're lower than what we were expecting as well."

CMS is the Centers for Medicare & Medicaid Services, the government's main health care bookkeeper. Last week CMS projected that health-expenditure growth would accelerate to 5.6 percent this year from an estimated 3.6 percent in 2013.

But health and social spending as measured by the Census Bureau grew by only 3.7 percent from the second quarter of 2013 to the same quarter of 2014. Hospital revenue increased 4.9 percent during the same period. Revenue for physician offices barely budged, growing by only 0.6 percent. Medical lab revenue rose 1.9 percent.

The report is far from being the last word. It doesn't include spending on prescription drugs, which has been rising this year thanks to new very expensive medicines for hepatitis C.

And while the Census Bureau's year-over-year results for the second quarter show tame cost trends, the increase from the first quarter to the second was more substantial. Total health and social spending rose at an annual rate of more than 12 percent from first quarter to the next. If sustained, such acceleration would raise alarms and actuaries' blood pressure.

But some who follow costs closely don't think the pace will continue.

First, health spending suffered a mini-crash over the winter, as bad storms kept people away from caregivers. Hospitals and doctors billed less from January to March than they did last fall. Part of the second-quarter recovery may just have been catch-up, analysts said.

At the same time, many people covered through the health law's online marketplaces didn't sign up until close to the deadline at the end of March. Much of the spring increase may represent a one-time surge as those folks sought treatment for previously neglected conditions.

For those reasons, the year-over-year results for the second quarter may give a better indication of longer-term cost trends than the change from the first quarter to the second, Roehrig said.

Estimates vary, but no one disputes the idea that the Affordable Care Act's health insurance marketplaces and expansion of Medicaid for the poor have added millions of previously uninsured people to coverage rosters this year.

History and logic suggest that expanded coverage and an improving economy will boost long-term, national health expenditures from their average growth rate of 3.7 percent during the past five years. (That's spending by everybody — government programs, employer insurance, commercial plans and consumers paying out of pocket.)

But so far the speedup seems nowhere close to the near-double-digit rates in the early 2000s.

Nutrition

6 foods that are making you tired

Women'sHealth

By Jenna Birch Published September 15, 2014

Ever wonder why your energy level takes such a nose dive in the afternoon? Your favorite breakfast, lunch or snack foods may be to blame. Dawn Napoli, R.D., says certain foods are big energy sappers. See your favorite foods are on the list of the biggest culprits.

Bananas
“High-magnesium foods like banana, pumpkin seeds, and halibut can make you tired,” Napoli said. “This mineral is actually a muscle relaxant, so it’s great before bed but could affect your energy during the day.”

White-Bread
If you’re choosing carbs with a high glycemic index (like white bread and white rice) instead of those with whole grains (like whole-wheat bread and brown rice), then you’re not getting the key elements that keep you feeling strong and satiated.

“High-glycemic carbs don’t have a lot of fiber, so they break down quickly, and you don’t get that steady stream of energy like you do with the whole grains,” said Napoli.

MORE: 5 Healthy Foods That Have More Carbs Than a Slice of Bread

Red-Meat
The high fat content of red meat like steaks and hamburgers could leave you feeling drowsy.

“It takes a lot of energy to break these down, so all your body’s energy is going to be focused on that,” said Napoli, who suggests opting for salmon instead. “Something with omega-3's should give you a pick-me-up since omega-3 fatty acids are proven to help with brain function and focus.”

Cherries
Research has shown that cherries and tart cherry juice work well as a natural sleep aid because they are high in melatonin.

“Cherries will actually help regulate sleep, so it’s great as an aid but may be poor as a midday snack,” said Napoli.

They’re still a great thing to nosh on, especially if you’re trying to lose weight (the pits make you slow down while you’re eating). However, you might want to save cherries for a bedtime snack.

Sweets

Having high-sugar sweet treats after lunch can put you in a food coma faster than you can say "yum."

“The amount of sugar going into your body releases insulin, which frees up too much of the amino acid tryptophan in the brain, which will make you sleepy,” said Napoli. “You get that rush, and then that crash.”

Skip the after-lunch pastry, and wait to indulge until a time when it won't be a huge deal if you start dragging.

Coffee

While this one seems counter-intuitive, Napoli says caffeine-rich drinks like coffee and tea might be causing your tiredness.

