

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 6, 2009

Our Motto: “What you don’t know, can’t help you.”

Important Correction... In the last issue of the newsletter, *I made in error in point no. 7 of the article* on the introduction of the new series of Medicare Supplement Plans, which will take effect on June 1, 2010. The item said, “Plans A, C **AND** F must now be offered by all companies offering Plan A, which essentially means all companies who want to market Med Supp.” **That is incorrect.** It should have said Plans A and Plans C **OR** F must now be offered...” Sorry for the *“mistake,”* and I’m glad it happened far enough in advance to be corrected. Also, **a big “Thank You”** to some people at **Bankers Fidelity Life Insurance Company** for alerting me.

Our first NAMSA Webinar with **Mr. Sam Halpern** was well received by those who plugged in. Sam delivered a **concise discussion of eight different ways** to sell Medicare Supplements, three of which were traditional methods, and five of which involve a step forward in marketing and sales of Med Supps. There is no doubt **that telephonic and electronic sales techniques** of Med Supps are a **“wave of the future,”** and over the past year I have been impressed that so **many of our members are already using** these methods to acquire business. And, **companies are gearing up** to accommodate producers who want to market their wares in different ways. **Telephonic apps with company voice signatures** are already under way, and **electronic opportunities with e-signatures** are being implemented by insurance companies for a variety of life and health products. In fact, some producers have told me that their **approach was modeled** after certain requirements in their Medicare Advantage marketing.

What this means is that **most agents will continue to employ** what they and their customers have come to rely on—**personal service (the “sit-down” app)**—for a long, long time, in fact, probably forever. **But electronic and telephone selling** does offer a **continuum to producers** who would like to sell in a different way. As the **culture of the internet and e-mail** coincides with a

growing demographic of baby boomers who are **reliant on and “tuned-in” to the computer world**, Sam’s suggestions are worthwhile considering, at this stage in your selling efforts. **Thanks again, Sam.**

Now, have you ever put off something you didn’t really want to do?

That’s the way I feel about the rest of the letter, and something I had said I wouldn’t do—to **try and figure out where the health care debates are going** and what really to say until something concrete has developed. But, **I have no choice**, because all of the rancor and angst currently generated has much of its’ foundation in our business—Medicare and various “solutions” to the benefits, costs, and interpretations of how best to deliver it—and the **sale of Medicare related products**. **To not summarize** some of it would mean I am ignoring your needs for updates, as if you don’t get enough of it through the media.

We all, someplace in our lives have seen pictures of **giant balls of string** that someone has collected over the years. **That’s what we have with health care**. But as you unroll or unravel the ball, **Medicare strings** are on the outside, the middle, and way down deep in the inside. So unraveling forty-four years of Medicare health care takes a great deal of work. **It is an understatement to say that every player is being represented at the unraveling table**, with **millions being spent** by lobbyists, protagonists, and antagonists, and politicians each pretending they have the best way to unravel things and **create a new ball of string**.

I sit in a position of being an **“agonist”—this is driving me nuttier**. I question why it takes **thousand page bills to accomplish things in Washington anymore**, and as complicated as lawmakers make things, the general public is left to decipher for themselves what the media reports, which is generally tainted, slanted, or “Yellow.” If five different bills will eventually be submitted, each containing roughly a thousand pages, that should total out somewhere around five thousand pages, which the **public cannot read**, and **Congressmen will not read**.

My own collection of ongoing events in the health care “reform” discussion totals three reams of paper, or **roughly 1,500 pages**, most of which I cannot (and do not have the time or interest) to read beyond the headline and searching for a few paragraphs of value.

There are some generalizations, which bother me, and which I feel **should be emphasized to you**. Let’s tackle ‘em.

