Hammett Insurance
SERVICES INC.

Introducing
Access Based
Health Insurance

Use this eBook to Grow Your Client Base & Acquire New BOR's

HOURLY WORK BENEFITS
HWB
RECRUIT RETAIN REWARD

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CHAPTER ONE

Introduction to:

Access Based

Health Insurance Plans?

Access Based Plans

The recent emergence and popularity of **"Access Based"** plans (MEC and MEC Plus Hospital Indemnity Plans) aka (Value Based or Incentive based) among service sector employees (food, nursing home, hotel, agriculture, and retail) have been explosive, particularly after the **Affordable Care Act** became law. Employers who previously did not provide health insurance to working-class employees found that not only were these indemnity style plans affordable, they were more popular than traditional plans, largely due to the elimination of disincentive barriers such as deductibles and coinsurance. Unanticipated was the potential to retain employees with a relatively small budgetary impact, particularly when compared to the high cost of turnover.

What is the practical value to employers? Foremost among the benefits of offering first dollar (Access-based) coverage to hourly employees, is the positive effect that this has on recruitment and retention. In an economy that enjoys almost full employment, this approach offers a compelling reason for service (hourly) employees to stay with that employer, particularly if these benefits increase in direct proportion to the length of employment (escalator clause)

Access Based

Vs.

Disincentive Based

Why are traditional health plans losing favor among most employees? Answer:

Most group health plans are governed by and dependent on *disincentives*, they do still serve an important function and enjoy a certain perception of value, but only for those who need to protect assets (homes, investments, and pensions) this demographic represents about 50% of salaried employees and only around 5% of moderate to low wage hourly workers. This is where the promise of traditional plans begins to fall apart.

Providing a low wage worker with a plan that requires substantial shared expense up front and most tangible benefits pushed to the back end, is of little perceived value to that employee, therefore a rather dubious “benefit of employment”, yet we (brokers and employers) still believe we are providing the *gold standard* in employee benefits and everything else is settling for second best.

CHAPTER TWO

Access Based *Plus*

Self-Funded MEC + Indemnity

Part One - Sample 1st Dollar Indemnity (Excepted Benefit)

Hospital (60 Days Per Year)

Admission Bonus (Additional to Room/Board)

Emergency Room

ICU (2 X Daily Hospital Benefit)

Surgical

Doctor Office (Little out of Pocket)

Lab/Imaging (CAT Scans & MRI)

Accident (Reduces Work Comp Claims)

Prescriptions (Discount & Co-Pay Plans)

Substance/Mental

Skilled Nursing

24/7 Doctor Access (Telephone)

Part Two - Self-Funded Wellness (ACA Required)

Minimum Essential Coverage is the minimum coverage a large employer must offer to at least 95% of its full-time employees to SATISFY the "A" Tax Penalty imposed by ACA (IRC Section 4980H(a) and the minimum coverage most US Citizens must have to satisfy their individual mandate. *It is not major medical or minimum value coverage and as such it will not satisfy the "B" Tax Penalty that may be imposed by ACA (IRC Section 4980H(b) for not offering Affordable Minimum Value Coverage.*

The MEC plan only includes the minimum Preventive coverage required by law as long as services are rendered or performed by an in-network provider.

Sample Pricing

Standard Plan	Employee	Employee + Spouse	Employee + Child(ren)	Family
Part 2 (Self Funded)	$21.65	$54.86	$61.06	$103.34
Part 1 (Indemnity)	$70.50	$152.71	$127.64	$208.67
Combined Premium	$92.15	$207.57	$188.70	$312.01

CHAPTER THREE

Most Common Plans

Designed for but Not Limited to:

Low Wage Hourly

Hourly Worker *Access* Plans

(1) **MEC <u>Only</u>** – This option utilizes self-funding to take advantage of the fewer federal requirement for compliance with ACA, by offering what the government has defined as minimum *preventive care benefits aka minimum essential coverage* (63 preventive and wellness services mandated U.S. Preventive Services Task Force USPSTF).
Cost Range - $50 to $70 pepm
Satisfies - PPACA "A" Requirement ($2,160) AKA the "Sledgehammer"
Satisfies – PPACA "Individual Mandate" by providing MEC
<u>Does Not</u> Satisfy – PPACA "B" Requirement AKA "sledgehammer" for Minimum Value

Opinion – The least cost effective of the pay or play options. These plans are usually loaded with far too much administration (often over 60 percent of the required funding levels) and are not particularly popular among employees, due to limited benefits (preventive and wellness only) Because these plans are considered extremely minimal by those they cover, there is a much higher tendency for qualifying employees to opt out and seek coverage from the exchanges (costing the employer the B tax or $270 per month).

