



Calendar of events

March 11 8:00am-12:00pm **Mercer Survey Results/ State Healthcare Reform Update Vendor Fair**
Kent State Stark Professional Education & Conference Center
(Breakfast & Registration 8:00-8:30 am)

March 12 8:00am-10:30am **Mercer Survey Results/ State Healthcare Reform Update**
The Blackwell Hotel & Conference Center - Columbus
(Breakfast & Registration 8:00-8:30 am)

April 16 8:00am-12:30pm **Caremark Annual Review**
Kent State Stark Professional Education & Conference Center
(Breakfast & Registration 8:00-8:30 am, Lunch provided)

May 7 8:00am-5:00pm **Employers Health Annual Symposium**
Kent State Stark Professional Education & Conference Center
More details to come.

Mark Your Calendar and Keep an Eye on Our Website for Additional Future Events!
www.ehpco.com

Welcome New Members

Youngstown City Schools

CBIZ
Benefits & Insurance Services of Ohio

Arcelor Mittal VEBA
Retiree Drug Plan



Health Scope

Winter 2008
www.ehpco.com

A Note from Chris:



Welcome to the first 2008 issue of *HealthScope*. We look forward to celebrating the Coalition's 25th Anniversary during 2008. Although the anniversary date is July 18th, we will celebrate the event during our Annual Employer Symposium on Wednesday, May 7, 2008 by inviting some special guests to the event.

We continued to grow our membership in 2007, especially in the central Ohio region. As some may recall, greater Columbus has been without an employer led health coalition since the Health Coalition of Central Ohio discontinued its operations at the end of 1997. Over the past two years, we expanded our education initiatives to the Columbus market as well as our Consumer Guide to Ohio Hospital Quality. In September 2007, our Board of Directors made a major commitment to the Central Ohio region by approving the opening of a new office. As a result, Employers Health's central Ohio office will open on February 4th in The Preserve, an office complex located at 5400 Frantz Road in Dublin.



As part of our expansion, Mike Stull has been promoted to Regional Vice President. Mike will lead our efforts in demonstrating the value of the Coalition to central Ohio employers and relevant stakeholders. Joining us in the Dublin office will be Charity Rausch, R.Ph., Director, Analytics and Clinical Initiatives and Dave Uldricks, J.D., LL.M., Director, Operations. Ms. Rausch comes to Employers Health most recently from Affiliated Computer Services in Westerville, where she held the position of Clinical Pharmacy Manager. Previously, she served in various pharmacy positions at the Veterans Administration, Cardinal Health and Medco Health Solutions. She holds a Bachelor of Science degree in pharmacy from Ohio Northern University and is currently completing a doctorate in pharmacy at Ohio Northern. Mr. Uldricks comes to us most recently from SXC Health Solutions, where he was Director, Trade Relations. Previously, he served in various legal and operation positions at Pharmaceutical Horizons and PricewaterhouseCoopers. He holds two law degrees from Capital University Law School and a Bachelor of Business Administration from Ohio University. Congratulations Mike, and welcome Charity and Dave!

In other news for 2008, Employers Health will collaborate with the Health Action Council of Northeast Ohio to implement eValue8, a health Plan Performance Project (P3) in association with the National Business Coalition on Health. eValue8 is a tool that employers can use to:

- Identify results-oriented disease management programs
- Designate "best-in-class" health plans
- Establish performance goals and measure quality
- Improve community health quality

All Coalition members will be invited to the Plan Performance Project (P3) meetings with participating health plans in late spring/early summer.

Finally, four of the five employer-led health coalitions have agreed to collaborate with this year's Leapfrog Group Hospital Quality & Patient Safety survey. These four coalitions, including EHCO, will encourage all Ohio hospitals to complete this year's survey.

In closing, I want to welcome our new members: Youngstown City Schools, CBIZ, and Arcelor Mittal VEBA Retiree Drug Plan.

Sincerely,

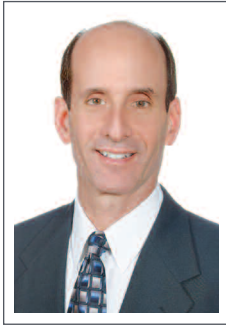
Christopher V. Goff, Esq.
CEO & General Counsel



High Deductible Health Plan or Value-Based Benefit Design??

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by Bruce Sherman, MD, FCCP



Many employers feel like they've pushed traditional management of healthcare costs to the limit. With negligible room for additional provider discounts, employers have been forced to shift more costs to employees in an effort to remain competitive in the business world. Recently, two progressive approaches have emerged as seemingly viable options.

On one hand, high deductible health plans have experienced increasing popularity since they were recently introduced. The rationale for their use stems from a RAND health insurance experiment study started in 1974, showing that individuals spent less on healthcare when they had direct financial responsibility. The high-deductible health plan includes an initial high level deductible, which employees must pay before receiving more usual health benefit coverage. Employees typically have either a health savings account (HSA) or a health reimbursement account (HRA) that serves as a pre-tax source of funds that employees manage. Any unused funds are carried over for use in subsequent years, giving employees the sense of ownership to wisely manage their funds and associated healthcare utilization.

