



QUOTE:

“Life is 10% what happens to us and 90% how we react.”
John Maxwell

SAAHU NEWS

Dear Members and Friends:

Take a look at our new NAHU logo below. The design of the logo is symbolic. The arc represents the protection health insurance brings to all Americans, while the tagline “America’s Benefit Specialists” describes who we are & what we do daily for America’s health care consumers. “Protecting the Consumer’s Future” denotes our unwavering commitment to provide the best professional service and advocacy to American families and businesses.

Considering ongoing changes in our industry & economy, our customers need our commitment to continue as their advocate. We do make a difference for them and ourselves now and in the future.

I encourage you to commit to continuing and increasing your contributions to HUPAC.

Together we are strong!

Sincerely,
Randy McDaniel,
Your President



Volume 14 Issue 14

September 2011



MEMBERSHIP DRIVE ON ! Invite guests! WIN! Quarterly Drawings.
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SAVE THE DATES! 2011 SAAHU MEETINGS

* Thursday, October 20

Shannon Hsu– Ashford Advisors– “Disability & Your Client’s Financial Security”

* Thursday, November 17

Lisa Wetherton– The Palmer Agency—”Expanding Your Horizons with Total Account Development.”

JANUARY 19, 2011- ANNUAL SYMPOSIUM

ATTENTION NEW MEMBERS! There will be a new member’s meeting 30 minutes prior to the regular meeting start time. Please meet Linda McCoy in the Atrium for guidance.



Poverty at new heights in Georgia, nation

(AJC 9/14, Teegardin, Schneider) reports, "The rate of Georgians without health insurance, 19.4 percent...was 3 points above the national number." Notably, Georgia's "uninsured rate fell slightly from 2009, but only because more people found coverage through government programs. The share of Georgians who got insurance at work declined." Georgia's poverty rate reached its highest point since 1983 last year, according to Census Bureau figures, as stubbornly high unemployment and the housing bust strained finances. Georgia's poverty rate reflects the toll of the recession in a state that had greatly depended on construction and real estate. The figure also reflects a kind of economic stagnation, as reflected in a jobless rate of around 10 percent that has barely budged in the past year, experts said. "We have people out of work one year and two years, and some who have stopped looking for a job," said Harvey Newman, chairman of public management and policy at the Andrew Young School of Policy Studies at Georgia State University.

Many of the poor appear outwardly to be solidly middle class, with a car and a home, said Vonda Malbrough, development director at North Fulton Community Charities. "They're your neighbor, but then you realize their car hasn't left the driveway for a week," she said. The charity has added programs to help the long term unemployed, including counseling on how to switch careers and training to adjust to a lower income. The charity served 5,088 families in its last fiscal year, up 18 percent over the past three years, she said.

Georgia's large population of uninsured residents -- 1.9 million -- has implications well beyond the families that lack coverage. Taxpayers face a larger burden as more people turn to Medicaid. People with insurance pay higher prices as hospitals shift the cost of caring for the uninsured onto the bills of those who can pay. Even getting care in an emergency room can take longer for everyone.

The demands extend well beyond public hospitals such as Atlanta's Grady Memorial, well-known for providing indigent care. At WellStar Health System, which operates five hospitals in Cobb, Paulding and Douglas counties, 9.8 percent of hospital patients lacked insurance in the 2011 fiscal year, compared with 6.7 percent in 2007. Uninsured patients accounted for about 30 percent of all emergency room visits for WellStar's hospitals. Jim Budzinski, WellStar's chief financial officer, said "this rising level of unreimbursed care is straining many hospital providers' financial stability and is of concern to us as well."

While uninsured Georgians can use emergency rooms for medical care, other services, such as dental care, can be almost impossible to get without money or a health plan. In 2010, Georgia saw a more pronounced version of the national trend -- increases in coverage through government plans as coverage at work declined. "Georgia has more people at or near poverty and we have more workers who are employed at smaller firms that are less likely to offer coverage," said Bill Custer, a Georgia State University expert on health insurance. "We also have a significant rural population, and that goes hand-in-hand with small firms and lack of coverage."

Officials opposed to U.S. health-care law seeking interstate compact

[From the Washington Post by Guy Gugliotta, Published: September 17](#) State governors and legislators opposed to the federal health-care law are eyeing a novel approach to escape its provisions: joining an "interstate compact" that would replace federal programs — including Medicare and Medicaid — with block grants to the states.