What is Minimum Essential Coverage (MEC)?

Minimum Essential Coverage is the minimum coverage a large employer must offer to at least 95% of its full-time employees to SATISFY the "A" Tax Penalty imposed by ACA (IRC Section 4980H(a) and the minimum coverage most US Citizens must have to satisfy their individual mandate. *It is not major medical or minimum value coverage and as such it will not satisfy the "B" Tax Penalty that may be imposed by ACA (IRC Section 4980H(b) for not offering Affordable Minimum Value Coverage.*

Hourly Worker *Access* Plans

Targeting the low wage hourly work force, most popular solutions

(2) MEC Plus Indemnity – This is a hybrid of the MEC Only approach that adds low cost first dollar benefit coverage to the MEC. Sanctioned by HHS under conditions laid out for these plans (designated as *Excepted Benefit Plans* under ACA). They offer access to basic medical care without deductibles, coinsurance or co-pays, thus making them substantially more popular, particularly for lower wage earners.

Cost Range - $95 to $120 pepm (100 percent paid by employer)

Risk – Minimal, if employer auto enrolls all eligible employees. Likely exposure to *B* tax ($250 per month) has historically been under 5 percent (of eligible employees) likely much less. Note – Auto-enrolled participation precludes Medicaid and other legal waivers and likely will be effect under 70 percent of all eligible employees.
Satisfies - PPACA "*A*" Requirement ($2,160) AKA the "Sledgehammer"
Satisfies – PPACA "Individual Mandate" by providing MEC
Does Not Satisfy – PPACA "B" Requirement for *Minimum Value*

Opinion – Most cost effective of all of the solutions. By including first dollar benefits in this option and contributing 100% of the combined cost (premium and self-funding) the employer can effectively reduce the percentage of employees inclined to apply for subsidized coverage in the exchanges (actual experience shows under 1% opt for exchange coverage). Also, since this approach (MEC Plus Indemnity only) does not prevent high risk employees from going to the exchange, the result is affordable catastrophic options for high risk employees that are far below market rates for an employer sponsored major medical option.

Hourly Worker *Access* Plans

Targeting the low wage hourly work force, most popular solutions

(3) Minimum Value aka MVP Plans – Designed by TPA's, these plans initially provided just barely enough outpatient coverage to meet the safe harbor test for 4980H(b) *Minimum Value*, but because they were designed not to cover any hospital claims and were often coupled with a 9.5% employee payroll deduction, they obviously appealed to the employer looking to comply for the least expense. Furthermore, these plans were designed to discourage employee participation, yet block access to subsidized exchange benefits (rectified in 2015). Due to low risk and low employer contributions, *MV Light and MVP's* plans initially gained significant market share in 2014. That was until they were ruled non-compliant ("Final Notice of Benefit and Payment Parameters for 2016," issued by the Department of Health and Human Services HHS). **After the Nov. 4, 2014** notice, any plans that did not meet the new criteria (include significant hospitalization benefits) will no longer be allowed and all such arrangements will be illegal after 2015. Suddenly this option became much less attractive

Cost Range (New in 2016) - $350 to $500 pepm. Participation will need to be driven by a higher employer contribution and a reduction in the allowable 9.66% (gross monthly income equivalent) employee *shared contribution*.

Risk – The above, employers (and reinsurers) must assume substantial(and arguably unnecessary) hospitalization risk (without limit).
Satisfies - PPACA "*A*" Requirement ($2,000) AKA the "Sledgehammer"
Satisfies – PPACA "Individual Mandate" by providing MEC
Satisfies – PPACA "B" Requirement for Minimum Value **(unnecessary)**

Opinion - Risk is unacceptably high, in our judgement.

