

PRESIDENT'S MESSAGE:

Dear SAAHU Members and Friends:

HAPPY NEW YEAR! I trust your Christmas holiday was joyful.

Are you consumed with planning and strategizing your business for 2011?

How does a broker continue to stay relevant and valuable in the new environment ? This question was recently posed as part of a panel discussion among MVP's selected by a well known National Carrier. A Consultant, Lawyer, Carrier and Broker were responding.

As we close 2010 and delve into our future, perhaps these "borrowed" thoughts will be insightful.

1. Strategy drives structure. Update both if you have not yet done so.
2. Are you moving forward with Wellness initiatives? Population health is not an option anymore.
3. Still chasing business? Hopefully not.... It doesn't work in fast changing environment.
4. What about the agency compensation strategy? Commissions have and will continue to change and all producers will be impacted.
5. Are you paying attention to Medicare happenings? Remember that Medicare's fee for service model is tied to the insurance industry significantly.
- 6 Remember to plan for the known and not on speculation.

So, ongoing communication, more effort, less commission...wrap these around the 'Change' dynamic in a new day in our professional lives. Again, HAPPY NEW YEAR!

Yours in Service,

Jaki Turner, President, SAAHU

South Atlanta Association of Health Underwriters



QUOTE:

Watch your thoughts, for they become words. Choose your words, for they become actions. Understand your actions, for they become habits. Study your habits, for they will become your character. Develop your character, for it becomes your destiny."

Samuel Johnson

SAAHUNNEWS

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SAVE THE DATES! 2011 SAAHU MEETINGS

• **THURSDAY, JANUARY 20, 2011 ANNUAL SYMPOSIUM**

ATTENTION NEW MEMBERS! There will be a new member's meeting from 12-12:30 pm just after the Symposium. Please meet Linda McCoy in the Atrium for session guidance.

- February 17th (Thursday) • March 17th (Thursday) • April 21st (Thursday)
- May 19th (Thursday) • June 23rd (Thursday)

WHO: **South Atlanta Association of Health Underwriters (SAAHU)**

WHAT: **Annual Symposium** WHEN: **January 20, 2011 (TH)**
9:00AM– 12:00PM

WHERE: Wyndham Garden - Atlanta Airport South
5010 Old National Highway College Park, GA 30349 (404) 201-6165

WHY: **MEET YOUR NEWLY ELECTED CONSTITUTIONAL OFFICERS**

3 Hours Continuing Education Breakfast and Registration **Begins 8:30 AM.**

9:00 – 10:15 AM Governor, Commissioner of Insurance and Safety Fire, Commissioner of Labor, Secretary of State

10:15 – 10:45 AM Question and Answers with All Officers

10:45 – 12:00PM Lt. Governor, Commissioner of Agriculture, Attorney General, State School Superintendent

For more info & RSVP go to www.saahu.com Contact Charli Smith at charlotte.m.smith@kp.org



YOU CAN HELP SUPPORT SAAHU
BUY 5 TICKETS FOR \$20.00
SELL SELL SELL TICKETS
WIN WIN WIN a KINDLE!
MUST BE PRESENT TO WIN!
JOIN US ! TELL OTHERS .
BRING YOUR PEERS on the 20th.

♦ South Atlanta AHU maintains a sunshine policy regarding our financials. Financial statements are available to all members at any time by contacting our Chapter Treasurer,

Mark Phillips at markhp@comcast.net.



Savings Needed for Health Expenses For Medicare Eligible's

By Paul Fronstin, Dallas Salisbury, Jack VanDerhei, Employee Benefit Research Institute Dec 2010

Conclusion This report provides estimates for savings needed to cover health insurance to supplement Medicare and out-of-pocket expenses for health care services in retirement. Men age 65 in 2010 retiring at age 65 will need from \$65,000-\$109,000 in savings to cover health insurance premiums & out-of-pocket expenses in retirement if they want a 50-50 chance of being able to have enough money, & \$124,000 - \$211,000 if they prefer a 90 percent chance. Other findings:

Men: □ Men who supplement traditional Medicare w/ Medigap & Medicare Part D w/ relatively high prescription drug expenses will need \$100,000 for 50% chances of having enough; increase odds to 90 % =\$187,000. □ Men with subsidized retiree health benefits will need \$66,000, if comfy w/ 50 percent chances of having enough savings to cover health care expenses in retirement. Those w/ unsubsidized retiree health benefits who want a 90 percent chance of having enough savings will need \$211,000.

