

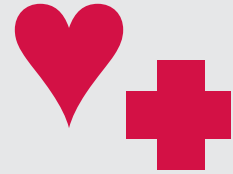
Life & Health Insurance Advisor

PO Box 12342
Scottsdale, AZ 85267



480.443.3249 • 866.655.4637
www.GaryInsuranceGroup.com

Our Passion is to make a positive difference in our client's lives



Medical Insurance

July 2010

Volume 3 • Number 7

Take Advantage of Your Disease Management Benefits!



Treatment of chronic diseases accounts for an estimated 75 percent of healthcare expenditures in the U.S. They are also the leading causes of death and disability. Disease management programs aim to help individuals control their chronic conditions, reducing treatment costs and improving quality of life.

Consider the following statistics:

- * 7 out of 10 deaths among Americans each year are from chronic diseases.
- * In 2005, 133 million Americans—almost 1 out of every 2 adults—had at least one chronic illness.
- * About one-fourth of people with chronic conditions have one or more daily activity limitations. (Source: Centers for Disease Control)

Individuals with chronic disease use more healthcare services and use them more frequently than those without chronic conditions. If you or a family member have a chronic illness, a disease management program might help you get your health

condition—and expenses—under control.

What are chronic diseases?

A “chronic disease” is one that can be treated but not cured, one that lasts more than six months, or one that recurs. Common chronic diseases include heart disease, diabetes and asthma.

According to the Robert Wood Johnson Foundation, “Because the health care system is not designed to meet the needs of people with chronic conditions, their care is not coordinated, which leads to unnecessary service use. Individuals often receive conflicting advice from different providers, report difficulty accessing services and have difficulty paying out-of-pocket for health care. As a result, people

with chronic conditions rely on others for financial support and personal assistance.”

A disease management program will help individuals identify chronic conditions or their risk factors, develop appropriate treatment or prevention plans and then help people comply with their treatment plans. In short, disease management programs help people learn to take better care of themselves. They usually involve a combination of nurse counseling, behavior modification programs, communications, support and involvement by the participant’s physician.

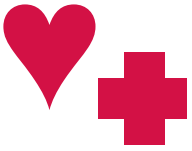
America’s Health Insurance Plans, an insurer trade organization, says, “There’s strong evidence that health plans’ disease management programs pay off for participating patients: In

This Just In...

The percentage of workers who say they are very confident about having enough money to pay for their basic expenses in retirement has rebounded slightly, from 25 percent in 2009 to 29 percent in 2010. The Employee Benefit Research Institute’s annual Retirement Confidence Survey also found the share of workers very confident of having enough money to pay for medical expenses (12 percent) and long-term care expenses (10 percent) in retirement remains stable.

Meanwhile, the share of workers “not too” or “not at all” confident about being able to cover these expenses has continued to rise. Fifty-one percent now say they are not confident about having enough money to pay for medical expenses, compared with 43 percent in 2008 and 44 percent in 2009, and 61 percent are not confident about paying for long-term care expenses, compared with 54 percent in 2008 and 56 percent in 2009.

Among those already retired, the percentages saying they are very confident about having enough money for basic expenses (33 percent), medical expenses (23 percent), and long-term care expenses (13 percent) are statistically unchanged from last year.



Health Reform and Medicare

In April, the independent Office of the Actuary released a statement saying: "... the Affordable Care Act will...strengthen Medicare by cracking down on waste, fraud and abuse, modernizing payment systems and improving benefits by providing free preventive services, supporting innovations that help control chronic disease and closing the prescription drug "donut hole." The Actuaries also find that under the new law, the life of the Medicare trust fund is extended by 12 years while reducing annual Medicare premiums by nearly \$200 per senior in the coming years."

That's the official view. What will the new healthcare reform law really mean for your Medicare coverage?

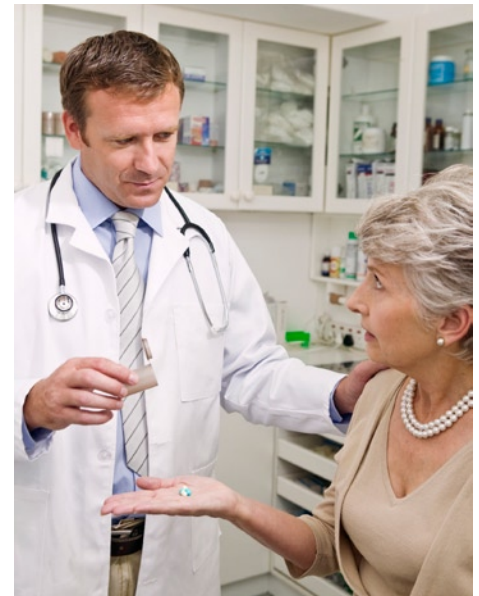
The healthcare reform law explicitly states that no reductions in Medicare guaranteed benefits will be made and that any savings generated for the Medicare program will extend Medicare solvency, reduce Medicare premiums and cost-sharing for beneficiaries, improve or expand Medicare guaranteed benefits, and preserve access to Medicare health care providers.