CHAPTER FOUR

Compare

Access vs. Bronze

Access Based (MEC) Plan

Compare Value Proposition

Compliant Access Plans Under $100 Month

There is a misconception among many executives, human resources directors, insurance agents/brokers and many employees, that limited benefit programs (MEC + Limited Medical Plan) are inherently less valuable than a **MVP** option with Major Medical.

Although this is certainly true for highly compensated employees, it is often not so for the most hourly workers. Below is comparative evidence demonstrating how limited coverage *MEC plus* programs deliver more relative value than common deductible/coinsurance major medical (when measured in out-of-pocket costs for the most commonly incurred claims)

Exhibit1: Comparing Limited Med with MEC to Bronze Major Medical

Common Claims	(MEC Plus)	PPO Adjusted	Bronze (Major Medical)
Annual Deductibles	No Deductible	N/A	$5720 (average)
% Coinsurance	No Coinsurance	N/A	40% to 20% Of Charges
Annual physical	Plan pays 100%	$250	Plan pays 100%
Colonoscopy	Plan pays 100%	$3000-$10,000	Plan pays 100%
Mammogram	Plan pays 100%	$650-$850	Plan pays 100%
Automobile Accident: Emergency Room X-Rays **Attending physician**	Plan pays 100% up to **$2500** per accident (after $100 deductible)	ER – $1000 X-Rays – $200 Attending – $500	Plan Pays - Nothing and until the deductible is reached.
Routine Childbirth **1 Facility** **2 OB physician charges** **3 Anesthesiology**	Plan pays **$1000** upon admission and **$3000** total for two days. Plan pays an additional **$2500** (OB plus Anesthesia)	$4000 facility $2000 OB $800 Anesthesia **$6800 total**	Plan Pays – Nothing until deductible is reached. Out-of-pocket maximums are around **$6500**
Outpatient Surgery (mole removal)	Plan pays up to $2000	$1500	Plan Pays – Nothing until deductible is reached

Access Based (MEC) Plan

Compare Value Proposition

Exhibit1: Comparing Limited Med with MEC to Bronze Major Medical (continued)

Routine Doctor's Office Visit	Plan pays $75 to $100 (Usually 100% of PPO Discount)	$95	Plan Pays – Nothing until deductible is reached
Prescription drugs	$10/$15 co-pay to $300 per Year	Variable	Plan Pays – Nothing until deductible is reached
Cash for Critical Illness	$10,000 to $20,000 (used to begin treatment until enrolled in a Major Med plan)	N/A	No Supplemental Critical Illness Benefit
Estimated Single Premium	$200	N/A	$450 (age determined)
Employee Cost after Company Contribution	$0.00 ($200 contribution)	N/A	$250 ($200 contribution)
Total Out-Of-Pocket	$3100	N/A	$6500 per Covered Individual
	Advantage		**Disadvantage**

The value of MEC/Indemnity ONLY coverage goes well beyond simply complying with **The Affordable Care Act**, we know that when properly communicated, plans like **MEC Plus** are actually preferred by hourly employees because they provide first dollar coverage for the most common health care expenses. With little or no out of pocket costs to covered members for most routine services, health access is significantly increased.

Changing the conception of value? Employees need to be educated on exactly how to best use the first dollar features of these plans. **Example:** Providing educational videos to be used to introduce all new employees (and even new HR people) to the concept of 1st dollar benefits inherent in MEC Plus. Once an employee understands how to use the plan, the value becomes obvious.

CHAPTER FIVE

Coverage Comparisons

Indemnity Plans vs. Traditional Major Medical

Disincentive Based Plans - Use deductibles, coinsurance and co-payments to restrict access to medical services

Access Based Plans – Waive deductibles, coinsurance and most co-payments for medical services