Value-based benefit design (VBBD) is a different approach to managing healthcare costs. With this strategy, out-of-pocket costs are adjusted based on an assessment of the clinical value of a medical treatment or intervention for a specific patient population. The more clinically beneficial the service, the lower the patient cost should be. One familiar example of a VBBD strategy is the waiver of out-of-pocket costs for age and gender-specific preventive care examinations. Perhaps the best example of a VBBD approach is reducing or waiving co-pays for medications needed for chronic disease care. This action may well increase pharmacy costs. However, improved compliance with medication results in better disease control and reduced condition-specific healthcare costs — and

employer cost savings. This approach has been popularized by experiences at Pitney Bowes and in Asheville, NC, with adoption escalating among employers.

What's the problem? High-deductible plans can directly lower costs by curbing the use of both essential and unnecessary medical care, as employees try to conserve their HSA or HRA funds. VBBD indirectly lowers costs by incentivizing employees to use the care that will provide them with the greatest benefit, resulting in improved condition management.

Proponents of high deductible plans champion their ability to reduce healthcare costs, but the long-term impact on health management remains to be seen. Will individuals avoid necessary care, resulting in delayed diagnosis and significantly increased costs? For VBBD, the issue is to more clearly understand how to structure pricing for medical care, recognizing that the cost of a colonoscopy for a 26 year old who is insistent on the procedure despite lack of medical justification should be more than the cost of this cancer screening exam for a 50 year old with a family history of colon cancer.

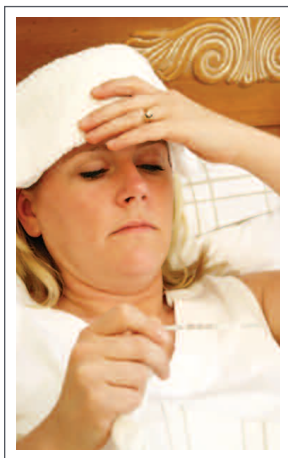
To be successful, consumer-driven benefits strategies must give employees the right incentives. High deductible plans may not be right on target, since the primary incentive is to avoid spending money on healthcare. However, these plans can yield near-term healthcare cost reductions which many employers urgently need. VBBD has demonstrated effectiveness and helps patients become better consumers by directly incorporating the value of provided services into the employee cost — and may ultimately provide greater value to employers.

Regardless of the particular strategy your organization chooses, ensure that your employees and their family members have resources to help them understand how to use medical care appropriately. Be sure to also promote awareness of provider and hospital quality and efficiency reporting. Employers Health can help.

| Objective | High-Deductible Health Plan Promote Healthcare Consumerism | Value-Based Benefit Design Financial Incentives for Appropriate Care |
|---|---|---|
| Plan design | Simple | Complex |
| Plan design role to help consumers differentiate between appropriate and inappropriate care | Negligible | Significant |
| Individuals most impacted to reduce healthcare costs | Healthy | Healthcare system users - existing conditions |
| Differential effect on low vs. high income groups | Significant | Minimal |
| Employer cost savings benefit | Immediate | Gradual |
| Preventive care coverage | 100% | 100% |

Pandemic Preparedness – An Employer Perspective

On October 23, public health officials, business leaders, employers and safety experts came together to discuss the importance of planning for an impending influenza pandemic. Pandemic flu occurs when a new influenza virus appears or emerges in the human population and causes a global outbreak of the disease, resulting in serious illness as it spreads from person to person.



Participants in the daylong workshop, sponsored by Roche Laboratories, learned that pandemics are unpredictable and it is hard to know when one will occur, what type of flu it will be, and how severe it will be. A flu pandemic could cause many deaths and severe illnesses, disrupt some parts of daily life, and limit the amount of health and other services available. Gatherings of people might be limited to control the spread of the disease (schools and businesses may close, sporting events

could be cancelled, and transportation could be limited). Additionally, hospitals could be overloaded if doctors and nurses are sick. There also may be more people with the flu than the hospitals can take. In this case, some people would need to be cared for in their homes or other places.

Because businesses will certainly be impacted and will see a reduction in workforce by about 40% during a pandemic outbreak, it is important that a plan is in place to ensure that infrastructure will be maintained and consumer expectations will be met. Two panels of experts consisting of representatives from organizations such as the Ohio Department of Health, Ohio Hospital Association, The Goodyear Tire & Rubber Company, Caremark and Roche Labs provided insight into how each respective organization is planning for such a scenario. Additional insight was provided by national human resource and legal experts affirming how companies need to be prepared to face issues that will arise during such a vulnerable time. Tabletop exercises played an integral role in the workshop, giving participants an opportunity to role play and see what obstacles may be faced during a pandemic, and to have dialogue with their peers in order to formulate what decisions should be made.

Most organizations have talked about the need for planning for a pandemic influenza crises, but many have failed to put together actionable steps and integrate them into a business continuity plan. Experts reiterate that another pandemic will be seen in this lifetime, yet planning for such an event remains on the back

Pandemic flu has occurred naturally throughout history.

