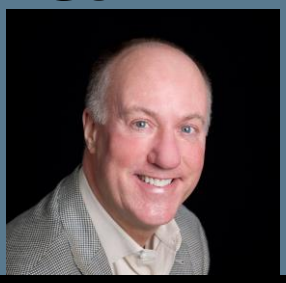
BENEFITS CORNER



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"Changes (Part 1: Insurance Companies)**"**

The Affordable Care Act (ACA) is changing the landscape of healthcare in many expected and unexpected ways. All sectors of healthcare; insurance companies, providers and consumers will be impacted by this sweeping law. Many of the impacts are just beginning to be felt while others will take years to be realized. This article marks the first in a three-part series that will examine some of the changes occurring.

Health insurance companies (carriers) have felt the biggest immediate impacts of the Affordable Care Act to date. Insurance companies have essentially had to change most of their once standard business practices. Carriers are now some of the most heavily government regulated entities in our country. What follows is a review of many of the changes carriers have to adhere to moving forward:

Medical Loss Ratio- This rule is meant to help control health care coverage costs and ensure that enrollees receive value for their premium dollars. These rules require health insurance issuers to spend at 80% of their premium dollars on medical care and health care quality improvement, rather than administrative costs and profit. Insurers that do not meet these requirements must provide rebates to their policy holders.

Limits on Cost-Sharing- Beginning in-network covered out of pocket expenses cannot exceed $6,350 for an individual. This limit includes all copays, deductible and coinsurance amounts. In the past, most copays did not accumulate towards the overall out of pocket limit.

Comprehensive Benefits Coverage- Health plans are now required to meet standards of coverage on 10 "Essential Health Benefits". The defined "Essentials" are very broad in scope; ranging from inpatient hospital services to pediatric dental services.

Preventive Care Coverage- All carriers must now pay for a defined list of preventive care services. This list of services is very extensive. The insured enrollee cannot be asked to pay any deductible or copay when the services are provided by one of the carrier's "in-network" providers.

Annual or Lifetime Limits Prohibited- Carriers cannot impose annual or lifetime limits on the defined essential health benefits. This is effective for plans issued after January 1, 2014. In the past, it was common for carriers to impose a $1 million lifetime cap or $500,000 per occurrence limit.

Insurance Premium Restrictions- Health insurance issuers in the individual and small group markets (except grandfathered plans) may not charge higher rates due to health status, gender or other factors. Premiums may only vary based on age, geography, family size and tobacco use. Additionally, carriers cannot have a rate variance greater than 3:1 when comparing the oldest age insured to the youngest. These limits do not apply to issuers in the large group market unless the state elects to offer large group coverage through the state Exchange.

Appeals Process and External Review Requirements- Enhanced internal claims and appeals requirements and external review procedures apply for group health plans and health insurance issuers, and insurers offering individual coverage. This requirement is meant to standardize and streamline coverage appeals in the event a carrier has denied an individual's claim.

Dependent Coverage for Children Under Age 26- If a group health plan or insurer provides dependent coverage of children, the plan must make that coverage available until a child turns age 26.

Another major change for insurance companies is the compression of their normal business cycle. Most carriers' client retention, acquisition and enrollment departments will see upwards of 75% of their activity occur in the fourth quarter of every year. Staffing for this volume of activity, while maintaining an acceptable level of accuracy and customer service, will be of particular concern.

In summary, health insurance companies are now required to offer more comprehensive coverage with fewer restrictions to essentially all-comers without knowing their customers beforehand- all the while having restrictions placed on the price they can charge or the profits they can make. With coverage being much more standardized between carriers the premium cost is now, more than ever, likely the most important consumer decision making metric. This is probably a good deal for American consumers, but not necessarily an attractive business model.

Carriers are reacting to this change in business model in several ways. Probably the two most important are in moving to "narrow network" plans and pharmacy formulary restrictions.

Almost all carriers in Colorado now have a narrow network option. These means that only those providers that can offer a high quality of care at a lower overall cost will be included in these plans as covered providers. Outside of emergency situations, this narrowed list of providers is the only one that an insured will be allowed to see for care.

Pharmacy formulary restrictions are fairly self-explanatory. State and Federal law defines "adequate" pharmacy coverage to include at least one medication from each treatment class or category to be included in the formulary. Quite a few carriers are now offering these selective prescription programs.

As you can see, the operating environment has changed significantly for health insurance companies. On the whole, this is probably a good thing for the American consumer; except for possibly the cost of these changes. Next month I will take a look at changes implemented or looming in the provider community

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