“They give you a quick burst of alertness for maybe an hour or an hour and a half but eventually you to crash and burn when the caffeine wears off,” she said. “I tend to tell my clients to stick to 200 to 300 milligrams [of caffeine] per day, but drink it in small doses over a longer period of time—maybe until noon. It’ll keep you going until around 2 p.m. so you’re not wired by the time you get home at night.”

Napoli also said the best morning energy fix is breakfast, not just java. It’s the meal that lets you literally “break the fast” you experience at nighttime, and thus it helps power you up for the day. She suggested trying to pack in nutrients with a mix of whole grains with fiber, lean protein, and some fruit.

“And if you can get a dairy product in there, even better,” said Napoli. “That combination will help give you lasting energy for the day.”

Employers Reining In Health Care Costs, But With A Twist

The 2014 Kaiser/HRET Employer Health Benefits Survey came out last week, with the remarkable news that employers are reining in health costs. Premiums for employer-based health insurance are up an average of just 3% this year, relatively little considering the steep increases from the first decade of the century, when health costs more than doubled.

The key to this achievement: employers' widespread adoption of high-deductible health plans. The phenomenon is an unintended consequence of Obamacare and an intended consequence of "Bushcare," as I've described before.

The Kaiser/HRET study confirms the prevalence of these high deductible plans; one in five workers is now enrolled, and deductible levels continue to rise. These plans have an average deductible of more than $2,200 for an individual and $4,300 for family coverage. And unlike more traditional plans, until the employee hits his or her deductible, they pay everything—office visits, X-rays and tests that other plans simply charge a copay for.

The Twist: It's Not All About Controlling Costs

But here's a surprising twist: Employers may be cost-conscious, but they are still spending more money.

The same report shows that employers are spending more than they did last year on their portion of the premiums. Moreover, they are voluntarily spending additional sums of money above and beyond what they pay in health insurance premiums. Here are some examples.

First, about two-thirds of the large employers that offer high-deductible plans voluntarily pair them with tax-protected health savings accounts that help employees pay out-of-pocket costs. Many of these employers pay into these accounts, again voluntarily, as much as $3,000 a year for a single-family savings account.

Many are also paying to exclude some benefits from the deductible requirements, such as preventive care, prescription medications or physician services for diabetics. What are we to make of this? Employers' first consideration is not cost, but value. Employers are giving employees incentives to shop for the right care at the right price, without sacrificing necessary care when money is tight. It's a tough balance, but employers appear to be grappling with it very seriously, and it's costing them.

Investing In Wellness (Wisely)

Another dramatic example is employers' investment in wellness and disease management programs. Such programs are not cheap, and the research suggests employers don't see a financial return on that investment. Yet it is worthwhile to them anyway, and hard-nosed leading CEOs take pride in these programs. Virtually all large employers in the Kaiser/HRET study report some kind of wellness or disease management program such as smoking cessation classes, exercise programs, and health coaching.

But this rapid escalation in employer investment has spawned a “Wild West” kind of market for wellness and disease management, with thousands of vendors overwhelming employers, often touting exaggerated claims of effectiveness.

Frustrated by this, two leading employers have stepped forward as the new sheriffs in town: Intel INTC +1.93% and GE. The two companies just launched the Validation Institute, to subject these vendors to “the highest standards of validity, allowing them to compete on the basis of integrity and performance.” (They will also validate nonprofit ventures that don’t sell anything, as they did for my organization’s Calculator of the hidden surcharge Americans pay for hospital errors, a free tool for employers).

Not only will the Validation Institute publish the names of products or services they review and deem valid, the Institute will indemnify those successfully validated enterprises for up to $20,000. Companies can pay the Institute to review them for potential validation, or the Institute will simply publish for free the name of any company that supplies documentation that another credible organization has validated and indemnified them.

I’ve been told the Validation Institute has already uncovered eyebrow-raising claims from some popular vendors, like the vendor that claims to save more than an employer spends in health benefits. Employers are already bookmarking the Validation Institute site to “check the wellness math.”

Thoughtful Spending Is The Game Plan For Employers

These are truly interesting times for employers and employees navigating health care. Employers are intent on controlling health costs and, for the first time, succeeding in doing so. But they are also intent on contributing to their employees’ good health, and willing to spend more money if it accomplishes that goal. The trend we are seeing is not one of merciless cost-cutting, but compassionate and thoughtful spending. Employers are beginning to treat health benefits the way they treat any other service they purchase: Get the right care for the right price, and hold providers accountable.

To contact us: go to www.healthcareil.com or Call (800) 739-4700