There have been three pandemics in the last 100 years:

- **1918 - 1919: "Spanish flu" : Ohio reported 1,113,797 cases and 8,602 deaths**
- **1957 - 1958: "Asian flu" : One or more outbreaks were reported in 71 counties with deaths in 63 counties.**
- **1968 - 1969: "Hong Kong flu" : Very mild flu pandemic, similar to seasonal flu.**

burner within many organizations. Including this in the next round of organizational planning items may be integral to the future validity of infrastructure and business continuity.

Best Practice - The Goodyear Tire & Rubber Company

In March 2005, Goodyear's manager of global business continuity, Mike Janko, listened to a presentation about pandemic influenza at a conference. This spurred a discussion upon his return to corporate headquarters in Akron about what Goodyear would do should the H5N1 virus circulating in Asia spark this century's first pandemic influenza. Company leaders agreed this was an important aspect of business continuity and began planning Goodyear's response to an influenza pandemic.

Goodyear is one of the world's largest tire companies. The company employs about 70,000 people and manufactures its products in more than 60 facilities in 26 countries around the world.

Identify Key Players

Goodyear's first step in planning for a pandemic was identifying regional leaders around the world who could assist with messages and goals throughout their region and could identify key players in the planning process. Those key players were provided background materials and planning templates with established timelines and deliverables. They participated in regular conference calls and developed tactical teams in their regions to address all aspects of business continuity in the face of a pandemic. The tactical teams consisted of a key member and an alternate for each functional business role. Within two months of forming a global leadership team, Goodyear had detailed plans for 15 countries in Asia.



Key Elements of Goodyear's Pandemic Flu Plan

- 1) **Communications** - Ensure the business has the means to reach associates, customers, suppliers and shareholders and that communications are accurate. Communication channels need to be redundant (e.g., having a process for communicating if telephone lines are inoperable). Another aspect of communication is developing relationships within the community before a pandemic. Regular communications with medical experts and local emergency operations centers is suggested.
- 2) **Medical knowledge** - It is essential to address medical preparedness, risk reduction and hygiene practices for associates in the workplace and at home with their families. Goodyear follows World Health Organization and Centers for Disease Control and Prevention advice on social distancing, hand washing and staying home when sick. Goodyear also elected to participate in International SOS, a fee-based service that helps organizations manage the health and safety risks facing their travelers, and follow the International SOS protocols for disinfection.
- 3) **Business resiliency** - Strategies to address include ensuring business resiliency models to address both customer needs and supplier raw material sourcing. For Goodyear, each region and facility assessed its operations for responding to a pandemic, identified critical customers and suppliers and established triggers for altering production schedules during a pandemic.
- 4) **Essential functions** - Each facility has identified critical functions. For a highly critical function they have focused on critical jobs and tasks and ensured cross training has been provided where redundancy is not yet in place.

Test Your Plans

Once plans were complete, Goodyear's strategy included conducting tabletop exercises to validate the plan and systems. About 170 Goodyear employees from 15 countries participated in a three-hour tabletop exercise to practice implementation of plans for Asia. Shortly afterward, plans from facilities in Africa, Europe and the Middle East faced the same tests.

Goodyear's exercises were facilitated on an Internet meeting space and posed escalating scenarios to the various locations for offline discussion and online report-back. The goal of the exercises was to locate any deficiencies in the response plans and identify other critical incidents that could impact operations, such as volcanoes and earthquakes that threaten some of their plants in Asia. Teams utilize a formal incident command system and have established timelines for correcting plans based on lessons learned in exercises.

Manage Your Plans

The plans for all of Goodyear's tactical teams are centrally coordinated to help facilitate sharing of best practices and ensure the plans do not overlap or conflict with one another. As in any emergency plan, feedback systems should be built in to allow for continuous improvement and updates as situations shift.

"The key is preparation, preparation, preparation," says Janko. "You need to be able to easily answer these questions - What do you do beforehand? How do you address it during the pandemic? Then you have to maintain your focus on recovery, which for a pandemic, could be a long time."

More information and resources can be found at www.ohiopandemicflu.gov.



Employers Health Staff Participate in Local and National Presentations and Programs

• Christopher Goff:

Co-presented "Bridges-to-Excellence: Coalition, Employer and Physician Experiences" with Ken Braun, Executive Director of Human Resources, Republic Engineered Products and John Westerbeck, MD, primary care physician, West Medical, Inc. at the Institute for Health & Productivity Management Conference in Scottsdale on October 18, 2007.

Presented "PBM 101" at the College for Advanced Management of Health Benefits in Columbus on October 25, 2007.

Co-presented "Pharmacy Benefit Management Accreditation" with Alan Spielman, President & CEO of URAC, at the National Business Coalition on Health Annual Conference in Scottsdale on November 11, 2007.

Presented "Health & Pharmacy Benefits" to the County Commissioners Association of Ohio in Columbus on December 3, 2007.

Was elected to the Jackson Local Board of Education.

• Bruce Sherman:

Presented practical Aspects of Implementing a Return to Work Process: Industry Culture Change. DSI Conference: Work Injury Management and Prevention: Functional Fitness for Duty II. Chicago, IL, October, 2007.

