From:
To:

Subject: Email Blast #18 Feds Require Consumer-Friendly Health Plan Briefs.
Date: Tuesday, February 21, 2012 3:47:00 PM
Attachments: blank-sbc-template-finalpdf.pdf

---

by The Associated Press

WASHINGTON February 9, 2012, 06:18 pm ET

WASHINGTON (AP) — Don't have the slightest clue what your health insurance covers? The Obama administration says that's going to change. Officials announced Thursday that starting later this year private health plans will have to provide consumers with a user-friendly summary of what's covered, along with key cost details such as co pays and deductibles.

Just six pages long. No fine print.

And because the summaries will use a single standard format, it will allow "apples to apples" comparisons among health plans that aren't possible now. That will help working spouses trying to pick between employer plans, as well as people who buy coverage directly from an insurance company.

"If an insurance plan offers substandard coverage in some area, they won't be able to hide it in dozens of pages of text," said Medicare chief Marilyn Tavenner, who also oversees implementation of President Barack Obama's health care law.

Insurers and business groups were unhappy, calling it another costly new regulation under the overhaul. Consumer groups said the new summaries won't be perfect, but called them a strong start. Employees should start seeing them during open enrollment season this fall.

One shortcoming is that the summaries won't include premiums. Administration officials said they ran into logistical problems trying to do that, and that premiums should be easily available anyway, either from their employer or directly from a health plan. Part of the problem with listing premiums is that insurers can currently charge more for the exact coverage to people in poor health.

Although the health system overhaul itself continues to divide the public, a major poll last year found that 84 percent of Americans support insurance summaries. The requirement takes effect Sept. 23 and applies to all private insurance, including employer coverage and plans purchased individually, affecting about 150 million to 180 million Americans.

Many big employers currently provide such information to workers during open enrollment. But the federal summary goes further. It requires something new — so-called coverage examples that give a ballpark estimate of the cost of treatment for a typical individual for two common health conditions: normal childbirth and managing diabetes.

A preliminary version of the regulations also called for an example focusing on breast cancer. But Health and Human Services officials said that proved too complicated, since there are different approaches to treatment.

"We didn't take this off because (treatment) happens to be more expensive," said Steve Larsen, head of the Center for Consumer Information and Insurance Oversight. "It just needed more work."

In the future, up to six such coverage examples may be required, he said.

Advocates for cancer patients were disappointed.

"I'm a little surprised by that," said Stephen Finan, senior policy director at the American Cancer Society Cancer Action Network. "The example was based on a standardized regimen of treatment, and it's my understanding it was vetted by the National Cancer Institute. I don't understand why they decided to leave it out."

The administration appears to have taken arguments from both sides into consideration.

Insurers and employers had complained that providing paper copies of the summaries would be a huge new cost. The administration will allow them to comply by providing an online version, but consumers must be told that they can receive a paper copy promptly upon request.

Large employers had asked that the summaries be phased in over a longer period for them. But instead, they will have to comply this fall, for coverage that starts Jan. 1, 2013.

Business groups were not satisfied. "We don't like it, even though they have taken steps to make it a little more palatable," said Neil Trautwein, vice president of the National Retail Federation.

The insurance industry said it already provides user-friendly materials to consumers and having to adopt the new requirements will lead to duplication and increase costs.

Some wondered why the government doesn't practice what it preaches by providing a similar user-friendly summary for Medicare, the health care program for seniors and disabled people. Indeed, the "Medicare & You" booklet runs to nearly 150 pages. Larsen said Congress didn't think of that in the health care law.

From:
To:
Bcc:

Subject: Email Blast #19 What is the most cost efficient method to handle Rx?
Date: Wednesday, February 22, 2012 2:53:00 PM

Independence Blue Cross

IBC study proves integrated medical and prescription benefits save money

We have exciting news to share with you about the results of a three-year Independence Blue Cross (IBC) study that analyzed the effects of integrated prescription drug benefits on medical costs. This study, published online in *Benefits Magazine*, proves that group customers can save money by purchasing drug and medical benefits together. The data contained in this study is another resource you can use to establish value when selling IBC integrated drug and medical plans.

