

NAMSA



NEWSLETTER

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The official newsletter of the National Association of Medicare Supplement Advisors, Inc. This letter is sent to people who qualify for membership in NAMSA. It is sent on an irregular basis, as developments occur regarding Medicare, CMS, Medicare Supplement and Medicare Advantage. The letter will provide a forward looking, ongoing effort for NAMSA members to be updated regarding information useful to our industry.

AUGUST 20, 2009

NAMSA MOTTO: “What you don’t know, can’t help you”

I had promised myself, and you, that we would get to **one of the newest innovations** in health care and actually, health care “reform,” some day soon. **Today is that day.** Last issue I mentioned “**Medical Homes**” being right under our noses as a genuine solution to **some** of the problems that are being kicked around by people of every sway in the big debates. In our ongoing effort to update members in the “**continuing education**” segment of the newsletter, and introduce you to new terminologies and events, we are going to **discuss Medical Homes and the terrific opportunity they present to lower Medicare costs.** More on Medical Homes down below.

But first, some housekeeping...

Danielle, you have made us proud... By now people would have received their August issue of **Benefits Selling Magazine**, if you are a subscriber (you can get it free). In the section “Broker on Record,” ***the magazine gives a whole page, and picture, to NAMSA member, Danielle Kunkle,*** of Consumer Benefits Group in Benbrook (Fort Worth), Texas.

The introduction of her story relates how she is “co-owner (with her brother) of a family-owned agency **specializing in Medicare products.** As a **Medicare Supplement Accredited Advisor**, she focuses on **Medicare education** for Texas beneficiaries, **so they can make informed coverage choices.**” Danielle’s article relates the “**Top 10 things I’ve learned...**” David Letterman would simply be out of the competition here!

We’re going to forward some of them to you. Danielle lists and simplifies some important “**givens**” **that we all need to remember**, as we start a new fall sales season.

- 1) ***Don’t be a jack-of-all-trades***—Pick a specialty, then do everything you can to be the very best and knowledgeable agent you can be in that market segment.”

- 2) **Join a professional association**, such as NAHU, and **support the industry that's putting food on your table**. You'll meet agents who specialize in other segments and need your help when they run across **business they can't write**. **And you'll get those referrals**.
- 3) **Be real**. More than ever, **clients are seeking agents** who know them, understand them, care about them, and remember them when they call.
- 4) **Document, document, document**. E&O insurance exists for a reason. Be ethical every single day, and back yourself up with a history of your contacts, presentations and phone calls should you ever be questioned about your actions.
- 5) **Create a Web site** and an e-mail address linked to that site.
- 6) **Pick something unique** about you and **brand your business** with it. My agency is family-owned—two siblings. We send clients an annual newsletter telling them about our nephew, our family traditions. **They get a kick out of it!** Remember, **be real to your clients, and you'll win their loyalty**.
- 7) **Don't partner with other agents** unless you know them thoroughly, and take the time to **be certain their work ethic is the same as your own**.

Well said, Danielle, and **NAMSA thanks you for reminding us** that it's the little things that lead to lifelong relationships, continued retention, renewal service compensation, and customer satisfaction.

Last issue I asked for your help in **understanding "co-ops"** which are being discussed in the health care reform issue. **Jay Cox**, a NAMSA member from Fishers, Indiana responded with an article from the **LA Times** discussing agricultural medical co-ops in California. **Thanks, Jay**. I knew a little bit about them, but I'm afraid what Jay and I were referring to is not the same thing as is being proposed. You may remember that **during the weekend, the "Public Option" was being sent to the back of the bus**, while the **idea of Medical Co-ops was moving forward**. It appears that the bill (as yet unwritten), which will be proposed by Max Baucus in the Senate Finance Committee, will substitute the term "Public Option" for the "Co-op" venture. Then, **this week things reversed**, with Public Option back in the media spotlight.

Apparently, the **feds would "seed" the "consumer owned non-profit" co-ops** with \$3 to \$4 billion dollars (whoops, that changed to \$6 billion this week) to help them get off the ground, then would establish a federal program, which the various "state, national, or regional co-ops" would subscribe to as affiliates, but **"independent of the government."** **That last phrase mystifies me**. I don't know how that works, maybe you do, but the concept seems to have plenty of support.