Presented smoking Cessation: An Employer's Perspective. Pittsburgh Business Group on Health. Pittsburgh, PA, October, 2007.

Presented how to Maximize the Value of Health Promotion Programs through the Effective Use of Data. Healthy Ohioans 4th Annual Conference, Columbus, OH, November, 2007. Co-presenting was Rob Petit, Seaman Corporation, an Employers Health member company.

Participated in a conference jointly sponsored by the National Committee for Quality Assurance (NCQA) and Pfizer regarding development of a best practices approach to smoking cessation for employers.

• Mike Stull:

Presented to the Wooster Rotary Club - November, 2007

Although Employers Need Depression Programs, They May Not Know It Yet

Research says the hidden cost of untreated depression far outweighs the cost of treatment. Plans need to get this information to purchasers.

by Margaretann Cross and Martin Sipkoff, Contributing Editors

Aetna members participating in one of three initiatives targeting depression are using fewer medical services, spending more time at work, and saying they feel better overall, says Hyong Un, MD, Aetna's national medical director for behavioral health. "That's good news for members, employers, and the health plan."

The insurer's three-pronged approach to depression casts a wide net, helping members find help in primary care settings, through a disease management approach, and with an innovative program that screens members with chronic diseases for signs of depression. Top Aetna leaders, including chairman and CEO John W. Rowe, MD, have made the disease a priority, Un says.

Aetna is not alone in its focus on depression, as most health plan medical directors recognize the need and the business case for addressing the condition, Un says. Responding in part to increasing recognition by employers that depression is costly both in terms of medical care and lost productivity, many health plans are striving to make a difference in this area.

"What insurers need to figure out now is how to get the right programs implemented in different settings," Un says.

Working but Depressed

Depression affects a significant number of people - between 1 percent and 3 percent of the U.S. population during any six-month period. About 15 percent of people experience the condition during their lifetimes, according to Bernard Bloom, PhD, a senior fellow at the Leonard Davis Institute of Health Economics at the University of Pennsylvania. More than 70 percent of people diagnosed with depression are employed, says Keith Dixon, PhD, president of Cigna Behavioral Health.

Depressed employees use, on average, more than \$4,000 per year in medical services versus less than \$1,000 per year used by employees without depression, Dixon says.

Yet while direct treatment costs concern employers, the indirect costs of untreated depression are an even more serious issue, Dixon says. "These indirect costs show up as absenteeism, poor productivity, flawed decision making, accidents, turnover, failed projects, faulty products, poor customer service and poor teamwork."

About \$26.1 billion is spent on medical care for depression, but it costs employers \$51.5 billion a year in lost productivity, according to a report published in *Psychiatric Services*, the journal of the American Psychiatric Association.



In a study published in the *American Journal of Psychiatry* that looked at how seven health conditions - major depression, allergies, arthritis, asthma, back pain, headaches, and high blood pressure - affect work performance, Phillip Wang, PhD, a professor at Harvard Medical School, found that only depression significantly affects both a person's ability to focus on a task and his or her productivity. "These effects were equivalent to approximately 2.3 days absent because of sickness per depressed worker per month of being depressed."

Increasing awareness of these costs is driving employers' interest in addressing depression in the workplace. Sprint last year rolled out a depression awareness and education program for employees, building on its previous success in areas such as cancer, low-back pain, diabetes, and asthma. The company also joined other employers in the Kansas City area to launch a five-year project called the Community Initiative on Depression through the Mid-America Coalition on Health Care.

One of the coalition's first endeavors was to help improve the way physicians are paid for treating depression. Realizing that physicians were not screening for depression because they thought they would not be paid for their time, employers asked insurers to educate physician office managers on how to code a visit so that a screening test would be covered.

"It was less a matter of changing policy than of communicating with one another," says William L. Bruning, president of the coalition, an organization that coordinates health care efforts of employers, health care providers, labor, and local government in Kansas City.

The coalition's employers were initially skeptical that depression warranted their efforts and that they could have an impact on the disease, Bruning says. "Seven out of eight employers at first voted

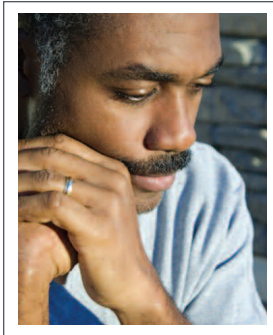
cont. on page 6



Although Employers Need Depression Programs, They May Not Know It Yet cont. from page 5

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to focus on diabetes. In 2000, when we first started thinking about this, there was a lot less discussion nationally about depression."



Employer Ignorance

Employers may still need to be convinced that programs targeting the disease are worthwhile. Many companies don't know the extent to which depression affects their workforce, the high indirect costs of the disease, or the availability of effective treatment options, the University of Pennsylvania's Bloom reports.

Still, managers believe that depression is the leading inhibitor of worker productivity, according to a survey by the University of Michigan Depression Center. A majority of benefits managers also believe that the costs of treating depression are less than the costs imposed by the disease itself. Seventy-eight percent of benefits managers who responded to the survey said absenteeism or lost productivity at work due to depression would cost more than helping to treat all of their employees with depression.