Starting in 2011, Medicare beneficiaries

will receive all Medicare preventive services, such as annual wellness visits and screenings for colon, prostate and breast cancer, at no cost. The bill does not contain cuts to traditional Medicare benefits. Of course, this means premiums will likely increase.

Medicare Advantage plans likely to see biggest benefit changes

Those with Medicare Advantage plans could see the most changes. Nearly one-quarter (24 percent) of Medicare beneficiaries are enrolled in Medicare Advantage plans, according to the Kaiser Family Foun-



REFORM—continued on Page 3

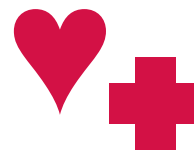
If you are currently enrolled in a Medicare plan, you can make changes to your plan during one of the open enrollment periods:

November 15–December 31
Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage

During this time you can...
Change from Original Medicare to a Medicare Advantage Plan or vice versa.
Switch from one Medicare Advantage Plan to another.
Switch from a Medicare Advantage Plan that doesn't offer drug coverage to one that does.
Switch from a Medicare Advantage Plan that offers drug coverage to one that doesn't.
Join a Medicare Prescription Drug Plan.
Switch from one Medicare Prescription Drug Plan to another.
Drop your Medicare Prescription Drug coverage completely.

January 1–March 31
Open Enrollment Period for Medicare Advantage Plans only. (Note: You can't make any changes to your drug coverage during this period. If you already have drug coverage, you must keep it. If you don't have drug coverage, you can't add it during this period.)

If you have a Medicare Advantage Plan with drug coverage, you can do one of the following:
Switch to a different Medicare Advantage Plan with drug coverage.
Drop your Medicare Advantage Plan, go back to Original Medicare, and join a Medicare Prescription Drug Plan.
If you have a Medicare Advantage Plan without drug coverage, you can do one of the following:
Switch to a different Medicare Advantage Plan that doesn't have drug coverage.
Switch back to Original Medicare.
If you have Original Medicare and a Medicare Prescription Drug Plan, you can join a Medicare Advantage Plan that includes drug coverage.
If you have Original Medicare with no drug coverage, you can join a Medicare Advantage Plan that doesn't include drug coverage.



DISEASE—continued from Page 1

its first year of operation, an asthma management program run by a Florida health plan reduced emergency room visits among members participating in the program by 22 percent—from 18.6 visits per 10,000 to 14.0 visits per 10,000.” The organization cites similar benefits for programs to manage other chronic diseases, from depression to diabetes to back problems.

You’re more likely to find disease management benefits included in employer-sponsored group health plans (because employers want to reduce absenteeism and increase productivity, in addition to controlling

their healthcare costs), health management organization (HMO) plans or Medicare Advantage plans than in individual medical plans. However, some individual medical plans do include disease management benefits, although they might have a different name. Check your plan’s Summary of Benefits. Your plan might cover disease management for specific conditions, such as breast or lung cancer, cardiac conditions or diabetes.

Some individual health plans also provide case management services for complex or catastrophic medical conditions. Your insurer might offer you these services, which

are voluntary for plan members, after you file a claim that meets certain criteria, or upon referral from your doctor. If you think you need a case manager to help you navigate multiple healthcare providers and health benefits, you can also self-refer.

Although your chronic condition, by definition, will never go away, keeping it under control can prevent recurrences and complications, enhance your quality of life and reduce your medical costs.

For more information on the benefits under your health plan, please call us. ■

REFORM — continued from Page 2

ation. When you enroll in Medicare Advantage, you obtain coverage through a private insurer rather than the federal government’s Medicare Program. The Medicare program pays a set amount of money every month to your insurer, which must provide the complete Medicare fee-for-service benefit package (Medicare Parts A and B). Many plans also provide drug benefits (Medicare Part D), along with preventive services not covered under original Medicare. If you have a Medicare Advantage plan, you likely have benefits—such as vision care and preventive services—not covered by traditional Medicare.

The problem is that the federal government pays private insurance companies on average 14 percent more for providing coverage to Medicare Advantage beneficiaries than it would pay for the same beneficiary in the traditional Medicare program. This overpayment is as high as 20 percent in certain parts of the country.

The healthcare reform law restructures the way the federal government will make payments to private Medicare Advantage (MA) plans. The government will begin lowering payments to private plans beginning in 2012. The government links payments to Medicare Advantage plans to benchmarks tied to local spending on traditional Medicare fee-for-service plans. Similar to previous law, under

healthcare reform, a plan that bids below the benchmark would receive a rebate equal to 75 percent of the difference between the bid and the benchmark. The reform law requires the insurer to pass this rebate on to its enrollees in the form of healthcare services not covered by Medicare or reduced cost sharing. Plans that charge more than the benchmark would be required to charge the difference to their enrollees. The Congressional Budget Office estimates this will save Medicare more than \$130 billion over 10 years.