Or maybe not. Influential **Democrats contend that removing** the Public Option part of any bill **means losing their support**. Influential Republicans **contend that keeping a Public Option** in any bill **means losing their support**. So, here we go again. I wish that the Public Option part would at least extend to the right of age 50/55 to age 64 people to buy into Medicare, since they seem to be the

demographic that is seriously affected by a lack of insurance either through pre-exists or high premiums. I would think that would open up a new market for either Medicare Advantage or Medicare Supplement producers to fill. At any rate—the Public Option versus the co-ops issue—***is going to get seriously kicked around for weeks***, and no matter the outcome, I don't see how any of the provisions of health care “reform” ***can fit into any time frame of less than several years. Too bulky.***

Also, on the turmoil front... It would ***appear*** that the “death panel,” or “***end-of-life counseling provision***” part of any bill ***would be eliminated***. This part of House Bill 3200 has caused the most angst in all discussions to date. Justified or not, we should remember that this issue and the “Public Option” mentioned above (as well as several others) would not have gained notoriety without a ***serious clamor from much of the American public for their removal from any bill***. All of us in this business are well aware of “right to die” issues that confront many older people. But the provisions of the bill, which went too far, seemed to be a way for doctors and medical people to get paid for their consultations—a *part* of which hospice already does—and is already paid for—and will be further included as a “***Basic Benefit***” in ***the new Medicare Supplement Series***, which goes into effect next June 1.

One more item... while we're at it... one issue, which doesn't get much ***public*** attention, is the administration's attempt to take control of what some have called “***MedPac on steroids***.” The proposal is to give ***MedPac***, which is charged with setting Medicare reimbursement rates, ***more power by placing it under the authority of the administration***, rather than under the authority of Congress, where it now lies. Baucus' bill would prefer to rename MedPac to the “Medicare Preservation Committee.” The President wants to call it the “Independent Medicare Advisory Commission.” ***Note “Independent.”***

No matter what it's called, ***this has a bearing on Medicare and subsequently***, Medicare Supplement and Medicare Advantage. Some lawmakers feel that since MedPac currently reports to Congress, and, they claim, Congress doesn't have the will to control Medicare spending—with a transfer to the White House—that goal would be achieved. And, the payment structure would then become automatic, unless Congress overrode the rates. ***This measure would entail a serious structural change as to whom MedPac reports.***

Many opponents in Congress are obviously upset with this plan, and ***are distrustful of what the administration*** would accomplish in terms of ***political appointments*** to the MedPac Commission, and, most importantly, ***reliance on “comparative effectiveness” medicine*** (which we have discussed in previous NAMSA Newsletters). The ***distrust works its way back to*** the “best value for health care” issue, which led to the outcry against “***end of life counseling***” which we discussed above, and ***then becomes a “back-door” opportunity for implementing those issues.***

Keep your eye on this if you can. I know I will. It will become more than a typical “hot potato” issue. I doubt that Congress will give up their control of MedPac to the President, and the President will be very persistent in achieving this. **Stay tuned.**

Some smaller items...

...**Tort reform** in medical matters **seems not to be an issue** in any bill which has made it out of committee, with Washington expecting the states to enact control of the issues, which all medical entities face with **high Malpractice Insurance premiums, and endless repetitive tests which must be performed as “CYA” measures.**

...**CMS has operated without a named administrator** since October, 2006. It is the job of the President to name and appoint an administrator, and the Senate to approve the person in Senate-confirmed hearings. **Do you wonder why this hasn't been done** at a time when the nation is undergoing this health care upheaval?

...**As we relayed in a past issue, Mark Farrah Associates** has come out with a new report on the **growth of Medicare Advantage** in the past year. **MA growth continues to be robust**, as was also indicated regarding **Medicare Supplement**, in a previous report we presented in the NAMSAs Newsletter. Next issue we will cover the new MA information.

Now, for updating “Continuing Education” matters—Medical Homes...

For the past three months I have asked members if they had heard about the term “Medical Homes.” **Only one person had.** So, my guess is that most of you can say **you heard it first in the NAMSAs Newsletter!** My research on the topic is now two inches thick, but I pursue the knowledge because I feel so strongly that this is a **solution to much of the problem facing Medicare** (and the nation) regarding **reducing costs of medical care.**

First...A little history. Medical homes are nothing new. They were developed in 1967 as a solution to children’s needs for **continual care in matters of a chronic nature.** They were actually homes where the children were monitored around the clock by medical professionals. The idea centered on a **theme “as a single source of all medical information on a pediatric patient.”** Thus, the term **“Medical Homes.”**

Fast forward to the 1990’s. Some bright people saw the **value of adapting Medical Home care to all segments** of the population, and particularly to the **needs of the chronic care elderly.** By 2000, the idea had gained steam, and the concept of providing such care to Medicaid and Medicare recipients began to develop traction.