Increasing the number of people treated for depression is one of the main goals of health plan programs targeting depression. Three out of four depressed individuals do not seek treatment right away, the University of Michigan survey found. Lingering stigma associated with depression may be what is stopping health plan members from getting help sooner. People are concerned about how their careers might be affected if coworkers learn about their condition, the survey found.

Only one in five people with depression receive adequate treatment, and more than half do not receive even minimal treatment, according to Ronald Kessler, PhD, a professor of health care policy at Harvard Medical School.

Widespread underuse of treatment and poor quality treatment are among the reasons that the costs for depression are consistently high, experts say. Yet there's room for improvement that could result in lower costs for the employer and better health for health plan members, says Steven Avey, MS, RPh, executive director of the Foundation for Managed Care Pharmacy. In a report in the *International Journal of Methods in Psychiatric Research*, Wang and his colleagues noted that "recent effectiveness studies conducted in primary care have shown that a variety of models, which enhance care of depression through aggressive outreach and improved quality of treatments, are highly effective in clinical terms and in some cases on work performance outcomes as well."

The University of Michigan found, for example, that 88 percent of people who have sought help for depression feel that their

performance at work improved after receiving treatment. And treating depressed workers can yield \$1,100 to \$1,800 in savings per year of treatment, based on employees not missing work, according to Wang.

Two promising approaches

Aetna has documented success in two depression programs, one a disease management program for members who have been diagnosed with depression and the other a case management approach designed to help patients with conditions such as chronic heart failure who also are depressed. In that program, the member is assigned two case managers - one focusing on the depression and the other focusing on the other condition - who work together to help the patient navigate medical and behavioral health care. Both programs have improved the way members feel about their own health, Un says. Plus, members in the disease management program gain 1.8 to 2 days at work per month due to reduced absenteeism, and members of the case management program gain 3.9 days at work per month, Un says. The health plan is saving money because people feel better and use less medical care, and employers are seeing increased productivity, he says.

"Pharmacy costs overall have gone up, but only 25 percent of the increase is related to antidepressants," Un explains. "These members are taking all of their medications more regularly."

Another Aetna program aimed at providing depression resources to primary care physicians and their staffs and changing payment practices so that primary care physicians are paid for screening patients for depression is rolling out nationally after a successful pilot, Un says.

Like Aetna, many insurers are integrating depression programs into their health plan products. All of Aetna's fully insured members have access to the depression programs, and self-insured employers are given an opportunity to buy the programs for employees. Last year, Aetna held several education seminars for employers who wanted to learn more about the condition.

Cigna Healthcare this year launched its Well Aware Depression Management program, integrating the company's behavioral health, pharmacy, and medical management services. And United Behavioral HealthCare began taking a more comprehensive approach to its depression programs. The effort, designed to help employers identify more employees who could benefit from depression treatment, incorporates depression screening and education into such areas as employee assistance programs, disease management programs for chronic conditions, disability benefits, and self-help Web sites, says David Whitehouse, MD, chief medical officer for strategy and innovation.

Caremark, the pharmacy benefit manager, has also introduced a new depression disease management program, building on its

experience with depression in other areas, says Jan Berger, senior vice president and chief clinical officer. For more than six years, for instance, the company has offered employers a program that monitors physicians' prescribing habits as related to depression, with about 80 companies using the program today. Caremark also has long screened for depression in other disease management programs, such as those it offers for diabetes and heart disease. The new depression-specific disease management program is focused on newly diagnosed patients and is meant to ensure that patients are treated according to standard guidelines.



How good is the care?

Health plans, PBMs, and disease management companies interested in accreditation for disease management programs can do so through the National Committee for Quality Assurance and URAC, both of which offer disease management accreditation. In addition, the NCQA's Health Plan Employer Data and Information Set (HEDIS), includes depression measures. The HEDIS quality standards measure how health plans manage antidepressant medication and look at follow-up contacts with individuals after a diagnosis and a hospital stay. In 2004, 74.4 percent of health plans followed up with patients within 30 days of a hospital stay, but only 20.3 percent provided at least three follow-up contacts after a mental health diagnosis.

Measuring the quality of depression care has to be done by looking at the process a health plan follows, rather than outcomes, explains Dennis White, vice president for value-based purchasing at the National Business Coalition on Health. "With diseases such as diabetes, we can look at someone's hemoglobin A1C levels and know that members are receiving good care, but with depression, there is no such silver bullet." Many business coalitions and companies around the country use the National Business Coalition on Health's eValue8 program to assess health plans. Used by coalitions and companies, eValue8 asks health plans questions related to identification of members with depression, use of proper treatment guidelines, member and physician support, and more.

In measuring the success of a program, gauging its effect on

productivity is important, insurers and business leaders say, and Aetna's findings that depression programs reduce absenteeism from work is an example of such proof. Health plans can also look for forthcoming data from a cost-effectiveness study in which five large employers measured the effects of screening tens of thousands of employees and offering depression outreach treatment. The recently completed study was sponsored by the National Institute for Mental Health and titled "Outreach and Treatment for Depression in the Labor Force."

