

"How to Prosper" as an Health Insurance Agent **AFTER March 21st, 2010,**

REGARDLESS of Healthcare Reform

This is a supplement to the earlier report with comments more specific to the recently passes House Resolution on Healthcare Reform. We can look at several excerpts from the Bill, with personal commentary in BLUE. This is a continuation of a report that concluded that REGARDLESS of Healthcare Reform, a quality supplemental health benefit was essential to remain a viable health insurance professional. As this is written on the morning of March 22, 2010, it has not yet but will most certainly be 'signed into law' by President Obama, most likely later today. *What exactly does this mean? Frankly, not as much as you might think!*

The next step in the process is to present the bill back to the Senate. Perhaps the existing modifications will pass easily, but if even one single amendment out of the many proposed happens to pass, then we effectively start all over again!

Let's look at concise thumbnails of the recent bill: Here is what to expect **if** the bill becomes law:

WITHIN THE FIRST YEAR OF ENACTMENT

*Insurance companies will be barred from dropping people from coverage when they get sick. Lifetime coverage limits will be eliminated and annual limits are to be restricted. [This action is favored by both sides of the argument.](#)

*Insurers will be barred from excluding children for coverage because of pre-existing conditions. [This action will add exposure, thus cost, to all plans.](#)

*Young adults will be able to stay on their parents' health plans until the age of 26. Many health plans currently drop dependents from coverage when they turn 19 or finish college. [This will reduce 'temporary plans' and add cost to Major Medical plans.](#)

*Uninsured adults with a pre-existing conditions will be able to obtain health coverage through a new program that will expire once new insurance exchanges begin operating in 2014. [This equates to the State High Risk Pools, described as 'alternative mechanisms' in current, existing law, that are already in place in 36 states. Checked the premiums lately?](#)

*A temporary reinsurance program is created to help companies maintain health coverage for early retirees between the ages of 55 and 64. [This also expires in 2014. Similar to the state pool, but consisting of an even older, thus more expensive, population segment.](#)

*Medicare drug beneficiaries who fall into the "doughnut hole" coverage gap will get a \$250 rebate. The bill eventually closes that gap which currently begins after \$2,700 is spent on drugs. Coverage starts again after \$6,154 is spent. [How far will this go towards the actual \\$3,454 'hole?' \\$250! That is 7.23%. But, better than nothing.](#)

*A tax credit becomes available for some small businesses to help provide coverage for workers. ["Some" small businesses. How much? Which ones?](#)

*A 10 percent tax on indoor tanning services that use ultraviolet lamps goes into effect on July 1.

WHAT HAPPENS IN 2011

*Medicare provides 10 percent bonus payments to primary care physicians and general surgeons. Basically, comp to Dr's has been 'frozen' for three years, as Congress has annually voted not to implement existing law. [With physicians dropping from Medicare and more threatening to every day, how much longer do you believe this trend can continue? Please keep this in mind as statements pertaining to 'deficit reduction' are associated with this bill.](#)

*Medicare beneficiaries will be able to get a free annual wellness visit and personalized prevention plan service. New health plans will be required to cover preventive services with little or no cost to patients. [Original Medicare expands to provide services already associated with MA/MAPD plans.](#)

*A new program under the Medicaid plan for the poor goes into effect in October that allows states to offer home and community based care for the disabled that might otherwise require institutional care. [Also known as insufficient care to many.](#)

*Payments to insurers offering Medicare Advantage services are frozen at 2010 levels. These payments are to be gradually reduced to bring them more in line with traditional Medicare. [Currently, Medicare Advantage plans receive approximately 7% more for clients than is currently being spent on Original Medicare clients. This will automatically shrink as Original Medicare expands to feature wellness benefits, not just one upon entering eligibility. Reality suggests that rather than a 'gradual reduction' in MA/MAPD compensations until costs equal out, more likely will be an increase in the per beneficiary cost of Original Medicare until they meet, around 2012-13. The original concept of the MAPD program predecessors was simply that a private organization familiar with healthcare could function to adjudicate claims more efficiently than a government bureaucracy. On this concept I personally agree; let's find out.](#)

*Employers are required to disclose the value of health benefits on employees' W-2 tax forms. [Uh oh, for what reason, I wonder???](#)

*An annual fee is imposed on pharmaceutical companies according to market share. The fee does not apply to companies with sales of \$5 million or less. [Just another tax, of which MANY will be necessary.](#)

WHAT HAPPENS IN 2012

*Physician payment reforms are implemented in Medicare to enhance primary care services and encourage doctors to form "accountable care organizations" to improve quality and efficiency of care. [The situation suggests that it will not take until 2012 to address this issue.](#)

*An incentive program is established in Medicare for acute care hospitals to improve quality outcomes.

*The Centers for Medicare and Medicaid Services, which oversees the government programs, begin tracking hospital readmission rates and puts in place financial incentives to reduce preventable readmissions. [Plain English: CMS will begin to fine hospitals whose readmission rate is greater than the one that CMS deems appropriate.](#)

WHAT HAPPENS IN 2013

*A national pilot program is established for Medicare on payment bundling to encourage doctors, hospitals and other care providers to better coordinate patient care.