Medical Homes took on another name, “**Patient Centered Medical Homes,**” and goes by that name as well as several others, as programs expand in various ways.

Melanie Matthews, Executive Vice President of the **Healthcare Intelligence Network**, (a major player in educating the nation about MH) wrote in a March 9, 2009 bulletin, “In less than five years, the patient-centered medical home (PCMH) model **has quickly grown** from a pediatrics-based concept **to a care approach embraced by thousands of healthcare organizations hoping to improve care and costs for the chronically ill.**”

But the concept has even grown from the “**chronically ill**” to downright sensible applications of “**follow-up**” care from Primary Physicians and their medical staffs, such as RNs, LPNs, Physician Assistants, Hospitalists, Pharmacists, Health Care Practitioners, nursing homes, home health care agencies, hospice providers, and even hospitals. Acute care, as well as chronic care, include wellness and prevention services, as well as end-of-life considerations.

The **various definitions and objectives** of MH or PCMH are lengthy, but let me **simplify and somewhat organize them for you.**

- 1) The concept is based with the objective of a **Personal Physician** where each patient receives first contact, continuous care, and follow-up comprehensive care **from one Primary Care doctor.**
- 2) **Then**, a physician directed medical practice **leads a team of healthcare professionals**, like those listed above, who **collectively continue** each responsibility for the ongoing care of the patient. (Some estimates conclude that currently **50%-70%** of **chronic care patients** do not receive **adequate follow-up care after a hospitalization.**)
- 3) The personal physician **directs the team** in medical matters, as well as **arranging care with other qualified specialists.** This would include a large spectrum of specialists such as **cardio-vascular, diabetic, and cancer care doctors.**
- 4) **Community care based and public services** are included, as well as **family member** care education, monitoring, and knowledge services. **Patients actively participate in discussions and decision making**
- 5) **Quality and safety** then become paramount, and **continuous care is monitored**, to measure the success of each individual’s program.
- 6) Obviously, the need for some type of **common reporting and retrieving capabilities**, is included. This is where **up-to-date Information Technology** plays an important role.
- 7) **The “setting”** for a Medical Home can actually be a facility, such as a nursing home with a converted mission, **but it can also simply be a “program”**, where people remain at home, but the monitoring is achieved the same as in a facility.
- 8) Expectations (and proven examples) are that a **Primary Physician and his team can effectively handle around 200 cases at a time.** This seems like a

lot, but the incentive is for Primary Physicians to be **compensated on a per person basis**, with further incentives to demonstrate quality care.

- 9) There are several objectives at work here. But, probably, the two most important are; first, to **reduce expensive “Rehospitalizations”** (which we have discussed in past issues of the newsletter), and secondly, to **revitalize an interest in medical students** into becoming Primary Care physicians with an “equalizing” of compensation in comparison to specialists. Several medical practices and clinics **are converting, or have been converted**, to the MH concept.
- 10) The concept helps to **reduce uncompensated** care costs for the chronically ill.
- 11) **Hospitals now can partner** with the MH concept to deliver patient centered care.
- 12) **Emergency room usage is highly curtailed** due to utilization of the MH concept.

In consideration of the theory (and some studies) that **Medicare patients with five chronic illnesses, utilize 50% of the costs of Medicare**, and in consideration that as much as **80% of a recipient’s medical care costs can be eaten up in the last year of their lives**, a concentrated effort, such as the Medical Home concept is well worth the expense.

So, who’s using the MH or PCMH model?

Believe it or not, **hundreds of programs involving hundreds of thousands of patients** are already currently in force. Here’s kind of a roster.

- 1) **State Medicaid and Chip Programs** in more than 30 states have initiated projects to advance the MH concept, which include programs for Medicaid adults.
- 2) In 2007, **four major physician groups endorsed** a common MH concept. Supporters have joined together to form the **“Patient Centered Primary Care Collaborative” (PCPCC)** that includes employers, medical specialty societies, and health plans.
- 3) **The states** of Colorado, Idaho, Massachusetts, Oregon, and Pennsylvania will provide \$6 million to **help 68 community health centers to transform** themselves into PCMHs. The care delivery system will involve more than **500,000 patients**.
- 4) **New York State** has instituted MH as a part of its Health Care Transformation.
- 5) Twenty-six medical practices in **Maine** will participate in a three-year pilot.
- 6) **Several health plans**, including **WellPoint, United Healthcare, Cigna, Aetna, and Humana are working together** in PCMH projects in four states. Physicians will be paid **both on a fee-for-service basis and a per-member, per-month fee set by the individual insurers**.
- 7) The **Michigan Blues Plans** have launched the MH concept to incentivize its PPO providers to become PCMHs. The plans say “the initiatives could affect about **2 million members in the state** and represent the **largest foray into medical home-based care in the nation.**”