Health plans might also encourage employers to use the Productivity Impact Model developed by the U.S. Chamber of Commerce, the American Psychiatric Association, the Pharmaceutical Research and Manufacturers of America, the Institute for Health and Productivity Management, and the Mid-America Coalition on Health Care. The model is available at www.depressioncalculator.com. The tool can examine an employer's population by age, estimate how many employees in each age group are likely to be affected, and project savings based on reduced absenteeism as well as a reduction in direct medical costs.

"Employers now understand that they need to look at a full range of factors when it comes to depression, including how it relates to productivity," Bruning of the Mid-America Coalition says. "They've gotten much more sophisticated in dealing with depression."

Managing depression means overcoming barriers

As health plans work to help employers target depression in the workplace, they face many challenges. Barriers to successful programs, according to Sally Lusk, PhD, RN, professor emeritus at the University of Michigan school of nursing, include:

- Stigma that employees feel may be associated with the diagnosis
- Lack of motivation to seek care because of shame about needing care
- Ignorance about treatment available
- Lack of confidence in employee's physicians
- Deficiencies in primary care physician training related to mental health problems
- Health care system shortcomings

Source: Journal of the American Association of Occupational Health Nurses, 2002





Refuse to Misuse

Over the past four years, Employers Health has sponsored a community-wide campaign to halt the spread of antibiotic resistance. Entitled Refuse to Misuse, the campaign is aimed at increasing patient awareness regarding the problem of antibiotic misuse. Employers Health provides local physicians, clinics, and urgent care centers with a variety of materials for educating patients at the point of care.

Employers Health has teamed up with Wyeth Pharmaceuticals and Johnson & Johnson to repeat the program for the 2007-2008 cold and flu season. Patient care kits are currently available to Employers Health member companies wishing to distribute them to employees and utilize during health fairs etc...The patient care kits, include over-the-counter treatment samples of Tylenol Allergy® and Extra Strength Tylenol®, that can be used to aide in symptom relief. For more information and to arrange delivery, contact Marcas Miles at 330.639.2280 or mmiles@ehpco.com.

Know Your Numbers



If you're trying to eat healthier foods and getting in a little more exercise, good for you! Now there's one more thing to do to assure a healthier life: know your numbers — not just your height and weight, but also your blood pressure, cholesterol and blood sugar levels. That's the message that Employers Health is attempting to drive home with a new campaign entitled Know Your Numbers.

A report published in March 2006 by Milliman indicated that there is a surprisingly high portion of people with risk factors for high blood pressure, diabetes, and high cholesterol that are unaware or undiagnosed. As a result of this study, Employers Health felt this was an important topic to address. With the help of Merck-Schering Plough, sanofi-aventis, Novo Nordisk and Pfizer, an educational folder was developed outlining the various numbers that people need to know in order to be able to control and maintain their health. Included in the folder is information on education, prevention and maintenance of the specific disease states, as well as a handy pocket card for tracking these important numbers. Along with the educational folder, a multi media campaign is in full swing with radio spots, billboards and public transportation bus advertising, all branded back to the Employers Health website. Education kits are being distributed via employer member companies, community fairs, health clinics and can be requested through the Employers Health website at ehpco.com. Free biometric screenings in the community will also take place at various points throughout the six-month campaign.

If you would like to integrate the Know Your Numbers campaign into your health promotion activities, please contact Marcas Miles at 330.639.2280 or mmiles@ehpco.com.

A Consumer Guide to Ohio Hospital Quality Version 4.0



Employers Health recently released *A Consumer Guide to Ohio Hospital Quality Version 4.0*. For the last four years, the Coalition has published the Guide which encompasses all adult acute care hospitals in Ohio.

Representatives from Mercer Health & Benefits Consulting and WebMD Quality Services, the firms contracted to analyze and report the data, recently presented the 2007 results to Ohio hospitals and employers. The report is intended to provide consumers with a tool to use in evaluating hospital care. As the health care marketplace continues to change, consumers find themselves taking a more active role in selecting a provider for their health services. Just like other consumer transactions, Ohioans want to purchase high quality health care services. This is a valuable tool that consumers can use in dialogue with their physicians to determine the best path to care.

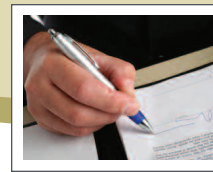
Unlike some studies that focus only on “process of care” measures, *A Consumer Guide to Ohio Hospital Quality Version 4.0* evaluates Ohio hospitals based on both “process of care” and “outcomes” measures, such as the number of mortalities and major complications for a given procedure within a specific hospital. The latest version of the Guide displays rankings in a new format, moving to a three category system rather than the five category star ranking system of previous versions. Based on its performance, and compared to all other hospitals in the state, each hospital is placed into a category of *Above Average*, *Average* or *Below Average* for 11 different conditions/procedures.