First there is the “quality, affordable health care” chant, which escapes the mouth of every politician. This is an **oxymoron, or perhaps just a moron**. We never have had, nor will we ever have, **both in the same sentence**. **“Quality”**

is pretty much what we have in America, but delivery of it to all our people is where the cheese begins to bind. So, delivery systems become the problem, and that's what we need to correct. "**Affordable**" only means for someone else. If you, or I or someone in our family needs "quality care" we pretty much expect it and it is "affordable." If someone else needs or wants it, the cost of quality care is too expensive. So, again, lawmakers wrestle with a delivery method, and some of their ideas (**comparative effectiveness**, which we discussed in the **May 29 issue of the NAMSA Newsletter**, comes to mind) seem to have created an aura of distrust and subterfuge.

(In regard to "comparative effectiveness," **it is already underway** with a \$1.1 billion appropriation to "Comparative Effectiveness Research" **to study** "clinical outcomes, effectiveness, and appropriateness" of medical treatment and therapies." The problem lies in the **perception of the issue—is it going to be a valuable tool in reducing health care costs—or is it going to be used to ration care to older people, and create a system of "triage" in our country?**)

Secondly, I am tired of hearing the recently invoked **buzzword "transparency" uttered by nearly everyone**. Transparency is far from what politicians are offering in this ongoing mayhem, with **everyone asking for it, and literally no one producing it**. Except for those who insist they have all the answers, there is no transparency in thousand page bills. There was a saying introduced in the '90s which went, "**trust, but verify**". That is not possible in this debate, which makes the American public a bunch of "**optimistic skeptics**."

Third, we have heard a lot about a resurfacing of "**racial profiling**" in the news lately. But, we are **subjected to some strange profiling** of a different nature.

First among those "profilings" are "**the big insurance companies**," continually being **admonished as a mantra to be assumed and accepted**. There are big insurance companies, there are medium insurance companies, and there small insurance companies, some of which play a role in health care, and most of which do not even represent health care. Let's assume the target is health insurance companies. Just because something is "big" does not mean it is bad, and "**broad-brushing the insurance industry as being bad because it is big is nonsense**". It is nonsense that we in the industry have come to expect from politicians and the media, but that doesn't make it any easier for the public to understand. "Big insurance companies" **should not be considered as a given monster** in a part of this debate. True, there are plenty of problems that can be directed at health insurance companies, and solutions should be offered to correct those inequities, but **to broadbrush the industry as the problem is "stupid"**. Consider first, that the combined Blue Cross Blue Shield Association reckons it has about half of America's health insurance market in force, then consider that the association breaks down to nearly sixty different companies, and the "**big company syndrome**" **loses all credence, and should**.

Next among the “profiling” is “Medicare Advantage” profiling, in which politicians **keep repeating a “\$177 billion savings”** over the next ten years. How does that figure become static, how was it developed, what is the real truth in that number, and how can anybody protect, defend and project it as a **sacred, magical number?** The supposed answer is **in “cutting back Medicare Advantage,”** a phrase which the President started using in his campaign, and has stuck by ever since, and **every politician drags out** when constituents ask about “cost-cutting.”

Here’s my problem with that worn out answer. Medicare Advantage covers about 12 million Americans—somewhere around **10 million on HMO and PPO Plans**, and a little over **2 million on PFFS plans**, many of which are going to be modified to PPO plans within a few years due to MIPPA 2008. And where will the savings come from? Well, they say, **Medicare Advantage overpayments.** Oh. So, what is going to be cut, **HMO/PPO plans or PFFS plans?** Few Medicare recipients know or care what kind of MA plan they are on, they just know they have “Medicare Advantage.” And, I’m sorry to say, **few politicians seem to know anything about the differences in the various MA plans either.** They have simply been told “We’re gonna cut Medicare Advantage.” OK. So do you suppose they know that most people who opt for MA are **by and large low-income households?** Do they know that about 8 million of them **are “duel eligibles,” on both Medicare and Medicaid?** Do they really believe that cutting Medicare and Medicaid costs are possible when **government advertises** for more people to **take advantage of Medicaid qualification programs**, including “Extra Help” with Part D, which is, in itself, so confusing and expensive that a partial overhaul of it is underway? I think the pols will hear a lot of **“Don’t touch my Medicare Advantage”** as well as **“Don’t touch my Medicare”** when they encounter the August recess. Some vacation. I believe they’d rather sign up for some **research project in the Antarctic** this time of year.