*The threshold for claiming medical expenses on itemized tax returns is raised to 10 percent from 7.5 percent of income. The threshold remains at 7.5 percent for the elderly through 2016. [Specifically, UNREIMBURSED MEDICAL EXPENSES. Why now? Could it be that escalating deductible and coinsurance exposure have driven experience to the point where more than an exceptional few qualify? Choose the motivation that gets you through the night...](#)

*The Medicare payroll tax is raised to 2.35 percent from 1.45 percent for individuals earning more than \$200,000 and married couples with incomes over \$250,000. The tax is imposed on some investment income for that income group. [Robin Hood strikes again!](#)

*A 2.9 percent excise tax is imposed on the sale of medical devices. Anything generally purchased at the retail level by the public is excluded from the tax.

WHAT HAPPENS IN 2014

*State health insurance exchanges for small businesses and individuals open.

*Most people will be required to obtain health insurance coverage or pay a fine if they don't. Healthcare tax credits become available to help people with incomes up to 400 percent of poverty purchase coverage on the exchange. [It may be interesting to see what constitutes the 'poverty level,' in 2014, currently \\$88,000 for the purposes of application here.](#)

*Health plans no longer can exclude people from coverage due to pre-existing conditions. [How do you expect this to impact the 'bottom line?'](#)

*Employers with 50 or more workers who do not offer coverage face a fine of \$2,000 for each employee if any worker receives subsidized insurance on the exchange. The first 30 employees aren't counted for the fine.

*Health insurance companies begin paying a fee based on their market share. [Robin Hood strikes once again! Go ahead, build a better mousetrap, Uncle Sam will fine the cheese out of you!](#)

WHAT HAPPENS IN 2015

*Medicare creates a physician payment program aimed at rewarding quality of care rather than volume of services. [Oh so admirable in intent; for practical application, however, your guess is as good as mine. I do, however, see Robin Hood playing an active role!](#)

WHAT HAPPENS IN 2018

*An excise tax on high cost employer-provided plans is imposed. The first \$27,500 of a family plan and \$10,200 for individual coverage is exempt from the tax. Higher levels are set for plans covering retirees and people in high risk professions. This gives the Government 8 years in which to placate the Unions.

So, down to the 'brass tacks' (only *one of several new 'taxes' in our apparent future, and for which pun I do not apologize*) One element not mentioned in the brief outline from which I borrowed, and one only casually mentioned by the news media to date, is the language that **"requires individual and small group market plans to spend 80% of premium**

dollars on medical services. Large group plans would have to spend 85%." It is with this mandate that, if ultimately enacted, our ability to earn a living in the business of Health Insurance sales will end! This assumption would clearly be premature, in part as **the National Association of Insurance Commissioners (NAIC)**, which is charged by the legislation with crafting the definitions that will govern the medical loss ratio requirements, as well as with the carriers on the implementation of those provisions over the next year, to hopefully minimize their effect on the private market, and will participate closely in the progress of the 'reconciliation' process about to begin.

I recently was an active contributor of a medical plan built from a "blank slate" upwards. As the actuarially driven 'pricing' element of the project entered the equation, an interesting development arose that impacted commissions significantly. First, let me point out that most states currently require a 55% loss ratio, basically that 55 cents of each premium dollar be used to pay claims, not other 'cost of doing business' expenses, of which commissions are significant. **Here is what developed.**

At the top marketing level, the plan was priced for a 60% first year commission in states that demanded a 55% loss ratio. In other states, however, such as Florida, which requires a 60% loss ratio, the seemingly small 5% difference in claims payments dropped the top compensation a full 17%, down to 43%! In a state like Minnesota, which demands a 65% loss ratio, we DID NOT EVEN BOTHER TO FILE? **Why?** Because the top available commission would have been too low to motivate an agent to consider! What do you think would have happened at 70%, or 75% loss ratio? **Well, mandating a loss ratio at 80%+ will effectively eliminate any commission payment for the sale of any product!**

Before you look for a TALL WINDOW TO JUMP FROM, PLEASE CONSIDER THE FOLLOWING:

- 1) The amendment package has not yet been approved by the Senate, and may not.
- 2) Individual components within the bill are subject to additional scrutiny prior to enactment.
- 3) Much could happen between the enactment of this legislation and the upcoming Midterm Elections, not to mention shortly thereafter.
- 4) There are likely to be, for the reasons expressed above, significant modifications to reform language between now and it's first meaningful impact in 2014.
- 5) Our financial survival, as well as the best interest of our clients, demands that we continue to perform 'business as usual' for the next several years, at minimum.
- 6) The very best way to do so, as expressed in the earlier report, is to incorporate benefit packages that feature a base of quality Major Medical with an inexpensive supplemental feature. This is greater magnified by the fact that the supplemental element will be your best chance to build and maintain a significant income. Both history and logic each suggest that strong, inexpensive supplemental products will be needed to augment the 'post reform' offerings from which we all must choose. The plans you sell today may well endure/persist loon after healthcare reform, in whatever then current for it might occupy, becomes fully enacted.