In addition, the study demonstrates that combining medical and drug benefits increases productivity, improves member health, and helps members with chronic conditions adhere to their medication regimens.

Key findings of the study

The study results, based on fully insured and self-funded employer groups with 100 or more contracts, showed that when combining medical and drug coverage, members receive preventive care more regularly for better health outcomes. And with healthier, more productive members, groups benefit from lower medical and prescription drug costs.

Here are some highlights:

- From 2008 to 2010, when IBC members had both our medical and pharmacy management program, members saw medical cost savings of $19.76 per member per month (PMPM), equating to $237,120 medical cost savings per 1,000 employees.

- Inpatient and emergency room (ER) admission costs were 9.3 percent lower with IBC's carved-in program.
- 5.8 percent of members had at least one hospital admission compared to 7.2 percent of those with a separate PBM (pharmacy benefits manager).
- Among members with integrated medical and pharmacy benefits versus members with medical or pharmacy only, results showed that the number of hospital admissions was 19 percent lower and the number of ER visits was 28.6 percent lower.
- Carved-in members were more likely to be compliant with their drug therapy, meaning they are more likely to take their medication as directed by their doctors.
- Members with chronic conditions and a pharmacy benefit carve-in had lower rates of hospital admissions and ER visits, and their overall medical costs were lower.

The key findings of this study demonstrate the benefits of integrated drug and medical. We encourage you to share this information with your prospective customers, as well as customers with medical-only coverage, to further illustrate the many advantages of combining drug and medical benefits to lower costs.

Read the full study today in *Benefits Magazine* online, as a Web-exclusive.

Read the press release for more information.

If you have any questions, please contact your IBC account executive.

Independence Blue Cross | 1901 Market Street | Philadelphia, PA 19103

Email Blast #20: U.S. Supreme Court Proceedings on Health Care Reform

Is the 2010 health care reform law's individual mandate constitutional? The oral arguments regarding the mandate wrapped up yesterday morning before the U.S. Supreme Court. The focus of Tuesday's arguments was on whether Congress has the power under the U.S. Constitution to require the acquisition of health coverage or pay a tax penalty. Yesterday addressed, if the individual mandate is found to be unconstitutional, what the U.S Supreme Court should do about the rest of the health care reform law. Would the 2010 law be invalid? Should it be allowed to take effect? The transcript and audio recording of yesterday's oral arguments can be found at the link below.

http://www.supremecourt.gov/oral_arguments/argument_audio_detail.aspx?argument=11-393

We will be putting up the transcripts as they are released on our website www.stalkerinc.com. If you have any questions, please feel free to ask and we will do everything we can to get an answer for you.

Have a nice day!

Stalker & Associates
301 S. State Street
Newtown Pa, 18940
Tel : 215.860.5504
Fax : 215.860.7044
www.stalkerinc.com

FW: Email Blast #21: HHS Releases Small Group Insurance Regulations

On Tuesday, November 20, the Department of Health and Human Services (HHS) released two sets of proposed regulations related to provisions of the Affordable Care Act (ACA) that are important to individual and fully-insured small group health plans. Rules were released regarding essential health benefits, plan actuarial valuation, and small group rating and underwriting rules.

While the group health plan guidance is specific to the small group market, some provisions will be of interest to all employers. Notably:

- HHS has released a calculator which may be helpful for employers attempting to estimate the actuarial value (AV) of a plan.
- The underwriting and rating rules could apply to fully-insured large employers beginning in 2017 if a state opens its exchange to the large group market.

IMPORTANT BACKGROUND NOTES FOR EMPLOYER-SPONSORED GROUP PLANS

The ACA defines the small group market as employers with 100 or fewer employees; however, states have the option to define small group as 50 or fewer until 2016. Beginning with plan years starting 1/1/2016, all employers with 100 or fewer employees will be included in the small group market rules.