	*Disincentive Based Plan	**Access Based Plans
Outpatient Services	After $3,750 deductible. You pay - $65 (primary) $85 (specialist)	$100 provided per visit (x10 per year) No deductible With Direct Primary Care (DPC) unlimited
Emergency Services	50% after $3,750 deductible also you pay 10% of ambulance cost	$150 to $5,000 (if cause accident) no deductible
Hospitalization	Up to $500 copayment on admission after ($6,300) deductible then 100%	$3,000 1st Day $1,000 per day to $60,000 per yr. ICU double to $120,000
Maternity & Newborn	First pre-natal visit Free – Delivery: You pay first $3,750 then 10% First post-natal visit is Free	Included in Hospital Surgical with up to $10,000 benefit for 3 day normal delivery (No deductible)
Prescription Drugs	After $225/$450 deductible - tier 1 $15 copay Tier 2 $50 copay tier 3 $75 copay tier 4 30% copay up to $500 per script	$0 Deductible $40 paid to member, regardless of drug cost or tier level. (Includes most generics at no out of pocket cost to member)
Lab & Imaging	You pay $3,750 deductible, then 10%	$75 per test plus up to $500 for MRI/CAT Imaging test
Preventive Wellness	Unlimited No Cost to Member	Unlimited No Cost to Member
Pediatric Services	Preventive services offered once child is added to plan	Automatically covered at birth first 30 days. Must be added to plan thereafter

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Differentiating Factors	Disincentive Based Plan	Access Based Plans
Out of Pocket Limits	$6,850 to $12,700 – For claims incurred in that calendar year. New claim, new year, new out of pocket max.	Not Applicable. Member is not protected against catastrophic claim
Deductible/Co-insurance	$3,750 to $13,600 for that calendar year	No Deductible or Coinsurance
Refund Unused Claims	Possibly negotiated, but in most cases not available	Provided for on Self-Insured MEC component of the plan

CHAPTER SIX

Reducing Turnover *Using* Access Based Health Plans

Cost of Turnover

Example: **Restaurant/Hotels**

Turnover is expensive. Other employees typically have to pick up the slack as managers fill the line positions, which can weaken morale and accelerate the cycle of turnover.

In 2017, the annual employee turnover rate in the restaurants and accommodations sector was a whopping 73%, according to *The United States Bureau of Labor Statistics*

According to a recent study from Cornell's School of Hotel Administration, The cost of losing and replacing one hourly employee can be as high as $5,864. If your restaurant is maintaining a 73% annual employee turnover rate, you're potentially losing $428,072 or more annually as a result.

Escalator Retention Strategy

30 | 60 | 90 Day Onboarding Checklist - Many businesses adopt a 90-day trial period for new employees so the restaurant/hotel and the employee have ample time to decide if their employment is a right fit. A customizable **90| 360 | 720 Day *Escalator Retention* Plan, using Access Based Health Insurance** will help incentivize your new employees' to remain with the restaurant/hotel a significantly longer term.

Access Based Insurance Plans can take any form you would like and are infinitely flexible, these examples below are flexible and affordable and reward the employee who stays:

- **90Days** – Employer provides a 75% contribution to a limited benefit plan (cost to employer approximately $75 pepm)

- **1 Year** – Employer pays either 100% of the health plan, 50% of the family coverage. (cost to employer $100 to $125 pepm)

- **2 Years** – Employer pays either 100% of the single cost for an upgraded plan or 100% for a basic plan on a composite basis (includes employee and family) (cost to employer $200 to $220 pepm)

Key to this strategy: *Constantly remind employee that they are mere months away from a bonus benefit increase*

CHAPTER SEVEN

Marketing 101

Take Advantage of Other Consultants Mistakes

Understanding & Using MEC or MEC Plus Plans

Question?

1) Do the following represent your current or preferred clients/prospects?

- Medium-sized (50 to 1000) hourly employees working 30+ hours per week?
- Over 50% medium to low wages blue collar/service sector employees?
- Service Employers: *Food Services, Hospitality, Agricultural, Nursing Homes*
- Franchise owner groups or single owner multiple franchises?

2) Have you recommended, inherited or been asked to evaluate any partially self-funded MEC/ MVP or Indemnity Plans?

- If Yes to the above - Do you have a sufficient information/experience or access to resources that can help you in your evaluation and consultation?

3) If you are not 100% certain to can assist your client in this area, would you consider using (MEC/MVP Indemnity plan expert or General Agent) particularly for the following?

- Creation of an ***ACA compliant employee recruitment, reward and retention strategy.***
- Evaluation and comparison of client/prospect MEC/MVP/Indemnity Plan?
- Evaluation and comparison of the top competitive MEC/MVP/Indemnity Plans available on the marketplace?

Common Mistakes other Consultants Make in This Market

Would you like to learn a simple strategy to compete for the BOR?