To date, legislation has been drafted or introduced in 14 states and brought to the floor by lawmakers in at least nine. Three Republican governors — in Georgia, Oklahoma and Texas — have signed the compact into law, while Missouri Gov. Jay Nixon (D) let the compact become law without signing it. Supporters say they hope to get 40 states to put it on the legislative calendar in 2012.

If a significant number of states pass the compact, supporters plan to submit it to Congress for approval in the same way that the body approves interstate compacts regulating commerce, transportation, and resource conservation and development. Although critics do not dismiss the compact out of hand, they say its chances of its becoming law are close to nil. Montana Gov. Brian Schweitzer (D) said in vetoing his state's bill, "we will put a person on Neptune" before Congress passes the compact. States have never sought a compact to shield them from a whole area of federal law, let alone been granted permission to form one. Some state officials, including Republicans such as Arizona Gov. Jan Brewer who vetoed the compact, are worried that it would usurp their authority. Many others point out that joining a compact would disqualify their states from receiving automatic federal funding increases during hard times and prevent them from getting their fair share of the available pool of money.

Continued on page 4



Leading Producers Round Table - The best of the best. That's what the Leading Producers Round Table (LPRT) is for America's benefits specialists. It's where the nation's best performers in the business get recognized for their leadership and rewarded for their accomplishments ... with tools and benefits that will keep them at the top of their game. Only members of NAHU can qualify. So, if you like the view from the top, visit <http://www.nahu.org/members/awards-lprt.cfm> for more information.

Health Industry Leaders Recommend Over \$410 Billion in Healthcare Savings to Congressional "Super Committee"

CEOs From All Health Sectors Call for Creation of New "Medicare Exchange" to Reduce Costs Through Competition, Raising of Medicare Eligibility Age, Changes in Medicare Cost-Sharing, Enactment of Medical Liability Reform

WASHINGTON – Leaders from many of the nation's leading healthcare companies and organizations today called upon the so-called congressional "super committee" to include in its deficit reduction proposals a set of reforms that would not only generate over \$410 billion in savings over 10 years, but would also strengthen Medicare's long-term sustainability.

Members of the Healthcare Leadership Council – chief executives from for-profit and non-profit companies representing all sectors of American healthcare – today endorsed reform recommendations that, according to HLC President Mary R. Grealy, "will contribute to deficit reduction without placing an unfair or disproportionate burden on patients, healthcare consumers or our most vulnerable citizens."

Ms. Grealy said the goal of HLC members is also to advocate reforms that address Medicare's shrinking window of financial solvency. "This 'super committee' process is a unique opportunity to do more than simply chop away at budgets. Rather than swing a conventional ax, why not take the bold step of pursuing reforms that save money while confronting the entitlement challenges that become more difficult to solve the longer we wait," she said.

The group's recommendations to the "super committee" include:

- **Create a new "Medicare Exchange" in which private plans would compete on the basis of cost, quality and value.**

HLC members acknowledged the proposed Exchange would inevitably be compared to the Medicare reform concept contained in Congressman Paul Ryan's (R-WI) proposed budget. Differences, however, include the fact that Medicare beneficiaries would have the option of staying in traditional fee-for-service Medicare and there would be a more generous inflation factor – growth in GDP plus one percent – for premium subsidies.

Ms. Grealy said Medicare beneficiaries should have the same freedom of choice as Medicare Part D prescription drug program participants, federal employees and members of Congress participating in the Federal Employees Health Benefits Program, and those who will utilize the new state-level health insurance exchanges created as part of the Affordable Care Act. She said the competitive environment will require healthcare providers, plans, manufacturers and distributors to achieve greater cost-efficiencies while still offering quality and value to beneficiaries.

"If given the choice between deeper provider cuts, which will reduce patient access to care, and reducing costs by using consumer choice to incentivize cost-effective innovation, it doesn't seem like a difficult decision," she said.

- **Gradually increase the Medicare eligibility age from 65 to 67.**

This transition would mirror the increase in the Social Security retirement age and reflect today's longer average lifespans. The increase would be implemented over roughly a decade, raising the eligibility age by two months annually.

The shrinking ratio of active workers to Medicare beneficiaries makes this change inevitable, Ms. Grealy said. Plus, the Affordable Care Act makes such a change possible in that Americans in their mid-60s not yet eligible for Medicare would be able to purchase health insurance on the new state exchanges without their health status affecting their ability to acquire coverage.

- **Reform Medicare's cost-sharing structure**

One reform would involve making the Medicare Part A and Part B beneficiary cost-sharing uniform, with a reasonable deductible and co-pays as well as a cap on annual out-of-pocket costs. This, Ms. Grealy said, would make Medicare costs more predictable and consistent for beneficiaries while also ensuring that seniors wouldn't be devastated by catastrophic care costs or faced with limits on hospital stays.

