Examining 2011 LTCI Stats

The largest long-term care insurance claim paid totaled $3 million while the largest claim still being paid has exceeded $1.7 million in paid benefits, according to a just-released report from the American Association for Long-Term Care Insurance (www.AALTCI.org).

"Last year the nation's long-term care insurance companies paid $6.6 billion in claim benefits to over 200,000 individuals," reports Jesse Slome, executive director of the Los Angeles-based organization. According to the association's report, the amount of claim benefits paid increased eight percent compared to the prior year.

The Association reports that women accounted for nearly two-thirds (65%) of new claims opened during 2011. About one in four (24.1%) new claims commence between ages 70 and 79 while 65.5% start after the policyholder reached age 80. "One in 10 claims start when policyholders are in their 50s or 60s," Slome acknowledged, "often the result of an accident or illness."

"The widespread question asked by individuals considering long-term care insurance is will I ever use it," Slome admits. "The best we can do is gather information on how people use their benefits."

According to association, Alzheimer's disease was the leading cause for claims in a nursing home or assisted living community while cancer was the top cause for claims that begin at home.

Half of all new individual long-term care insurance claims pay for home care services the association's research found. New claims by women receiving care at home accounted for 32% of new claims with 18% of men receiving benefits for home care. "Less than one-third (31%) of new claims begin with the policyholder receiving care in a nursing home," Slome adds.

The Association study revealed that the largest claim still being paid at the end of 2011 had reached $1.7 million. "There are a number of claims still being paid that have exceeded $1 million," Slome notes. "In this particular case, the claimant is a woman who purchased coverage and began receiving care three years later." She has been receiving care for nearly 15 years.

The State of the Dental Benefits Market

While the nation prepares for healthcare reform, the dental benefits market shows signs of excellent health. More than 175 million Americans, 57% of the population, were covered by some form of dental benefits at year-end 2010, according to the NADP Annual State of Dental Benefits Market report released in February 2012. The report indicates a significant market rebound when compared to the previous year's enrollment, as the dental benefits market was valued at $38.6 billion at the close of 2010 in contrast to $36.7 at the close of 2009.

The report highlights key findings from all 2011 NADP research, which is based on data effective December 31, 2010. Based on key market trends, the report includes the following expectations for 2012:

- Enrollment trends in 2011 and 2012 should continue to improve, as employment increased modestly in 2011 and will likely continue to improve in 2012.
- As the U.S. economy continues to expand, anticipate that (1) price competition should ease as more employers and individuals seek out dental benefits; (2) easing price pressures will make transition to a new regulatory environment easier to manage for dental plans; and (3) the dental benefits industry should continue to consolidate somewhat, as companies seek to achieve greater economies of scale, but that trend may change as the market for dental benefits improves.
- Between 2008 and 2011, there was significant growth in the percentage of employers with 25 to 100 employees offering dental.

The NADP continues to monitor and advocate for favorable federal and state regulations that will affect the dental benefits industry. Key issues on the 2012 radar include:

- Year end Affordable Care Act Conformity Bills (based on election results) covering exchanges, essential health benefits, market reforms, brokers and agents
- Non-covered services legislation
- All payers claims database (APCD) legislation

The NADP Annual State of the Dental Benefits Market offers a high-level national summary. NADP also publishes 51 State Fact Sheets with similar types of data. All reports are available in "Mall" section of www.nadp.org.

Health-Related Lost Productivity: Causes and Solutions

It is no secret that health care is on everyone's mind these days. Many—including employers, HR managers, brokers and consultants—are concerned about the uncertain direction health care will take in the United States. Furthermore, the rising cost of employer-provided health insurance is resulting in employers focusing intensely on how employee health affects organizational profitability. Surveys have estimated that the cost of healthcare averages 13.6% of an employer's payroll.

Given the intense focus on employee health, it might come as a surprise that recent research has estimated medical care and pharmaceutical costs to make up only 30% of the total cost of poor employee health. What about the other 70%? Those costs can be attributed to health-related lost productivity (HRLP). HRLP represents the decline in employee productivity due to employee absenteeism and presenteeism. The research cited suggests that, on average, for every $1 employers spend on worker medical or pharmacy costs, they absorb at least $2.30 of HRLP costs.

Based on the "iceberg concept," The Standard recommends that employers, brokers and consultants carefully consider the total cost of poor employee health, not just medical and pharmaceutical costs.

In 2008, Kronos and Mercer conducted the first survey on the Total Financial Impact of Employee Absences, published in October of that year. A follow-up survey report, which confirmed the findings of the first report, was issued in June 2010. The findings provided significant evidence that the direct and indirect costs of absence are much higher than previously thought.

Based on the 2010 survey results, the direct costs of incidental and extended absence averaged 2.6% of payroll. These direct costs are based on the pay or benefit provided to an employee for time not worked.4

But the survey also found that indirect costs of incidental and extended absence averaged an additional 6.1% of payroll and included costs related to overtime, turnover, temporary staffing, working slowly, late deliveries, replacement training, customer dissatisfaction and variable product quality. The total cost of incidental and extended absences for surveyed organizations amounted to 8.7% of base payroll.

Given this eye-opening number and its contribution to health-related lost productivity costs, it is crucial for organizations to take employee absence and disability seriously.

