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The Smallpox Vaccination Debate

By Paul Volberding, MD

Smallpox is a serious and frightening disease, reminding us of a past human history of unchecked fearful contagions. In the non-immune human, smallpox causes a disease characterized by extreme morbidity, deep scarring and a mortality rate of 30 percent. There is no approved treatment. The last case of smallpox in the United States was diagnosed in 1949 and routine vaccination ended in 1972 when the disease was considered eliminated here. But samples of the virus were kept frozen for research purposes in the U.S. and the Soviet Union. While no case of bioterrorism has been reported using smallpox, it's certainly possible. Because most Americans – even those vaccinated before 1972 – are not immune, the potential for any incident to cause a widespread outbreak cannot be ignored. Planning for ways to prevent what could be a catastrophe is certainly justified and, largely, center on vaccination.

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Fortunately, there is an established and reasonably safe smallpox vaccine that is almost completely effective. But while the vaccine is *relatively* safe, it's also the most dangerous vaccine in common use. For almost 300 years it has been known that prior infection with another virus, vaccinia, or cowpox, can lead to protection against the closely related smallpox. Smallpox vaccination involves intentionally infecting the vaccinee with vaccinia through the skin. Vaccination is followed by an intense local inflammation as well as systemic signs and symptoms – fever, fatigue, swollen lymph nodes most commonly – and, after several weeks, local scarring. The illness caused by local vaccinia infection is itself severe enough to cause missed days of work, but typically resolves uneventfully.

There are, however, several problems. First, if the vaccinee has a weak immune system – someone

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with HIV infection, or someone taking immunosuppressive medicines for asthma, for example – the vaccinia infection can become generalized. This can be a severe infection with extensive scarring, not unlike smallpox itself, and can even be fatal in rare cases. Also, because the vaccinia skin infection is an active infection, there is the real chance that the virus may be transmitted to someone else in the environment. If that person has a weakened immune system or the common skin condition, eczema, they are at risk for disseminated vaccinia disease. For all these reasons, there is an understandable anxiety about whom to vaccinate, when, and following which precautions to prevent these very real and potentially lethal adverse reactions.

In fact, policies regarding smallpox vaccination are very much in debate. The government is beginning with voluntary inoculations of relatively small numbers of persons who would form "first response" teams in the event of any reported smallpox virus release. Larger scale vaccine programs would then follow, again, perhaps, on a voluntary basis. Beyond that broad outline, however, there remains intense confusion and debate. While some health departments and medical centers are already beginning the first phase of vaccination, others have publicly stated their intention to wait, perhaps until any true case of smallpox is diagnosed. While large scale vaccination is being urged, other groups, including the influential Institute of Medicine of the National Academy of Science, is recommending a slower, staged approach.

What are the likely recommendations that will emerge?

- Vaccination will begin with those old enough (over 30) to have been previously vaccinated, as it's expected the side effects will be less in that group.
- Some will not be vaccinated, as they have a higher risk for side effects. These include:
  - HIV infection, regardless of CD4 cell count.
  - Others with weak immune systems due to cancer or those taking immunosuppressive drugs.
  - Those with eczema or atopic dermatitis (even if it's no longer active), as they have a higher risk for dissemination of the vaccinia infection with widespread scarring.
  - People with active skin infections, or psoriasis, or burns.
  - Women who are or may soon become pregnant.

The CDC also recommends that vaccination should not be used in infants, people allergic to the vaccine or ingredients, those who have a current illness like the flu, or breastfeeding women.

Clearly, we are in challenging times. To keep informed is difficult as policies are still being formulated. There are, however, good sources on the web.

The list of links on HIV InSite are quite good and other sites also have very good information including the Johns Hopkins AIDS Web Site, the Center for Civilian Biodefense Strategies, the Institute of Medicine and the Centers for Disease Control. ■

Website links to resources about smallpox are:

http://hivinsite.ucsf.edu

http://hopkins-aids.edu

http://www.hopkins-biodefense.org

http://www.iom.edu

http://www.cdc.gov/smallpox

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Updated HMO Reinsurance Agreement Easier to Understand

By Neil Fagerhaugh

One of the projects for the Medical and Managed Care Reinsurance Unit in 2002 was to revise the HMO Reinsurance Agreement to make it more user friendly, and to reflect our current benefit structure. The target was to have a new agreement ready for the January 2003 new and renewal business. A team representing Administration, Case Management, Claims, Law, and Underwriting started meeting in May to begin the work. Once a new agreement was completed the Proposals issued to prospective accounts and Administration Kits issued to new accounts could be revised to be consistent with the new agreement structure and language.

The project was completed on schedule, and the new Agreement, Proposals, and Administration Kits are now in use. Existing clients who recently received the new Agreement also received a cover letter to help them identify the key changes. A copy of that letter is shown at right:

Dear ING Re Client:

We are pleased to provide you with your new HMO Reinsurance Agreement. Our objective was to make the new Agreement shorter and easier to understand. We hope you will find that to be the case.