The other reform would be a requirement that individuals with annual incomes of \$150,000 and up pay their full premium costs for Medicare Parts B (physician services) and D (prescription drug benefit). This would affect less than three percent of Medicare beneficiaries, Ms. Grealy said, and would generate budget savings while protecting financially vulnerable beneficiaries.

- **Implement medical liability reform**

HLC members said the "super committee" should recommend liability reform measures including a cap on non-economic damages in medical malpractice cases, a one-year statute of limitations from the point of injury to the filing of litigation, and a "fair share" rule to have defendants pay damages commensurate with their responsibility for the injury involved.

Understanding the partisan difficulty in advancing tort reform legislation, Ms. Grealy said her organization would be open to alternative approaches including linking liability protections to healthcare providers' use of health information technology and practice of evidence-based medicine.

The four recommendations would generate just over \$410 billion in budget savings over a 10-year period, based on Congressional Budget Office estimates and other published budget projections.

The Healthcare Leadership Council submitted the recommendations in writing last week to members of the "super committee" as well as the leadership of both parties in the Senate and House.



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The ChHC—Chartered Healthcare Consultant—has been added. This and other designations openly exhibit for your clients and prospects that you are professional, knowledgeable, educated and have the integrity to

represent them well. There are several additional designations—RHU, REBC, DIA, LTCP, CSA and CLTC. For information on how to register for these, contact our President-Elect, Randy McDaniel at 770.954.1644 or imtheinsuranceman@charter.net or go to www.theamericancollege.com.

NAHU 2011: Cadillac Plan Tax May Trip Up Carriers

SAN ANTONIO – The new Cadillac plan excise tax could force health insurers to keep close watch on insureds' overall benefits packages. Seth Perretta, a partner at Crowell & Moring L.L.P., Washington, talked about the slippery nature of the new tax in a breakout session here at the annual convention of the National Association of Health Underwriters, Arlington, Va. The issue came up while Perretta was talking about the new Internal Revenue Service (IRS) Form W-2 reporting requirements for employer-sponsored group health coverage.

The Patient Protection and Affordable Care Act of 2010 (PPACA) is supposed to impose the Cadillac plan tax in 2018. The 40% tax will apply to health plan value over a specified threshold. The party that pays the tax will either be the insurer that provides the plan or, in the case of a self-insured plan, the employer that sponsors the plan. In part to start the process of implementing the tax, and in part to give policymakers more information about expenditures on group health benefits, the IRS will be asking for voluntary reports on group health expenditures for 2011 and requiring group health expenditure reports for 2012. Employers will report the expenditures using code DD in W-2 Box 12, Perretta said.

Along with major medical premiums, costs that must be reported in the group health cost total include Medicare supplement expenditures, any dental and vision benefits costs that are bundled together with major medical costs, limited benefit health plan premiums, and, possibly, costs related to on-site health clinics, and, possibly, expenditures on counseling services or wellness services delivered through group life plans or group disability plans, Perretta said. The total likely would not include the cost of stand-alone dental and vision benefits, but the cost of hospital indemnity plans, cancer insurance policies and critical illness policies apparently would be included if an employee paid for the benefits with pretax income, Perretta said. Perretta noted that group health insurance providers trying to avoid having to pay the tax may not necessarily know how much employers and employees are spending on benefits such as critical illness insurance, or counseling or screening services provided through an employee assistance program bundled with a group life plan. In some cases, employees might expose a health insurer to having to pay the Cadillac plan tax by signing up for critical illness insurance or some other ancillary benefit. "It will be interesting as we head to 2014 to see how employers respond," Perretta said.

From National Underwriter Life and Health for NAHU: 7/5/11 by Allison Bell

Continued from Page 2- Officials....Interstate Compact

Still, even if its prospects are more dubious than other methods of getting rid of last year's Patient Protection and Affordable Care Act — congressional repeal, judicial challenge or a Republican presidential victory in 2012 — the compact has become a popular way for conservatives to highlight their opposition.

And compacts might receive even more attention now that Texas Gov. Rick Perry signed his state's law July 18, just three weeks before he announced his candidacy for the Republican presidential nomination. The primacy of states' rights over federal powers is a tenet of tea party Republicans whose support is key for candidates during the primary season.

For the original drafters, health care is only the first compact in a longer list that would include measures giving states broad powers to control banking, education and energy. "Our view is that a good policy made under bad governance will morph into bad policy," said Houston businessman Leo Linbeck III, a key financial backer of the compact initiative. "Progress doesn't mean centralizing power. Progress pushes decision-making power back to the people."