Data for the report are obtained from claims data submitted by Ohio hospitals to the Centers for Medicare and Medicaid Services for the federal fiscal year 2006, the most recent public data available. The data are risk-adjusted so that hospitals treating higher risk patients can be accurately compared to those hospitals treating lower risk patients.

To obtain a free copy of the guide, or if you would like multiple copies for distribution, please contact Employers Health at 330-305-6565. In addition to the paper version, an interactive website is available at www.ohiohospitalquality.com.

E-Newsletter

A new way to stay connected to Employers Health meetings, resources and information is through a newly launched electronic publication called Employers Health eNotes. This monthly electronic publication will keep you informed of new and ongoing projects that are important to you and the populations that you serve. To receive eNotes please email Marcas Miles at mmiles@ehpco.com. As always, your feedback and insight on topics that are important to you is welcomed and appreciated.



Statehouse Insider

by William M. Fitzgibbon, CWS Governmental Relations, Ltd.



As the Statehouse winds down the first half of the 127th General Assembly, there are two issues that continue to dominate discussions on health care reform. The first is HB 125 (Huffman, R-Lima), a bill that deals with the contractual arrangement between physicians, insurance companies and employers. The second is the Governor's Health Care Coverage Reform Initiative. This Initiative is being driven by an advisory group appointed by the Governor, comprised of representatives from all facets of the health care arena, and

is charged with developing a plan to reduce the uninsured population in Ohio.

The last Statehouse Insider touched on some of the major components of HB 125. In this issue I will give a quick update on the status of the bill and outstanding issues that are of concern to employers in the state.

HB 125 passed the House of Representatives on October 9th, 2007 by a 91-5 vote and is currently having hearings in the Senate Judiciary — Civil Justice Committee. Some of the issues raised by the business community were addressed prior to passage by the House, but two main components of the bill continue to be the focus of intense debate in the Senate. The first is a provision of the bill that deals with an "all products" or multiple products ban. The second is the applicability of the provisions in this bill to self-insured employers normally exempt from these types of state laws under ERISA.

The multiple products ban would prohibit an insurer or self insured employer from requiring a provider to contract for more than one product as a condition of the contract. In practice, this would mean that a self-insured employer that offers a standard co-pay small deductible PPO product, a high deductible HSA product and a HMO plan to his employees could have different networks for all three plans. Not only would this be an administrative burden to plan administrators but also to employees that switch plans and now are unable to see the same in-network providers as they could have seen before.

The second issue of great concern to large employers is whether the provisions of this bill apply to their plans or are preempted by ERISA. While ultimately this could be decided by the courts, all employers must be aware that it is the intent, of both the sponsor of the bill and the

Public Policy Alert:

Medicare Will No Longer Pay for Some Medical Errors in Hospitals

On August 1st, the Centers for Medicare and Medicaid Services (CMS), the government agency that runs the Medicare program announced in a final regulation that it will no longer pay for certain medical mistakes. Beginning October 1, 2008, Medicare will no longer pay for the added costs of hospitalizations that include a secondary diagnosis of one of the following medical errors that should never happen if hospitals take appropriate steps to improve patient safety:

- Patient falls, burns or other injuries in the hospital
- Pressure ulcers (bedsores)
- Urinary tract infections
- Vascular-catheter-associated infections (intravenous or intubation infections)
- Mediastinitis (infection following coronary artery bypass surgery)
- Objects left in the body after surgery
- Air embolisms (air bubble in bloodstream),
- Blood transfusions with incompatible blood types

Legislature, to apply all provisions of this bill to self-insured ERISA employers. The proponents of this legislation are confident they have crafted the provisions in such a way that the provisions will apply to all plans in the state, both fully insured and self insured. I encourage all self insured plans to look at the provisions in HB 125 and determine, if implemented, both the cost impact to their plan and how these provisions might impact plan design in the future. The full text of the bill can be viewed at this web address:

http://www.legislature.state.oh.us/bills.cfm?ID=127_HB_125

Another major issue on the health care front is the Governor's Health Care Initiative. The State of Ohio received a grant to participate in the Robert Wood Johnson Foundation program called the State Coverage Initiative — Coverage Institute. From that grant the Governor's Health Care Reform Initiative was formed. The Advisory Committee is tasked with developing a plan with the end goal being reduction of the state's uninsured population by 500,000 people by the year 2011.

The state has contracted with a health care actuary firm out of Texas, Lewis & Ellis, to model different reform scenarios and their possible impact on Ohio's health insurance marketplace and uninsured population. The following scenarios are likely to be modeled:

- A baseline model of no changes, this will be used to compare other scenarios against
- A connector model as proposed by the Governor in his Turn Around Ohio proposal and similar to the Massachusetts plan
- A reinsurance model, similar to the Healthy NY
- Other scenarios being discussed include an expansion of the state Medicaid program and utilizing the State's employee benefit system to expand coverage.

All of these ideas will be modeled both with and without an individual mandate to purchase coverage. The Governor's office has stated their reluctance to include a mandate but acknowledge that it may be difficult to achieve large compliance without some type of mandate.