The reform law also creates a quality rating program starting in 2012. Based on a five-star scale, plans that meet the four-star quality of care standard will qualify for quality bonuses.

What does this mean for enrollees? Medicare Advantage plans will no longer be able to use the rebates to subsidize Part B or Part D premiums, and some plan extras—such as free eyeglasses or dental care and other benefits not covered by traditional Medicare—might disappear. Insurers’ costs will likely increase, but how that will affect your premiums will depend on the business decisions your insurer makes.

Part D Drug Benefit Changes

If you have a Medicare Advantage plan, your plan might include prescription drug benefits. Those with traditional Medicare can

buy separate Part D coverage for prescription drugs. The healthcare reform law makes several important changes to the Medicare Part D drug benefit that will affect all Medicare plans.

Starting in 2010, the law provides a \$250 rebate to Medicare beneficiaries who hit the “donut hole.” Most Medicare drug plans have a coverage gap, or “donut hole.” This means that after you and your drug plan have spent a certain amount of money for covered drugs (\$2,830 in 2010), you must pay all subsequent prescription drug costs out-of-pocket. When your out-of-pocket costs reach a specific annual limit (\$4,550 for 2010), you automatically get “catastrophic coverage.” Your yearly deductible, your coinsurance or copayments, and what you pay in the coverage gap all count toward this out-of-pocket limit. Once you reach the out-of-pocket limit, catastrophic coverage assures that you only pay a small coinsurance amount or copayment for the drug for the rest of the year.

Those who hit the donut hole in 2010 qualify for the \$250 rebate. Beginning in 2011, you will also receive a 50 percent discount on prescription drugs once you enter the donut hole. The healthcare reform law completely closes the donut hole by 2020.

For a review of your current Medicare coverage, or for guidance if you’re about to qualify for Medicare, please call us. ■



High-Limit Life Insurance

High net worth individuals and business owners need more life insurance than most people. Definitions vary by insurer, but with most insurers, if you need \$50-65 million or more in insurance, chances are your policy will be considered a “jumbo risk,” with special considerations.

According to “Capacity in the U.S. Life Insurance Market – A View from the Top of the Pyramid” (by Michael DeKoning, *Reinsurance News*, March 2004), “Back in the early ‘90s, jumbo limits typically were in the \$20-25 million range. In the mid to late ‘90s, jumbo limits exploded to \$75 million and even, in limited circumstances, to unlimited amounts.”

Today, however, most insurers limit their high-limit life insurance coverage to somewhere between \$20-\$65 million, depending on the age and health of the insured. How much coverage you apply for determines how the insurer will handle it.

When you buy a high-limit policy, most insurers will not retain all risk themselves. Instead, they retain a portion of the risk, or obligation to pay benefits, and then buy reinsurance to cover the remainder. Reinsurance helps insurers insulate themselves from unexpected losses and maintain solvency.

For most life insurers, when you buy less than \$5-\$10 million in coverage, the insurer will retain the risk itself. The maximum

amount of risk an insurer will carry on a single life is called its “internal retention limit.” When you need higher face amounts, the insurer retains either a percentage of the risk or a specific dollar amount, then cedes the rest to a reinsurer. Insurers can cede a portion of only specific risk or arrange to have a reinsurer pay a portion of any and all losses they cover.

Any reinsurance arrangement between your insurer and a reinsurer will not affect your policy. When you buy coverage from a specific carrier, that carrier will underwrite your policy, handle administration and, when the time comes, pay your claim.

Most reinsurance arrangements will allow an insurer to automatically bind policies up to a certain amount over the internal retention limit without requiring the reinsurer to do its own underwriting. In effect, the reinsurer is allowing your carrier to obligate it to providing a certain amount of reinsurance coverage without oversight. Many insurers have an automatic binding limit as high as \$50-\$65 million.

Once your total insurance needs exceed



that limit, however, the process becomes more complicated. Your policy will be considered a “jumbo risk,” and the reinsurer will want to do its own review of your underwriting file, in addition to the insurer’s review. It will consider not only the policy in question, but all policies in force on the insured, including permanent and universal life, individual and business policies. It also takes into consideration any automatic policy adjustments, such as inflation guard provisions.

If you need jumbo life coverage, you’ll need the services of an experienced agent. The reinsurance market is limited, so “shopping” a large case can flood the market with multiple applications on the same individual and slow the underwriting process.

For information on high-limit life insurance to protect your family or your business, please contact us. We can help you analyze your life insurance needs, both personal and business. ■

Where Does Your Health Insurance Dollar Go?