Women: □ Women retiring at age 65 in 2010 will need anywhere from \$88,000-\$146,000 in savings to cover health insurance premiums and out-of-pocket expenses in retirement if they are comfortable with a 50 percent chance of having enough money, and \$143,000-\$242,000 if they prefer a 90 percent chance. □ Women who supplement traditional Medicare w/Medigap and Medicare Part D & who have relatively high prescription drug expenses will need \$131,000 if comfortable with a 50 % chance of having enough savings, while those who prefer a 90 % chance of having enough savings would need \$213,000. □ Women with subsidized retiree health benefits will need \$88,000 if comfortable with a 50 percent chance of having enough savings to cover health care expenses in retirement. Women with unsubsidized retiree health benefits who want a 90 % chance of having enough savings will need \$242,000.

Persons age 55 will need even greater savings at 65 in 2020. Needed savings for men range from \$109,000-\$354,000, for women the range is \$147,000-\$406,000 depending on their source of health insurance coverage to supplement Medicare, any employer subsidies, prescription drug use, & their savings goal related to their comfort level (50%, 75 %, 90 % chance) of having enough savings to cover retirement health insurance premiums/ out-of-pocket health expenses. Most workers always had the responsibility for their health care in retirement. The fact that seniors had greater financial needs but less financial protection than younger workers is one reason leading up to the passage of Medicare. Nearly 90 % of Medicare beneficiaries have some form of supplement to Medicare Parts A and B. As employers continue to move away from providing retiree health benefits, more retirees had subsidized employment-based coverage in the past will have to assume risk associated w/ longevity. Predicted future Medicare erosion will exacerbate longevity risk. **While workers will have a difficult time saving enough money to cover health care expenses in retirement whether they live to average life expectancy or beyond, many are generally unprepared for both health care expenses in retirement & retirement expenses. In fact, many individuals will need more money than cited in this report because this analysis does not factor in the savings needed to cover long-term care expenses, nor does it take into account the fact that many individuals retire prior to becoming eligible for Medicare.** However, some workers will need to save less than what is reported if they choose to work during retirement and receive health benefits as active workers.

Finally, issues surrounding retirement income security are certain to become an even greater challenge in the future as employers continue to scale back retiree health benefits, and when policymakers begin to realistically address the financial shortfall in the Medicare program with solutions that are likely to shift more responsibility for health care costs to Medicare beneficiaries.

Following the Money, Doctors Ration Care



UNEQUAL access to health care is hardly a new phenomenon in the United States, but the country is moving toward rationing on a scale that is unprecedented here. Wealthy people will always be able to buy most of what they want. But for everyone else, if we stay on the current course, the lines are likely to get longer and longer. The underlying problem is that doctors are reimbursed at different rates, depending on whether they see a patient with private insurance, Medicare or Medicaid. As demand increases relative to supply, many doctors are likely to turn away patients whose coverage would pay the lower rates. Let's see how this works. Medicare is the major federal health program for the elderly, who vote at high rates and are politically influential, and so it is relatively well financed. Medicaid, which serves poorer people, is paid for partly by state governments, and the poor have less political clout than the elderly, so it is less well financed. Depending on the state and on the malady, it is common for Medicaid to reimburse at only 40 - 80 percent of the Medicare rate. Private insurance pays more than either. A result is that physicians often make Medicaid patients wait or refuse to see them altogether. Medicare patients are also beginning to face lines, as doctors increasingly prefer patients with private insurance. Access to health care will become problematic, and not only because the population is aging & demand is rising. Unfortunately, the new health care legislation is likely to speed this process. Under the new law, tens of millions of additional Americans will receive coverage, through Medicaid or private insurance. The new recipients of private insurance will gain the most, but people previously covered through Medicaid will lose. Ideally, higher demand for medical care would prompt increases in supply, which in turn would lower prices & expand access. But the health care sector does not always work this way. Doctors are highly regulated & in that manner restricted in supply.