Ask These Questions:

Has Your Consultant Ever Recommended the Following:

1) MEC Only

This approach is most commonly adopted on the advice of your well intentioned (but fee driven) local TPA. While this strategy technically complies with 4980H(a) the so-called "sledgehammer" penalty, it is also administratively bloated and wastes employer contributions on far too many expenses not associated with claims. Why? From our experience with hundreds of actual MEC plans, the 63 Preventive Services (required for a self-funded group to be considered a MEC plan) generate claims that average between $12 to $15 per member per month. ***MEC Only*** plans (we have reviewed) require contributions of $50 to $60 per employee per month. Obviously this *claims ratio* is popular among TPA's, but a terrible value proposition for the end user. We have found that once these numbers are disclosed, it is difficult to support.

NOTE: *For a marginally higher contribution (typically a total of $70 to $90 dollars per member per month) employers can add substantial insurance benefits that both enhance the preventive MEC services (MEC Plus) and make these plans a far greater value per dollar spent.*

Minimum Value

When the penalty is less than the cost of avoiding the penalty, it is best to ignore the problem to begin with

2) MVP (Minimum Value Plans)

As in the ***MEC Only*** example, the mistake is in the honest attempt to avoid certain penalties by adding a level of (mostly unnecessary) risk to your MEC solution. The problem (and mistake) is the assumption that the cost or risk of protecting the employer from exposure to penalty is less than the penalty itself. The so called "Minimum Value" or 4980H(b) penalty was intended to force employers into certain minimum standards for plan design. In reality, these standards are too high and potentially could cost the employer (and/or the reinsurer) far too much in potential claims to justify taking on the risk. This is particularly true when you compare the "worst case scenario" of an employee choosing to apply for a subsidized enrollment in a state or federal exchange (the action that triggers the "B" penalty) to basically ignoring the penalty, which could potentially cost the employer around $266 per month (far less than the cost to avoid the penalty)

NOTE: *Our experience with hundreds of thousands of employees who might voluntarily quit an employer sponsored health plan (even a relatively limited MEC Plus Indemnity benefit) is less than 1%. In other words, not really a tangible threat.*

Under Funding

Contribution is a Far Lesser Cost than Turnover

3) Under Contributing

Many employers are confused by the ACA cost sharing parameters which allow up to 9.66% of the employees monthly gross salary to be passed along to the employee via payroll deduction. Low cost ACA solutions were never considered when this guideline was put into the law.

Through our experience working with low income hourly employees, contributions to health insurance that cost more than $0.20 to $0.25 per hour will dramatically reduce participation in the offered plan. At $70 to $90 per month (for a combined MEC & Indemnity plan) we often successfully convince employers to take on the entire cost of the plan. This accomplishes two important goals (1) You assure the minimum amount of participation required by the offering carrier and (2) You deter employees from choosing to enroll in an exchange plan. As pointed out above, when offered to employees at or below a $0.20 (per hour) cost share, the basic MEC Plus ACA compliant solution will satisfy the larger penalty and garner enough participation to assure carrier approval, while acting as an effective deterrent to employees from seeking subsidized exchange coverage (which could expose the employer to a *B* penalty)

Note: *Employers may have a tendency to want to save money on contribution. We strongly encourage you to advise you client that being "penny wise" is also being "pound foolish" here, as participation is what you want, for all of the recruitment and retention reason stated on the other parts of this report.*

Dialing for Dollars
(The Easy Way)

Here are some relatively easy ways to (A) Meet new employer prospects (B) Rescue them from unnecessary cost and risk and (C) Look smarter than your competitors

The next time you are speaking with a prospect/client, ask the following questions. I guarantee you will pick up one new client for every ten you ask these question of.

1. Does this prospect/client suffer from more than 50% turnover in their hourly workforce?
2. Does this prospect/client employ more than 100 hourly or part-time employees working between, 30 – 40 hours per week?
3. Do they currently offer these hourly workers a limited medical plan, MEC (Minimum Essential Coverage) or MVP (Minimum Value Plan)?
4. Do their MEC plans include a supplementary indemnity benefit? Or are they MEC only? (Note: Try to determine if they pay more than $50 per member per month for a MEC only option)
5. Does their MVP plan have any enrolled employees? If yes, this is a red flag for follow-up
6. Does their MEC plan return unused claims surplus to the employer? Another red flag
7. Has your prospect/client experienced unusually poor administrative service from the carrier or TPA sponsoring their MEC or MVP programs? *Likely you will find that most service has been anywhere from poor to horrible*

Why Ask These Question?

