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## Inside this Issue

- 1** □ Protecting your privacy - new regulations are discussed
- 2** □ Protecting your privacy - new regulations are discussed (continued from page 1)
- "Have Insurance, will travel" - your guide to global health coverage
- 3** □ Federal Court rules on domestic partner issue, oral contraceptives
- Prescription Drug Costs on the Rise
- 4** □ Prescription Drug Costs on the Rise (continued from page 3)
- Carrier updates
- 5** □ Contact the Tech Team

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# Technical Advisory

## Protecting your privacy - a brief overview of Washington's newest laws

Due to growing concern over information privacy, Washington State has adopted their own versions of two recent pieces of Federal legislation - privacy provision in the "Patients Bill of Rights" and the "Gramm-Leach Bliley Act". These new laws take effect in Washington State July 1, 2001.

### What is the purpose of these new regulations?

The privacy provisions in the "Patient's Bill of Rights" have many intentions. The most significant are: limiting fraud and abuse, and limiting access to personal and private information.

The "Gramm-Leach-Bliley Act" further defines who is allowed access to personal and private information (PPI) and requires all companies subject to the laws to provide their consumers and customers with "privacy notices". The "Gramm-Leach-Bliley Act" further requires consumers and customers the ability to "opt-out" or not participate in information disclosures.

Effective 07/01/2001, to comply with Washington State's new privacy rules, any company with benefit plans will need to:

- Implement formal policies, standards and procedures consistent with HIPAA privacy regulations

- Identify, with job titles and descriptions, all persons authorized to disclose PPI.
- Put into place formal procedures for authorizing and restricting use of PPI information for use or disclosure to a 3rd party
- Distribute PPI information on a "need to know" basis
- Give consumers and clients the right to access their PPI and amend if necessary
- Set up a system for the appropriate handling, disposing and storing of PPI
- Train staff on the proper procedures for utilizing and disclosing PPI
- Set up disciplinary measures for internal violations
- Monitor employee compliance
- Give consumers and clients the right to limit disclosures (eff. 12/30/2002)
- Make all formal policies, standards and procedures available to the OIC.

Additionally, the "Gramm-Leach-Bliley Act" requires all companies subject to the law to:

- Send out initial privacy notices, which outline your company's privacy protection procedures by 07/01/2001. Customers must be notified annually.
- Give customers and consumers the right to opt-out of disclosures for any purpose other than service transactions (i.e.: claims)
- Service agreements must prohibit 3rd parties from reusing or re-disclosing information

### How does this affect your business practices?

Your company will now have additional compliance concerns.

*Continued on page 2*

**Continued from page 1**

You will need to mail your formal, written PPI policy to all consumers and customers (and employees) by July 1, 2001. An updated policy will need to be mailed annually to all customers.

Additionally, it is important to remember to send out a copy of the privacy notice to all new consumers and customers (as well as employees) for continued compliance.

All service agreements you prepare should have a clause prohibiting third parties from re-disclosing PPI. Failure do so may result in severe penalties.

How your employees receive service from your human resources department will also be affected. Human resource departments, insurance companies and insurance brokers will no longer be able to assist employees with questions specific to an employee without written authorization.

**Can employees sign a "blanket consent form" to give someone access to their claims information for the entire benefit year?**

No. You cannot design your own form or use a "blanket consent" form. A form must be completed for each inquiry and must include date and type of service.

**What are insurance companies doing to protect PPI?**

Some insurance companies are requiring that a special authorization form be completed before PPI will be released. One example is Premera Blue Cross.

Effective July 1, 2001, Premera will require a signed authorization from the employee before they will release any information regarding benefits or claims. Further, the

authorization form used must be from Premera. Without a signed authorization on file, Premera will not release any benefit or claims related information.

*(NOTE: At this time, we do not have procedural standards for any other insurance carrier. We will continue to update you as we receive information.)*

These privacy regulations are far reaching and require your company to review many current business practices. Heavy fines can be assessed for non-compliance.

To find out more, please contact your attorney.

To view more information, please visit the following websites:

*For WA State Regulations:*  
[www.state.wa.us](http://www.state.wa.us)

*For Federal Patient Privacy Regulations:* [www.hhs.gov](http://www.hhs.gov)

**Have Insurance, Will Travel - A Brief Guide to Global Health Benefits**

In today's global economy, the number of employees that travel and live abroad is increasing. Employees working or traveling outside of the home country may become ill and need to find effective, reliable healthcare. Finding care can be difficult, especially when the employee and their dependents are not familiar with local medical practices. Locally, there are carriers that offer coverage to employees abroad.