The next meeting of the Advisory Council will be on December 11th in Columbus at Lazarus Government Center Room 621 A & B from 9:00am until 4:30pm. More info about the members of the Council and their progress can be found at <http://www.healthcarereform.ohio.gov/>.

For additional information on these issues, please contact William Fitzgibbon, CWS Governmental Relations at (614) 334-7134 or wfitzgibbon@cwslaw.com

CMS will work to add the following events to the list in 2009:

- Ventilator associated pneumonia (hospital-acquired pneumonia)
- Staphylococcus aureus septicemia (hospital-acquired blood poisoning)
- Deep vein thromboses (blood clot in legs)/Pulmonary embolisms (blood clot in lungs)

Background Information on Medicare's New Hospital Payment Rule

The CMS decision carries out a provision of a 2005 law passed by Congress, the Deficit Reduction Act of 2005 (DRA), which called on Medicare to begin to revise its payment methods so that it would no longer pay more to hospitals for preventable medical errors. Medicare will only pay more for hospitalizations when patients were admitted to the hospital with one of these eight conditions already present. CMS will add 3 more conditions to the list next year.

Several states, including Minnesota, and a few health insurance plans have already stopped paying the extra costs for some medical errors.

[Q] What's the **#1 cost-effective** employee health insurance benefit for adults?

[A] Paying for **smoking cessation** treatments, says the CDC.¹

Employers have a lot of questions about smoking. The answers might be surprising.

[Q] I've implemented a **smoke-free workplace**, isn't that enough?

[A] Smoke-free workplaces reduce employees' exposure to second-hand smoke and may encourage some smokers to make a quit attempt. **But smoke-free areas alone can't ensure that smokers who want to quit will succeed in quitting.**

[Q] If smokers know the health risks of smoking, **why don't they just quit?**

[A] **Most people smoke because they are addicted to nicotine. Quitting is tough — employees need support.** Fewer than 5% of smokers who try to quit on their own achieve abstinence for six to 12 months.²

[Q] Do **treatments** work?

[A] Studies have shown that medication, in combination with behavioral counseling, can **increase the odds of quitting successfully.**³ When people quit, they gain major and immediate health benefits.⁴

[Q] How does providing **smoking cessation benefits** help my company's bottom line?

[A] **Employees who smoke are more costly than non-smokers.** Each adult smoker costs employers \$3,700 annually in lost productivity and excess medical expenditures due to all smoking-related illnesses.⁵ The cost of providing a comprehensive tobacco cessation benefit is between just 10 and 40 cents per member per month.¹

[Q] **Isn't it hard to provide** a smoking cessation benefit?

[A] **It's never been easier.** The new easy-to-use Purchaser's Guide for Clinical Preventive Services from the National Business Group on Health walks you through the recommended benefits for employees who smoke and helps you develop a plan for your company.



Help your employees quit smoking. It's good for them and your business. Go to www.businessgrouphealth.org/prevention/purchasers/ for a **FREE Purchaser's Guide from the National Business Group on Health.**

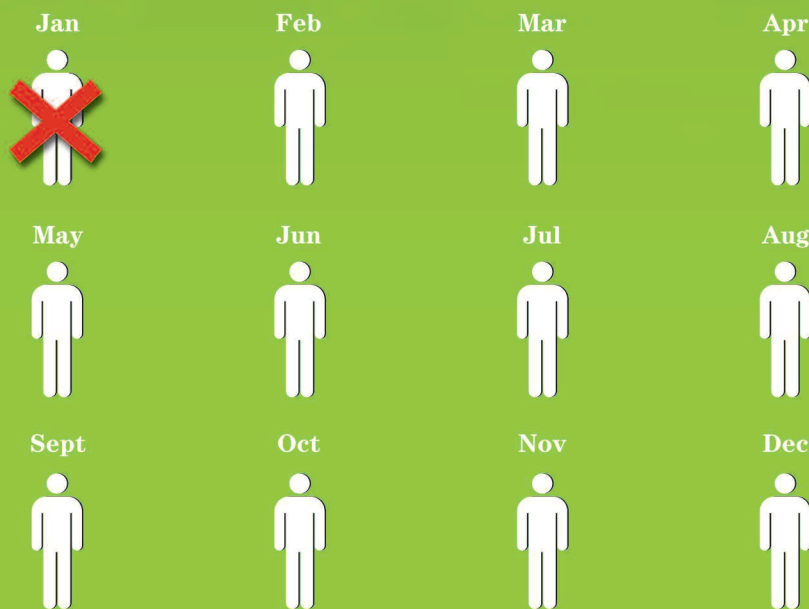


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Is your employee productivity

going up in smoke?

- Cigarette smoking is a leading cause of decreased productivity in the workplace
- Smokers take about 2 more sick days on average per year than nonsmokers
- 8% of smokers' workdays are wasted on smoking activities, which translates into 4 weeks of nonproductive time per year



Help your employees quit smoking—
it's good for them and
good for your business



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Marcas Miles, Editor
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Employers Health Coalition of Ohio, Inc.
4143 Fulton Drive NW - Canton, OH 44718
Phone 330.305.6565 - Fax 330.305.9055
www.ehpc.com