The Association of American Medical Colleges estimates that the US could face a shortage of 150,000 doctors in the next 15 years. To its credit, PPACA does improve incentives for general practitioners, but still, supply probably will not keep up with the crush of demand. We could go further by giving greater scope to nurse practitioners, admitting more immigrant doctors, reforming malpractice law & allowing cheap, retail "Wal-Mart style" medical care, all to increase access & affordability. Yet these changes do not seem to be in the offing, so access is likely to decline. The health care bill will further privilege private insurance coverage by offering many individuals new subsidies for its purchase. That will create incentives for employers to game the system, dropping or discouraging coverage sending their workers to buy from the more expensive federally subsidized exchanges. That will strain the federal health care budget. There is also the danger that a few governors with tight budgets will shirk their Medicaid responsibilities, with an eye toward sending potential recipients to the federally subsidized insurance exchanges. In both cases, the quest for a better deal will strain the budget. The American system of federalism, with its checks and balances and slow policy evolution, has many strengths, but it has also helped create this crazy quilt of health care reimbursement rates. The more demand-side pressure is placed on medical supply, the more Medicaid and Medicare reimbursements rates will determine who and what is rationed.

One option is to simply allow budget pressures to dominate, forcing down even private insurance reimbursements. Most people would end up with low, Medicaid-like reimbursement rates, and would endure long waits and low-quality service. But wealthier people could jump the line by paying more. Think of "Medicaid for everyone" but the rich. An alternative is giving most people means-tested vouchers for a fixed amount of insurance coverage — which can run out or face up-front caps — making Medicaid and Medicare less of a blank check. The cost explosion would be checked by shifting more of the burden onto consumers. We would have better incentives for consumer-oriented care, and cost control, but we would be making an explicit public decision, at some point or another, to let some people do without medical care. Recently the Arizona state government restricted transplant coverage for Medicaid patients, but it remains to be seen whether such measures can be applied to Medicare recipients. The President already has reversed some of the planned, budget-saving cuts to Medicare. An entirely different approach is suggested by the system in Singapore, where the government requires savings (say 10 percent to 12 percent of income), patients pay for medical care from those savings, and the government takes care of additional catastrophic expenses. That system has a good record for cost control and access, but would Americans accept so much required saving? The default course is to maintain or extend Medicare reimbursement rates, raise taxes considerably and accept that Medicaid recipients will face worsening health care access. If you hear of a new solution to the health care puzzle, put aside the politics and instead think through the endgame. Ask not about the rhetoric, but rather about the reimbursement rates.

Tyler Cowen is a professor of economics at George Mason University.

These 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 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.



Planning under way for new state-based insurance marketplace

Excerpts taken within this article originally written by Carrie Teegardin AJC November 25, 2010

Leaders in GA are beginning to imagine a new way for the state's consumers to buy health insurance. The national health care overhaul calls for every state to have its own "insurance exchange" -- a new marketplace created under government rules that will allow consumers to comparison shop for plans beginning in 2014. Officials in every state can design and run their own exchange, or simply punt the task to Washington. The process of creating this new way to shop for health insurance will be costly and enormously complicated. Though many Georgians will continue to get insurance at work & won't go to the exchange, it will still have far-reaching implications.



The 2014 deadline will be difficult to meet, and the General Assembly will have to at least open its debate about a Georgia exchange when it convenes in January. States that take on the task of running an exchange will have a significant amount of discretion that will determine the level of competition, the amount of choices for consumers and ultimately whether market forces work to help control insurance costs, as the law intends. The new exchange system will present a buffet of health insurance plans sold by private insurance companies with price tags attached. Exchanges are geared mostly toward people who buy individual or small group coverage or have gone without insurance coverage. Under PPACA, virtually every American will be required to have insurance beginning in 2014. The law will not allow insurers to consider whether someone has a pre-existing condition when extending coverage.