- 8) **Aetna** confirmed its support for PCMHs on April 23, 2009, **but also cautioned** that they still need the evidentiary base that will establish the impact on this model on quality, cost and patient satisfaction.
- 9) **IBM, and United Healthcare** have collaborated to launch a pilot program in the MH model of care for 7,000 patients, using physicians in **Tucson and Phoenix**.
- 10) **Humana and Metropolitan Health Networks** announced the availability of PCMH programs to **Humana Medicare Advantage** patients in **nine centers in central and South Florida**.
- 11) **Independence Blue Cross** launched a PCMH concept in **southeastern Pennsylvania in May**.

So, now for the BIG question... Where does Medicare fit into all of this?

Well, Medicare is making an honest attempt to try to catch up with private insurance and the medical community in the PCMH arena. However, when you read the **timeline of this effort, you will question why the process has been allowed to take so long**.

For openers, let's take a quote from **CMS Acting Director** (see "Smaller Items" above) **Charlene Frizzera**, "Our data (CMS') show that nearly **one in five patients** who leave the hospital today **will be re-admitted within the next month**, and that more than **three-quarters of these re-admissions are potentially preventable**. This situation can be changed by approaching health care quality from a community-wide perspective, and focusing on how all of the members of an area's **health care team** can better work together in the best interests of their shared patient population."

Okay, I have a feeling that the quote would indicate that **CMS didn't just find this out, and that they have known about it for some time**. Assuming that's the case, follow the timeline of these events.

- 1) **The Tax Relief and Health Care Act of 2006** created authorization for CMS to explore the concept of Medical Homes.
- 2) Actual demonstration projects were **created and authorized by MIPPA 2008**.
- 3) In January, 2009 CMS **began recruiting eligible medical practice sites in eight states to act as Medical Homes**.
- 4) In April, 2009, CMS **funded 14 projects** to address the issue, under the name of the **"Care Transitions Project"**.
- 5) The chosen medical **practices will begin providing services** to beneficiaries in January, 2010.
- 6) **Payments** for the Medical Homes demonstration project **end** December, 2012, and **final evaluations** are to be completed by December, 2013.
- 7) Which means that **any practical application would not begin nationwide** until sometime in 2014, if then.

So, it took Medicare over **two years (2006-2009)** to organize the effort, **one year (2009)** to put it together, and will take **three years (2010-2013)** to close the project, and probably **another year (2014)** to evaluate a program **that private insurance companies, the health industry, and some state Medicaid programs, which are a part of CMS, are already utilizing. Go figure.**

My assumption is that **CMS simply doesn't have the manpower and money** to move any faster on this. As you know, I have harped on an underemployed and underfunded CMS before, (Remember that CMS likes to refer to itself as having a "2% administrative fee.") Those of you who deal with Part D and MAPD, will attest to the problems encountered by undermanned (underwomaned) call centers for about four months out of a year.

But it sure seems like **a three-year demonstration project is just about two years too long**, and that the merits of PCMHs could be **evaluated comparatively sooner**. Again, my guess is that Medicare needs time to evaluate how they will include PCMHs into a **Medicare payment scenario**. Make no mistake about it, **PCMHs will become a huge part of American healthcare**. Now **CMS just needs to get into the ballgame quicker, and realize the savings** that **Acting Director Frizzera** describes in her comments.

That's it for now, folks.

I will be looking for comments at: RonIverson@guardingyourgold.com.

Also, please be thinking about sending me some thoughts about your value in meaningful agent relationships for your clients, and how you like your work, much as **Danielle related in the Benefits Selling article. I would like to print and share them with other members.**

So, 'til next time, keep a stiff upper lip. And remember the following:

- 1) "A bicycle can't stand alone; it is two tired."
- 2) "A backward poet writes inverse."
- 3) Two Eskimos sitting a kayak were chilly, so they lit a fire in the craft. Unsurprisingly it immediately sank, proving once again that you can't have your kayak and heat it too."

Help! Send better jokes.

**Ron Iverson, President,
National Association of Medicare Supplement Advisors, Inc.**