Q – 1. You want to lead with the cost of turnover and the use of structured Access Based benefit strategies to retain, reward and recruit.

Q – 2. You want to identify employers who employ hourly workers and are using *"*skinny options*" to comply with the employer mandate requirement under ACA. If they say no, this begs the question, "what exactly are you doing to comply with ACA employer mandate requirements?"

**Any solution using limited medical or MEC only coverage*

You may also want to determine whether this employer is using a MEC, MEC plus indemnity, or MVP plans. We know, for example, that MVP plans are likely **not necessary and carry with them an unacceptable amount of risk to the employer. This should be an opening for you to discuss eliminating the MVP and retaining a MEC plus replacement.

***The reasoning for this is that fewer than 1% of typical hourly employees exercise their rights to subsidized health plans on the exchange. Simply put, the penalty for not meeting Minimum Value is less than the cost (and potential risk to the employer for high claims) of implementing a Minimum Value solution.*

Q – 3. If your prospect is offering a MEC ONLY option, chances are it is grossly overpriced. Example: Claims typically run no more than $12 to $15 per covered employee per month. Most MEC Only plans charge an exorbitant administrative fee, compared to the actual claims being paid. This is another opportunity to make the incumbent broker look bad and you look good. The strategy here is to replace the MEC only, with a MEC plus insured indemnity for only a few dollars more.

Why Ask These Question?

(Continued)

Q – 4. Many, if not most of the MEC plans that we encounter, do not return unused claims dollars to the employer. Due to the predictability and relatively minimal risk, these plans are almost always overfunded. In some cases, no pre-funding is required, so the employer is required to fund claims on "on-call" basis, this can affect cash flow and is disruptive to budgeting and cash flow.

Q – 5. Focus on Service: Many of the TPAs sponsoring MEC/MVP plans have done an exceedingly poor job of handling billing administration. In some cases, we have found that they do not even answer the phone. Many employers assume that poor service comes with the territory in this market segment, this is absolutely not true and is unacceptable. Often, this simple question, "how has your service been" creates an opening to discuss improvement in the plan as well as provider services.

CHAPTER EIGHT

Existential Threats

Universal Healthcare
Single Payer
Medicare for All

Universal Healthcare

Public/Private Partnership

Make no mistake, universal healthcare reform, in the guise of a public option, whether S*ingle Payer* or *Medicare for All*, is coming, ignore it at your peril agents and brokers. The only question remains, what role will private insurance play in this revolution? Should we simply mimic what other nations do? Regardless of how politicians and reformers romanticize healthcare systems in other countries, certain undeniable truths (and problems) emerge as you put these publicly financed systems under the microscope.

Two-Tiered Healthcare Systems

This is a term commonly used to describe systems that employ a publicly funded universal healthcare plan but allow a role for private insurance (supplementary coverage) Why do we see elements of private insurance in almost all publicly financed systems? The driving force behind the demand for private sector coverage is two-fold and consistently found in all of the countries I researched (exception being Canada, but more on them later)

Examples:

- **Great Britain** – Two tiered, but with the public option paying a greater share of costs than most, resulting in cost overruns and severe access to care problems.
- **France** – So called "top up" which fills the gaps above the 70% to 80% paid by the public option. Note: this is the most expensive public option taking over 10% of Frances GDP

Universal Healthcare

What do Other Countries Do?

- **Australia** – Pure two-tiered with the government actually subsidizing the private plans (they also subsidize prescription drugs) One of the better financial performers.
- **Sweden** – Public/private cooperative. Excellent fiscal performance
- **Germany** – Not strictly two tiered as you must choose between the public option and the private one, not a combined supplemental option.
- **Mexico** – Public option is called Social Security. The country guarantees healthcare for all citizens, but there is a thriving second tier of private health care for those willing to pay.
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- **Sweden** – Public/private cooperative. Excellent fiscal performance
- **Germany** – Not strictly two tiered as you must choose between the public option and the private one, not a combined supplemental option.
- **Mexico** – Public option is called Social Security. The country guarantees healthcare for all citizens, but there is a thriving second tier of private health care for those willing to pay.