Most employees of large companies should expect to continue to get their coverage at work, experts said. But some small/ medium-size employers could end up dropping coverage and shifting their workers to the exchange. How many companies might do that is a big unknown. The way the law is written, some employers will be penalized for failing to offer coverage. But paying the penalty might be more cost-effective than providing the coverage.

The architects of the law say that the exchanges will for the first time give consumers who buy individual coverage the ability to tap into a giant insurance pool. That translates into the ability to negotiate for decent rates and a variety of options. And no one can be turned down for insurance. For Georgia's elected officials, taking part in the planning process for an exchange is tricky, especially considering who opposes the federal health care law.

Gov. Sonny Perdue signed on to a multistate lawsuit that is challenging the law on constitutional grounds. Gov.-elect Nathan Deal, incoming Attorney General Sam Olens and incoming Insurance Commissioner Ralph Hudgens oppose the law and support efforts to repeal it.

Nonetheless, state officials are in the early stages of developing design ideas for the exchange, in part because it will give them an opportunity to put a Georgia spin on the law. Ryan Teague, who is heading up the research on the exchange for Perdue, said the initial work is focused on looking at the varying approaches a state could take, as well as gathering information about the 1.9 million Georgians who have no health insurance to gauge how the exchange might serve them. The state's preliminary estimates project a 34 percent increase by 2020 in the number of Georgians covered by Medicaid or PeachCare for kids, both programs for low-income residents. That would bring an additional 656,000 Georgians into these programs.



How Insurance Brokers Can Survive Reforms

By Richard Millard,

Richard Millard is senior director of the healthcare practice at J.D. Power and Associates, based in Rochester, N.Y.

What are the different service models that brokers might apply, and which ones will produce the kind of customer satisfaction that may be necessary for them to stay in the picture? **Essentially, there are three ways that brokers work with employers to find insurance: the Shopper Model, the Full-Service Model, and the Collaborative Model.**

In the Shopper Model, the broker exits the picture after connecting an employer to a suitable health insurance carrier. The Full-Service Model funnels all communications through the broker for the full duration of the contract. The Collaborative Model consists of ongoing joint communications that engage the broker, employer (purchaser), and the health plan in a team approach. Employers indicate that they are most satisfied overall with the Collaborative Model.

How can brokers focus on service and best satisfy their clients who are seeking affordable coverage? It's not merely a question of finding the lowest costs.

When an employer shops with a broker, it can be the beginning of a relationship that continues over the term of their contract, all the while also interacting directly with their insurer. Satisfaction declines when the broker exits after the sale, as in the Shopper Model. Employers appear more satisfied with their health plan when a broker becomes integrated within communications that occur between them. Rather than acting like a gatekeeper, as in the Full Service model, it may help the broker to function more like a facilitator. The broker's role is to assure open and transparent dialogue, not simply to function as an agent of the health plan.

The Collaborative Model can be a demanding one for health insurance brokers, as it requires them to continuously facilitate communication between insurers and employers. It also requires excellent customer service, which can include issues such as speedy problem resolution or communication of account management details.

To justify their continued role in the new PPACA world, brokers will be challenged to move beyond simply finding coverage for their clients to focusing on how their clients' needs are fulfilled throughout the course of the relationship between the purchaser and the insurer. This kind of ongoing communication requires more effort by the broker, but it also appears to be the approach that best favors the broker's odds of survival.



SCENES FROM OUR LAST MEETING

Revised "Grandfathered" Health Plan Regulations Published

Employers will be able to change insurers and still keep health care plans that are similar to what they have had without having to meet all the new requirements of the health care reform law, under proposed and interim final rules issued earlier this week by the IRS, the Department of Labor's Employee Benefits Security Administration (EBSA) and the Office of Consumer Information and Insurance Oversight in the Department of Health and Human Services. They also issued a fact sheet on the new requirements.

♦ **YOUR NAHU TEAM HAS RESOURCES ON THIS & ALL HEALTH REFORM ISSUES AT NAHU.COM.**