The health-care compact grew out of discussions and research conducted a year ago at the Center for Tenth Amendment Studies at the Austin-based [Texas Public Policy Foundation](http://www.texaspublicpolicyfoundation.org), a conservative policy group. The 10th amendment to the Constitution leaves to the states all powers not conferred upon the federal government.

5 Myths About Health Insurance Exchanges

One of the greatest professional challenges that brokers and general agents will need to confront by mid-2013 will be how to survive in the emerging world of health insurance exchanges. Both you and your clients will be faced with new options to consider, new decisions to make, and new rules to follow. But just as an abundance of information has emerged regarding health insurance exchanges, there is sadly also a great deal of misinformation regarding how such exchanges will affect the marketplace. Here are five truths worth knowing.

Myth #1: If we build it, they will come. Truth: While health insurance exchanges hold many great benefits, the law as it's currently written contains very weak penalties for those employers that choose not to participate. As a result, some employers, at first glance, will likely opt to accept the penalties rather than provide coverage for their employees. To combat this, agents and brokers will need to aggressively reach out to inform employers of this new option and explain its many benefits. This is why brokers need to get up to speed as quickly as possible on this issue — and the time to start doing this is now.

Myth #2: New state exchanges are going to be strictly for the uninsured. Truth: To be sustainable, state exchanges will need to be as welcoming to those currently insured as they are to the uninsured. They will also need to appeal every bit as much to individuals and small groups that do not qualify for subsidies or tax credits as they do to those who qualify for these incentives. Recognizing this, some states have made it part of their goal to tap into currently insured individuals and groups. To do this, they would be well advised to not only harness private sector distribution channels (such as brokers) but to offer products and services that align with commercial purchaser interests and needs. Only by being inclusive to all individuals can an exchange attract the type of balanced enrollment that will allow it to be a meaningful force in the market.

Myth #3: It will be complicated for employers to cover employees through a health insurance exchange. Truth: Not true. The beauty of an exchange is that employees get access to a number of great health plans and benefit choices while employers get ease of administration and a single point of contact. The big change for employers will be to convert the funding of their employee health benefits program from defined-benefit to a defined-contribution model. Here employers provide employees with a voucher-like premium contribution; employees then use that premium contribution toward the health plan option they like best within the exchange. Employees who wish to “buy up” to coverage not covered by their employer’s contribution can do so by increasing their premium contribution, generally through payroll deduction.

Myth #4: Health insurance exchanges are expressly designed to save individuals and employers money. Truth: Some policy-makers falsely believe that by attracting a larger volume of purchasers, an exchange will turn around the rising cost curve. It doesn't work that way. Health plans will still need to price to the risk and underwriting losses that can't be made up strictly by volume. That's because medical trend increases are driven by utilization, provider costs, hospital costs, and an aging and often unhealthy population. So while there should be a small administrative savings, health insurance exchanges are really more about value-based purchasing. Exchanges create an online shopping mall where consumers, employers, and brokers can view health insurance plans side by side and compare benefits, costs, and other features. Each of the plans offered in an exchange includes an essential set of benefits at different levels of cost sharing. By giving individuals the freedom to choose what's right for their needs and budget, purchasers will be able to determine what is most valuable to them and, as a result, get the greatest value for their dollar.

Myth #5: The creation of health insurance exchanges will eliminate the need for brokers. Truth: While exchanges will be selling direct to consumers and using a still undefined network of “navigators,” the health reform legislation says that state exchanges can use brokers. But brokers who wish to stay competitive will need to ask themselves “Why would a client use me to purchase exchange coverage when they could go straight to the exchange themselves?” The answer is the same as to why employers use brokers today when they can go directly to a carrier. It's because brokers, more than anyone else, can provide the information and unbiased recommendations purchasers need to make well-informed decisions, as well as service for both routine issues and more serious policy interpretation concerns. Equally as important is the fact that, despite some other myths, exchanges will not turn health insurance purchasing into an annual transaction. During the course of a year, an individual can encounter many lifestyle changes – including a change in marital status, the birth of a child, a change in income, etc. This means that the need for the broker as “ombudsman” will not diminish, nor will the need for competent and responsive service.

The time to start speaking with your clients about exchanges is now. By separating fact from fiction, you can inspire their confidence and position yourself as a go-to person as exchanges continue to emerge.

By :Ron Goldstein – President of CHOICE Administrators® Exchanges.



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