Another type of profiling is “professional profiling,” wherein **all doctors and hospitals** are thrown into the same group. “We’re going to **cut doctors who continually provide bad service**, and **reward those** that continually provide good service.” Yeah. Uh-huh. That will be easy to ascertain. Cut and dried. No problemo! How about addressing a real problem with doctors? **That of primary care physicians, who have continually been underpaid** (in relation to specialists) and who are at the foundation of all medical care? This problem has led to a serious **undersupply of primary care physicians** in the US currently, and has **caused Medical students to shun** the private primary care practice, and seek the comfort of specialty care, where then make more money and work fewer and more consistent hours. Here’s a novel idea—**pay the student loan obligations of primary care physicians to encourage greater numbers of them**—forty million baby boomers are going to be thankful. The idea isn’t mine, and versions of it are actually being considered.

The same is true for hospitals. “We’ve going to fine or cut payments to the under-performers.” Well, there’s a little problem here too. Admittedly, several mistakes occur, particularly in operating rooms, and with medications and blood clots, etc., but most of what is being bandied about ***relates to “readmissions,”*** which we also discussed several issues ago in the NAMS Newsletter. However, with the current system, ***most hospitals are not really responsible*** for their patients after they are dismissed, so who’s to blame? Obviously, the ***“under-performers.”*** Yeah, again. Easy to calculate.

At this time, it behooves me to say that sometimes the answer is right under our noses. And it is a solution that is gaining steam rapidly. American medical care is being transformed in several states—and even in a Medicare study—to determine the value of what are called ***“Medical Homes.”*** We will have a ***major feature on Medical Homes soon in the newsletter,*** because ***they are truly a step forward in American medicine,*** but for now, let’s apply them to the issue at hand. Medical Homes, or ***“Patient Centered Medical Homes (PCMH)”*** as they are called, provide for the ***follow-up care*** of Physicians and Nurses ***after patient releases,*** in addition to tending to the needs of “chronic care patients.” The professional staff deals with maybe 200 patients at a time, and the ***coordinated follow-up care reduces readmissions of people,*** and the families of those people, who were generally left to figure things out for themselves. As I said, we will have a major feature on our updating and ***“continuing education” segment*** in the next issue. In the meantime, I am bewildered that Medicare has chosen a ***three-year “study”*** of this concept, ***when it is already being proven to work.*** I would guess that the delay is somehow tied to ***Medicare reimbursement plans*** for this somewhat new and unique health care delivery system.

Finally, in consideration of the fact that I can’t cover everything, and am feeling somewhat ill over what I have discussed, I want to ***mention an important item*** that seems to be missing from most of the discussion.

During the President’s national television news conference on the health care issue on July 22, ***no mention was made regarding the issue of getting a handle on the Medical Malpractice reforms.*** Nor have I read about that in more than a few “epistles.” I wonder why. Over the past few weeks I have talked to a couple of doctors, personal friends, (one a government doctor in the VA system, and one a retired GP) in casual conversations and asked them how they viewed the situation, and what they considered needed to be done. ***Both mentioned the cost of maintaining an office, filling in endless repetitive paperwork, and the cost of Medical Malpractice insurance.*** The VA doctor felt he had pretty much been forced into the government system ***because he couldn’t live with demands of a single general practice anymore.*** He cited some rather disenchanting info on ***malpractice,*** and in fact, started his conversation with “If I do something wrong, then I expect my patient to have redress to genuine and honest mistakes.” So, ***he was not in any way hostile to***

the issue of honest malpractice compensation. But, he indicated the chances of malpractice awards (he said most cases are settled outside of court, and that he had only had a few cases in 20 years as a private general practitioner) **growing after a jury receives them, and a lawyer has exacted his cut, are a major problem for medicine in America.** I opined that even a small hospital probably has a \$10 million malpractice premium. He didn't know about that, but guessed it would be pretty substantial.