Universal Healthcare

Unlikely Event - Private Insurance Outlawed

What if The New Law Prohibits Private Insurance or Private Networks?

In the (highly) unlikely event that Bernie, Liz or Kamala get their way and private health insurance is outlawed, entrepreneurs will spring into action and take a non-insured approach to providing access to healthcare services. How would this look? Check out the current unregulated model used by *faith-based groups* that co-op member contributions to cover members health needs. The last resort would be to simply take it offshore to Mexico, or accessible centers of excellence outside of the US.

In any case, there is simply no reasonably argument against the role of private insurance acting as a supplement to any government scheme or reform plan. What makes *Medicare* so popular and successful is not the government component, but private "medsupp" plans that almost everyone purchases.

The Future is Bright

One could argue, and I have done so in this very forum, that this new role for private insurance and broker/agents is far better than the traditional one. How? With all the catastrophic risk being borne by the government (taxpayers) insurance companies are free to develop creative designs with acceptable and controllable and profitable (underlying) risk. There will certainly be many more carriers interested in the market, creating much more competition and an even a greater role for the professional consultant.

Universal Healthcare

Role of Private Insurance

What is the Role for Private Insurance?

Regardless of the heated political rhetoric, private health insurance is never going away. Every country listed above, along with most nations who employ a primary publicly funded system, have two major problems directly attributable to government sponsored healthcare. These two problems are alleviated to some degree, by employing elements of the private insurance. Shared problems in government sponsored healthcare:

Availability of Providers

Timely Access to Care

Solutions for the above are usually market driven and, except for Canada, generally supported by the politicians and government officials (cynics would say the US is in effect, the second option for Canada). How will this private insurance solution work? I believe that the day after a universal government sponsored health plan goes into effect, private insurance will begin to finance "front of the line" programs using specialty networks, aka Direct Primary Care, Concierge or simply doctors who, in exchange for a monthly guarantee of capitation, will provide quicker access to care. The result? More time and service and entre to privately funded advanced diagnostic equipment (MRI/CAT/PET Scans).

Medicare for All

Not Likely to Happen

Medicare for All has no chance of ever happening. Forget all of the many complicated reasons for this being so, here are the three most compelling ones:

Number 1 - 2/3rds of the US is covered by private insurance (mostly through employers or individual plans) that a large majority (over 70% in recent polls) value and do not want to give up, certainly not for an unproven government scheme dependent on bureaucrats to create and manage.

Number 2 – Believe it or not, the estimated $32 Trillion price tag is NOT #2. At this price, reimbursement to hospitals and doctors will need to be reduced by something close to 40% because that is what Medicare currently uses for its payment formula. Doctors and hospitals can't simply absorb those kinds of pay cuts. Many healthcare facilities, especially those in rural areas, will close their doors, unable to cover their costs under the new payment schedule.

Number 3 – Access to providers. It is estimated that the primary sources of care (facilities and medical professionals) will be reduced by a factor of half in the first ten years after passage of this law. The result will be a healthcare system where everyone has insurance coverage — but not access to care. Proof? Look at wait times in countries with similar systems now in place (Canada and Great Britain)

There are many reasons why Medicare for All is a really bad proposition, but really do you need more than the three above?

New Strategies?
MEC/MVP Conversion Plans

Threats Exist if the Administration (Trump) Chooses to Cease to Enforce ACA Penalties

The survival of private health insurance, will largely depend on (1) Potential elimination of active enforcement of ACA penalties and (2) Unilateral efforts by the President to undermine the law or (3) Bi-partisan action in Congress. Legislative reforms including all new versions went down in flames, however we fully expect reform alternatives to be launched, either on a Federal level or by State (see CA SB 562 *Single Payer* as an example) in the next two years

A brand new term will be introduced to brokers, particularly those who concentrate on service employer clients. This new term will be called **MEC/MVP Conversion Plans** – These will be introduced to any employer who currently sponsors a partially self-funded MEC or MVP plan (aka Skinny Option) They will look and act in the same way and for the same purpose as the formerly ACA compliant MEC/MVP plans but, will remove any self-funding and convert the entire package (including wellness coverage) into a fully insured package. Cost will likely go down for this converted package.