**Regence Blue Shield** - Offers the BlueCard program

- Included on PPO and Indemnity plans through Regence
- Selections plan coverage is paid at "Out-of-Network" level

- Access to the BlueCross/BlueShield network found in 32 countries world wide
- Network Hospitals paid at highest level
- Hospital and Physicians on-line
- Reimbursements in U.S. currency

**Premera Blue Cross**-Also offers the BlueCard program

- Included on PPO and Indemnity plans
- Reimbursements in U.S. currency
- Hospital and Physicians on-line
- Access to the BlueCross/BlueShield network

**Aetna U.S. Healthcare/Aetna Global Benefits (For employees out of the country less than a year):**

- Coverage through the Aetna U.S. Healthcare group plan. Available if on a PPO plan. Only emergency or urgent care services are covered.

*For employees out of the country a year or more: (i.e.: Expatriates and Third Country Nationals)*

- Individual benefit plans arranged through Aetna Global Benefits
- PPO and Traditional plans available
- The contract is based in Bermuda, and therefore is not subject to HIPPA and COBRA Regulations. (These features can be added in for all or just particular employees)

**Continued on page 3**

**Continued from page 2**

- Offers direct pay to 60 hospitals world wide (must pay up front at "Non-Network" hospitals and then be reimbursed)
- Direct deposit reimbursement or wire transfer available
- Claim reimbursement in over 100 different currencies
- Dental, Life, AD&D and LTD coverage available
- Groups of 9 or fewer are medically underwritten
- Can customize programs for group 25 and larger

**CIGNA**

- Offers PPO and Indemnity plans
- If a group has a CIGNA PPO plan only, employees' abroad will receive "Out-of-Network" level of benefit.
- Groups can offer PPO plan to local employees and a Traditional plan to international employees in order to receive richer benefits.
- For those out of the country for more than a year, a contract through CIGNA International is recommended.
- Through CIGNA International, an advance fee payment plan is available

For more information, feel free to contact your representative in the Kibble & Prentice Employee Benefits Division at 1-800-767-0650.✿

**Recent Federal Court Rulings**

**1. Domestic Partner Issue**

On May 15, 2001, the U.S. Court of Appeals for the Seventh Circuit passed down a ruling regarding same sex domestic partners. The case involved a woman who lived with the same man for two decades. The two had children together, but were never married. In July 1999, her employer extended Domestic

Partner coverage to employees, but only to opposite sex Domestic Partners. The woman argued this stipulation is unconstitutional, but the court disagreed with her.

The employer in the case argued that they wanted to provide benefits to same sex couples but since same sex marriages are not legal in the U.S., they had to provide this benefit. They continued to argue that since opposite sex couples can legally marry, making the partner eligible for benefits, they should not be included in the Domestic Partner benefit. The court did not agree with the unconstitutionality arguments against same sex only Domestic Partner coverage.

Some insurance companies will charge an additional rate load to include Domestic Partner coverage. The usual load is an additional load of 1% to the rates. Most insurance companies will not make a distinction in costs between same sex and opposite sex Domestic Partner coverage. Of the insurance companies that make a distinction between the two types of Domestic Partner coverage, the rate load will be an equal amount for the two, in the range 0.5% to 1% for each.

**2. Oral Contraceptives**

In the first federal case of its kind, Defendant Bartell Drug Co. was ordered to include prescription contraceptive coverage in its health plan. Judge Robert Lasnik ruled that Bartell's policy of excluding [coverage for prescription contraception](#) from an otherwise comprehensive employee health plan constitutes sex discrimination in violation of Title VII of the Civil Rights Act of 1964.

*(NOTE: At this time, your benefit plans have not been affected. We will continue to keep our clients posted of any developments). ✿*

**Prescription Drug Costs are on the Rise**

Along with all the other components of healthcare, the cost of prescription drugs continues to rise. The annual rate of increase for prescription drugs has gone from 9.8% to 18% over the last seven years. A study in 1999 from the Health Care Financing Administration suggests that prescription drug cost could make up as much as 25% of total healthcare expenditures by the year 2007.

So why is this happening? What are the factors that are driving up the cost of our prescription drugs?

**Inflation**

- Naturally inflation has played part. Costs for goods and services increase from year to year. The current rate of inflation is 4.2%.