Which brings me to a point. **I do not know if any of the bills** presented at this point (except for one) **reference some kind of a limit to malpractice awards,** but you can bet it is on the minds of providers. **The one bill I refer to as the exception, was crafted (drafted) by House Rep. Tom Price, a Republican from Georgia, and himself a physician.** Now there's a **novel refreshment—a doctor who can bring some knowledgeable experience to the table.**

According to an Associated Press article last week, Rep. Price's "GOP bill would take on medical malpractice, **limiting jury award for pain and suffering,** and **creating new health courts** in which a specially trained judge would hear and decide cases involving medical negligence."

As a note of interest, **the American public will be hearing more from this man,** he is particularly well spoken, and well-spoken of, and his ideas need to be heard. He also **has an ear to the opinions of the Medicare Supplement industry,** through a personal friend of his. We should be so lucky.

I only have time for a **few more tidbits**—some related to the debates, and some not—either way, you may find an interest in the following:

- 1) **Medical co-ops** seem to be gaining steam in the issue. Some already exist, but if you have information on how they can help our delivery system I would like to know. I don't understand how they would work and how they help provide a solution. If you have something to say, please contact me at: RonIverson@guardingyourgold.com
- 2) Some have said to model a national program after the **Mass. Model.** With that particular plan suffering from "overcosts," I'm skeptical.
- 3) One great problem for Medicare is the **issue of chronic care patients,** wherein, it is estimated that nearly **50% of Medicare costs** are directed. I would think that Medical Homes are a solution to at least a part of that.
- 4) **Medical tourism** is a relevant issue. We have discussed it in a previous newsletter. If the "boogyman" insurance companies are finding it suitable for patients who want to do it, why would Medicare not adopt the option?
- 5) How are reports of **increasing obesity** among children and middle-age adults going to affect health care in general, and Medicare in particular, in the not-too-distant future? **Do wellness programs really work,** and why

- do doctors say they are tired of trying to get overweight (undertall) people to pay attention to what they say in regard to their weight and health?
- 6) In case you didn't hear, **Medicare turned 44 last week**. It has worked well so far, considering benefits for the 65+ and early disabled, but the **financial toll on taxpayers is showing in scary ways**. Obviously, that has become a major talking point in the debates.
 - 7) **The "Class Act"** offered by **Ted Kennedy** in Senate Bill No. 697 **is bad legislation**. It would allow for people to buy into \$50 per day Long Term Care Government Insurance program. There is great consternation among LTC producers **because \$50 per day creates a false sense of security for buyers**, especially when even \$150 today won't get the job done in most areas. **Beware of this one**—camel's nose under the tent.

As I said, there is much more involved in the speculation of all the bills, which now won't be officially addressed (shuffled and reshuffled) **until about Sept 15**. Until then, as the waiter at your favorite restaurant says, **"Enjoy."** But don't hold your breath on any of the issues **making it to the table for a couple of months**.

Above all, please send me any comments you can offer. I like to hear from our members, so e-mail me at the address cited above.

In the meantime, ponder the following light-hearted items a little bit. Just proving once again that **we don't have to be so danged serious all the time**.

- 1) **A calendar's days are numbered.**
- 2) **A boiled egg is hard to beat.**
- 3) **Two hydrogen atoms meet. One says, "I've lost my electron." The other says, "Are you sure?" The first replies, "Yes, I'm positive."**
- 4) **Rejected Children's Book titles:**
 - A) **"Strangers Have The Best Candy"**
 - B) **"The Kid's Guide to Hitchhiking"**

Ok, maybe a little lame.

Anyway, **we need more members**, so tell your friends, and let them know what they are missing out on in the NAMSAs Newsletter, and other benefits, which we will be growing. As we mentioned a few weeks ago, we will be **changing some of our membership qualifications** starting around the beginning of the school year—Sept. 1.

Gear up for your production to get on fire during the fall of '09. Also, I would like to ***solicit ideas from you and your production secrets for sharing*** with other members. I have received some ***very interesting "testimonials"*** about what being in this business means to agents, and would like to hear yours.

My best,

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