In addition to absenteeism, presenteeism has been identified as a major contributor to HRLP. The term "presenteeism" was coined in 2004, around the time the topic began to be researched. Presenteeism is commonly referred to as the productivity loss caused by employees at work with medical conditions, either physical or mental. Major causes of presenteeism include, but are not limited to, behavioral health conditions, musculoskeletal conditions, arthritis, obesity and allergies.

Given those causes, it made sense that the employees who went off of work with medical conditions, must have been at work with those same conditions for a period of time before they became disabled. Therefore, some of these employees must have suffered a productivity decline while at work.

While there has been a limited number of major studies of presenteeism to date, the known data is quite compelling:

- Presenteeism costs American businesses $150 billion in decreased productivity.
- On-the-job losses from presenteeism are 60 percent of the total cost of worker illnesses, which exceeds what companies are spending on medical, disability and absenteeism.

Behavioral health conditions are a major cause of presenteeism and directly affect an employee's productivity. Consider these statistics:

- Approximately one in three adults suffers from a mental disorder in a given year.
- According to the World Health Organization, four of the six leading causes of disability are due to neuropsychiatric disorders (depression, alcohol-use disorders, schizophrenia and bipolar disorder).
- Depression is estimated to cost $83 billion annually in the U.S. and is the highest-cost health condition in the country, especially in terms of presenteeism.

Many employers have implemented health management programs aimed at improving employee health. These programs fall into three major categories:

- Employee Assistance Programs (EAP) – give employees access to personal counseling services for themselves and their family members
- Disease Management—targets specific medical conditions prevalent in a workforce and offers screening, case management and treatment solutions
- Wellness/Health Promotion—attempts to improve the health of all employees by targeting such broad health-related goals as smoking cessation, weight loss and nutrition

Facilitating the utilization of health-management programs just before or just after an employee goes out on short-term disability is critically important to reducing health-related lost productivity. Employees who are struggling at work with a medical condition, and those who are already away on a disability absence, are two groups that can greatly benefit from their employers' health-management programs. Their situations present the "window of opportunity" for health management.

HR managers and brokers/consultants have an opportunity to assist employers in viewing disability carrier products and services in a different light. In the past, the focus was primarily on how one could obtain STD, LTD and absence management services at the lowest price. Often, the relationship between these services and HRLP was overlooked. The assumption was that reducing medical and pharmacy costs would produce the most immediate, cost-effective benefit solutions. However, as we have demonstrated, those costs are just the tip of the iceberg.

For tips and tools you can use to manage absence and disability, visit www.workplacepossibilities.com.

Employers Are Not Prepared for PPACA

The 2012 Deloitte Survey of U.S. Employers provides insight into employers' opinions about the U.S. healthcare system and plans for employee health benefits, particularly as it relates to PPACA.

The results revealed that surveyed employers:

- Are concerned with rising health costs, however they are unaware of solutions that could improve the safety and quality of care, and simultaneously reduce cost
- Do not intend to drop health benefits coverage but expect to pass additional costs to employees
- Do not understand the full scope of PPACA and are not prepared to implement its provisions

Additional key insights:

- Employers believe that the U.S. healthcare system underperforms. Thirty-five percent of employers surveyed grade system performance as an "A" or a "B," while 64% give it a "C," "D" or "F." Employers hold favorable views about the system's clinical capabilities and medical innovation; unfavorable views center on its wastefulness and high costs.
- Employers believe that they have a "good" understanding of the Affordable Care Act, HR professionals more so than C-suite executives. Familiarity with the individual mandate is the highest (72%); understanding of delivery system changes in ACA is low. Most employers say their company is "not well prepared" to implement the 2014 provisions of the ACA.
- Thirty percent think the ACA is "a good start," 59% "a step in the wrong direction." There was a wide range of opinions reported, from human resources, who responded more positively, to C-suite respondents, who think it's a step in the wrong direction.
- To manage healthcare costs, increased cost-sharing with employees is considered the optimal strategy. Health insurances exchanges and direct contracting with provider organizations are viable benefits strategies, as well.
- When considering healthcare-related strategies to reduce the deficit, employers support reforms in medical liability, Medicare and Medicaid, and repeal/delay of the ACA. Across-the-board cuts in government spending are considered a higher priority than changes to the healthcare system.

The full survey results can be found at www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/21c1f310fb8b8310VgnVCM3000001c56f00aRCRD.htm.

One-Third of Doctors May Leave Medicine within Next Decade

A new nationwide survey of U.S. physicians shows that 34% say they will leave the practice of medicine in the next decade.

In 2012 alone, 16% of physicians are going part-time, retiring or leaving medicine or considering retiring or leaving medicine in 2012, according to the survey conducted by Jackson Healthcare, one of the nation's largest healthcare staffing companies.

"Physicians are retiring in large numbers just as baby boomers are starting to turn 65," said Richard L. Jackson, chairman and CEO of Jackson Healthcare. "That creates a real healthcare access problem. Many are demoralized and weighing their options."

The primary reason doctors cite are economic and political: medical malpractice and overhead costs closely followed by not wanting to practice medicine in the era of health reform. Fifty-six percent cited economic factors for retiring or leaving medicine in 2012, while 51% cited health reform.

The survey was conducted prior to the U.S. Supreme Court ruling upholding much of the Affordable Care Act.

"For doctors, there is little reward in this era of high cost, high regulation," Jackson said.