Here are some of the more significant differences between the old and new agreements:

1. Length:

The new agreement is considerably shorter, by approximately 30 pages, thanks to removing the renewal forms and instructions, and by making the ROSE® and ROSEBUD® Services a separate document.

2. Readability:

A Schedule of Coverage page has been added, providing key information at a glance. We have also tried to state provisions as clearly as possible. This also contributed to a shorter document.

3. SNF, Acute Rehab, and Outpatient Services:

In the past, if coverage for these services was purchased, it was often subject to daily limits (e.g., $500 dollars per day for 60 days). These limits added to the administrative cost of adjudicating claims properly. Our new approach eliminates the daily limit and uses an annual maximum, per person. This simplifies administration of your reinsurance claims.

4. Home Health Care:

In the past, Home Health Care was often sold as a separate coverage. While this is still possible, we think it

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HMO REINSURANCE AGREEMENT

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makes sense to include it in the category of "Outpatient Services".

5. Drug Related Services:

These services are now defined, and the description of when they are covered, and to what limits, has been expanded and, we hope, clarified.

6. Out of Area Emergency Services:

These services continue to be covered, but no longer require a separate section or description. The terms that apply to "out of network" also cover emergency services when provided out of area.

7. Physician and Related Physician Services:

In the past these categories of services were defined separately. They are now covered in a single category of "Physician Services".

8. Material Change:

A new provision has been added to better define what events constitute a material change to the Agreement, and what effect these changes may have on the coverage.

We hope you will find this new Agreement to be an improvement over the previous version. Your questions or comments are welcome. Please direct them to your Agent or your ING Re (ReliaStar) Underwriter.

So far feedback has been positive. We believe we met all of the objectives, and clients, brokers, and company personnel will all find the new agreement easier to use and understand. ■

__Neil Fagerhaugh__, Senior Marketing Underwriter at ING Re has 40 years experience in Group Reinsurance and more than 11 years in managed care.

Earn CEUs through ING Re Teleconferences

New ROSE® Service Valued by Clients

ING Re's ROSE Program (Reinsurance Outcomes and Service Experts) recently rolled out a new service for ING Re clients. The first CEU teleconference was held on February 26, 2003, on the topic of *Outcome Reporting in Health Insurance Case Management*.

Nearly 200 people, representing 32 clients, participated in the teleconference, which provided continuing education credit of 1.2 contact hours for nurses and 1.0 CEU for social workers. This service was provided at no charge for ING Re clients.

The speaker for the teleconference was Sandra Lowery, BSN, RN, CRRN, CCM, President of CCMI Associates in Francestown, NH. Ms. Lowery is a past president of the Case Management Society of America and a consultant to the ROSE Program.

Evaluations from participants were very positive. One attendee stated, "The presentation was excellent. Thank you for the ability to attend this telephonic conference; I shall look forward to the next conference."

The next CEU teleconference is planned for April 16, 2003, on the topic of *Hemophilia*. Future topics will be presented approximately every other month, and will be driven by client requests.

For more information, contact Jane Johnson at 800-767-3509 or jane.johnson@ing-re.com ■

ING Re Client-Driven Market Research Services

Claims Practices for Multiple Surgery Billing

There are many complex rules for billing when multiple surgeries occur. You have to consider all the variables to meet appropriate billing practices. Multiple surgeries are separate (planned) procedures performed by a single physician or physicians on the same patient during the same operative period or on the same day. Multiple surgeries may also include incidental surgeries which are unplanned procedures that occur to the same patient during the time of a planned surgery. Incidental surgeries would not have been performed in the absence of the planned surgery. Knowing which category the surgery charges belong to is only one aspect of this process.

A client recently asked ING Re for assistance in identifying billing practices with multiple surgery billing. Nineteen companies participated in this survey, which addressed the following questions:

- How have Health Plans reimbursed for multiple surgery billing?
- What guidelines are used when unbundling charges occur in multiple procedures?
- How have Health Plans tracked the occurrence of incorrect billing?

For the purpose of this survey, the term "multiple surgeries" referred to the incidence of more than one procedure, taking place from one incision site or one entry point. According to coding standards, multiple surgery procedures are paid at varying levels based on which procedure(s) were assigned as the primary, secondary, and subsequent procedures for a particular claimant.

The common billing practice is "bundling" the charges for these surgeries into one billing and charge according to the level the procedures are coded. Unbundling occurs when multiple diagnostic and/or surgical procedures are coded and charged for separately or office visits for uncomplicated follow-up care are separately reported and also charged. These separate billings, or unbundlings, are considered inappropriate and a portion of the fee is disallowed by most Health Plans. In many cases, software programs can capture unbundling by applying appropriate guidelines.

ING Re provides Client-Driven Market Research services, free of charge, to our reinsurance clients. Each survey questionnaire is uniquely designed to meet your information needs because we consult with our client directly to target their areas of concern. Only survey participants receive a complete copy of the final survey report. The final data is provided in an aggregate form, which ensures the confidentiality of all participant responses.

For more information on how this service can work for your market information needs, please contact your ING Re ROSE Program Health Services Consultant at 800-767-3509. ■

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HEALTHCARE MANAGEMENT FORUM

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