**Advertising influencing competition among physicians**

- Physicians know that if they don't give the patients what they want, they will find another provider who will. So instead of losing a patient, physicians will give the patient what they want.
- Direct-to-consumer advertising. Generic substitution is minimized because people will see a brand name drug in an ad and ask for it specifically from their physician.
- New drugs are entering the market place at a faster rate than ever before.

*Continued on page 4*

**Continued from page 3**

- Since 1996 the Food and Drug Administration has approved an average of more than 40 drugs a year, compared to 25 a year in the early 90's. With more new drugs available each year and greater consumer demand for the new drugs, physicians are switching from the older generic drug to the newer brand names that often cost four to six times as much.

**The changing U.S. demographic**

- Our population is getting older. Nearly 30% of the United States population will be 50 years old or older by 2005. Those who are 65 years or older use one-third of all prescriptions dispensed.

How is the industry reacting to this trend?

For years we seen carriers use *Pharmacy Networks* to help control costs. These networks act similar to a managed care health network, in that, consumers receive a higher level of coverage as incentive to use particular pharmacies.

Carriers are also continuing their effort to increase generic utilization, with those who still choose name-brand drugs having to accept more of the cost. The most common way to do this is having a "Formulary". Carriers will select a group of drugs that are less costly yet effective and create a list of these drugs, called a formulary. Though formulary lists have some name brand drugs, for the most part they are made up of generics in an attempt to steer the consumer in that direction.

There are three types of formularies. An *Open Formulary* is the least restrictive of the three, because even if a drug is not on the list it will still be covered. A *Closed Formulary* is the most restrictive. If a drug is not on the list then it is not

covered. The shifting of cost back to consumers can be clearly seen under a closed formulary. The patient will be responsible for the cost of a drug not on the formulary. *Incentive Formularies* have become the most common in the healthcare industry. We see this strategy in the form of three-tier copay. In this system a low copay is offered to those who stay within the formulary (even lower if a generic is prescribed), at the same time the patient can have a non-formulary drug if they are willing to pay more.

Although prescription drugs continue to be one of the most cost-effective means of treating disease, some in the industry feel the cost will continue to rise over the next few years. As the increases continue, we can expect even more new ideas from the insurance industry to combat the trend.✂

**Carrier News**

**Prudential looks to demutualize**

If you are a policyholder with The Prudential Insurance Company of America, you should have received information in the mail regarding the companies impending demutualization. Prudential currently is a mutual company, meaning the policyholders are part owners of the company. In December of 2000 Prudential's Board of Directors unanimously voted to convert from a mutual life insurance company to a publicly traded company. It is the feeling of Prudential that by becoming a publicly traded stock company, they will be able to raise additional capital. The increased cash flow will potentially allow for more growth and increase the company's ability to pursue strategic opportunities.

In May, the New Jersey Banking and Insurance Commissioner's office accepted Prudential's application to demutualize and gave the company the go ahead to start

mailing information packets to its policyholders. The information packet should include a letter from the Prudential's Chairman and CEO, a set of four reply and Information Cards, a Voting Guide and Policyholder Information Booklets (Two Parts). The package asks policyholders to vote on the demutualization plan and certify their Tax I.D. number.

Votes can be cast by mail, telephone, the Internet, or in person at the Special Policyholders Meeting. The New Jersey Demutualization Law requires that at least one million policy and contract holders vote and at least two-thirds are in favor of the plan for it to pass. Votes must be received by Prudential by July 31, 2001.

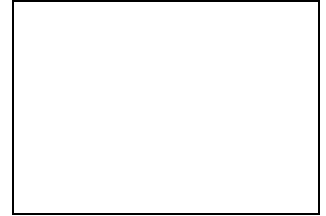
The Commissioner has 45 days after the public record has been closed to make a decision on approving the plan. If the Prudential's move is approved, policyholders will receive compensation for ownership in the company. The packet will have information on selecting between three compensatory options. Policyholders can convert their ownership into stock, cash or policy credits. If all goes as planned, Prudential expects an Initial Public Offering sometime in the fourth quarter of this year.✂

**AETNA**

Effective August 18, 2001, Orthopedic Consultants of Washington (OCW) is terminating from the Aetna U.S. Healthcare Network in Western Washington.

Letters will be sent to affected members on the HMO plan notifying them that their specialist is terminating. PPO members will not receive a letter. The letters will be sent by July, 15, 2001.✂

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