- The insurance rating and underwriting rules apply to all fully-insured small group plans offered both through a state or federal exchange, and also to plans sold outside, or separate from, an exchange. While a health insurance carrier may offer different plan designs inside or out of the exchange, they will not be able to apply different underwriting or rating rules.
- The essential health benefits rules apply only to fully-insured small group health insurance plans. Fully-insured large group plans and self-funded plans are not required to offer plan designs which meet the essential health benefit set requirements.
- Most of the rating and underwriting requirements described in the rules apply directly to the health insurance "issuer" (the term used in the regulations for the health insurance carrier). Consequently, small employers will not be directly responsible for the implementation of, and compliance with, most of these rules. However, the group health plans which will be available for purchase by small employers beginning in 2014 will be dramatically impacted.

RULES OF PARTICULAR INTEREST TO EMPLOYERS

Executives and product managers at health insurance carriers will be very busy redesigning their small group plans to meet a wide range of new requirements beginning in 2014. In particular, carriers will need to redesign plans to provide all essential health benefits as defined by the HHS and each state's specific requirements. The regulations contain detailed and extensive rules controlling how carriers will design and rate small group plans. Following is a more detailed description of a couple of issues of particular interest to small employers.

LIMIT ON DEDUCTIBLES

Beginning in 2014, the ACA limits plan deductibles in the small group market to no more than $2,000 for self-only coverage and $4,000 for non-self-only coverage (indexed in future years). In the preamble to the rules, HHS recognized that it may not be practical to design a 60% "bronze plan" as required by the law, while still maintaining the $2,000 deductible maximum.

In a welcome development for small employers, the proposed rules allow carriers to offer plan designs with a higher deductible, if necessary, to offer a 60% plan. While plan design details will vary from carrier to carrier, it is expected that due to this rule, some carriers will offer "bronze" small group plans with deductibles exceeding $3000.

"MODIFIED COMMUNITY RATING" RULES

Health insurance issuers may vary premiums based on a very limited set of specified factors:

1. Whether the plan or coverage applies to an individual or family
2. Rating areas within a state
3. Age, limited to a variation of 3:1 for adults
4. Tobacco use, limited to a variation of 1.5:1

All other rating factors are prohibited. Consequently, small employer rates may not be based on the group's claims experience. The rules permit the use of both age-banded and composite rating, and employers are allowed to set required employee contributions based on either approach.

ACTUARIAL VALUE CALCULATOR

The ACA requires carriers to offer different level plans, referred to as the metal tiers (bronze, silver, gold and platinum). Plans in each tier must meet an actuarial value within a specific range (e.g. 60% for bronze, 70% for silver, etc.). HHS has released an actuarial value (AV) calculator to assist health insurance issuers in determining the value of different plan designs. The calculator will be used by carriers to make sure a specific plan design falls within the allowed value ranges for each metal tier.

WHAT ABOUT LARGE AND SELF-FUNDED EMPLOYERS?

A separate section of the ACA (the shared responsibility or "play or pay" rules) requires large fully-insured and self-funded employers, to offer a "minimum value" plan to all full-time employees, or face the risk of paying an employer penalty. Minimum value (MV) is defined as an actuarial value of at least 60% (similar to a "bronze" plan in the small group market).

The AV calculator released with this guidance uses assumptions and claims data specific to the small group market, thus it does not directly address the MV requirement for large employers. However, in a separate section of the guidance, HHS states they will also be releasing a minimum value calculator for large and self-funded employers to use, and that the MV calculator will be very similar to the existing AV tool for carrier use.

Until the large employer MV calculator is released, employers can get at least a rough estimate of their plans by using the new HHS AV calculator. Once the MV calculator is released, employers can more accurately verify their plan's status using that tool. The rules also allow an employer to obtain an actuarial valuation by a qualified actuary to determine plan value. The HHS AV calculator can be found at http://cciio.cms.gov/resources/regulations/index.html#pm under the "Plan Management" section of the page.

SUMMARY

This new guidance primarily provides health insurance companies with many of the rules they need to begin to design their 2014 plan offerings in the individual and small group market. It is widely expected that the regulatory agencies will be releasing a large volume of additional ACA-related guidance in the coming months applicable to all employer-sponsored health plans.

Stalker & Associates
301 S. State Street
Newtown, PA 18940
T : 215.860.5504
F : 215.860.7044
www.stalkerinc.com