Lack of enforcement cuts both ways, it also opens the door for more creative limited benefits designs, we will be on the lookout for these and others on your behalf.

What Effect Does Mandate (Penalty) Removal Have?

Penalties Are No Longer Necessary to Motivate Employers to Offer Benefits. Why?

We know that there is a critical shortage and high demand for service sector employees willing and able to work for relatively low hourly wages. We also know, that the Trump administration has exacerbated this problem with their immigration policies.

What does this mean to those of us in the group health insurance business, particularly agents who have a large block of service sector clients? It is my belief that even with the removal of employer mandates, most employers will continue to offer limited benefit plans to these employees, why ? Because these workers are hard to find and retain and their competition will if they won't.

What Happens to MEC Plans If Mandates Are Eliminated

It is my belief that carriers and administrators who have previously delivered partially self-funded MEC and *MEC Plus Indemnity* solutions, will simply eliminate the self-funded aspects of the plan (Minimum Essential Coverage) and morph the preventive elements into a fully insured version of the *MEC Plus Plan*, all fully insured. As an added bonus, this new version of a *MEC Plus Plan* will, in all likelihood cost less and deliver higher levels of benefits.

CHAPTER NINE

Plan Sponsors

Carriers and Organizations in This Space

Participating Insurers/TPA's

Insurance Darwinism – Who Will Survive?

There are any number of local and regional TPAs who have taken advantage of the poorly written aspects of the Affordable Care Act. These should be your first target. The following are plans and programs who will likely survive the coming changes but share fatal flaws in design or concept that could be exploited when compared and evaluated

- **Affinity Group Underwriters** – MEC/Indemnity Aggregator
- **Humana** – MEC/Indemnity Large National Carrier – a.k.a. MEC Plus
- **Key Benefits Administrators** (a.k.a. KBA) – Large National TPA (outsource risk)
- **Pan American Life** – MEC/Indemnity/TPA/Reinsurance & Medium Sized National Carrier (Strongest carrier in this market space)
- **Reliance Standard** – MEC/Indemnity Aggregator (Fully Insured MEC)
- **Ternian** – MEC/Indemnity Aggregator
- **Ben-E-Lect** – Regional TPA (outsource risk)
- **FreedomCare** – Tax Benefit Driven Partially Compliant Scheme (not benefit driven) Good conversion target
- **TransAmerica** – MEC/Indemnity Large National Carrier
- **OptiMed** – Smaller national player, located on the East Coast (Florida)
- **WelMec** – Smaller TPA (less than three years old)
- **Capital Administrators** – Regional TPA
- **WH Administrators** – East Coast TPA (Warning Notice Here)

Note: Upon request Hammett Insurance Services will be happy to provide detailed comparisons of these and any other plans (not highlighted here)

CHAPTER TEN

Hammett

Insurance Services Inc.

Our Credentials

William C Hammett
Principal
Hammett Insurance Services Inc. (A California Corporation & Legal Entity)
Consulting Specialties

- National Broker Network Support & Consultation
- Self-Insured PPACA Compliant Health Plans
- Enrollment Strategies
- (Non ACA) Group Limited Medical Plans

Mr. Hammett brings over 39 years of management and sales experience along with a substantial national reputation as a pioneer in commercial limited medical benefits, with emphasis on ACA Compliance and penalty avoidance strategies. With a keen understanding of the needs of direct distributors (brokers & agents) in the low-wage hourly workforce space.

Recently, Mr. Hammett has been called upon by our broker clients to conduct training for employers, the goal being to better understand a very unique compliance and implementation strategy for the Affordable Care Act (Obamacare) using the so-called "MEC" or "Skinny Option" as the platform. Because of Mr. Hammett's record of success and his innovative strategies, many organizations have requested him as a key speaker or trainer. Some of the organizations he has addressed include:

- **California Council of Community Clinics – Key Note**
- **The Leavitt Group (brokers) – Training**
- **Burnham Benefits (brokers) - Training**
- **Arthur J Gallagher (brokers) - Training**
- **NAHU California – CE Credit Presentation**
- **Pan American Life – National Agent Training Conference - Speaker**
- **Louisiana Private Practice Physicians IPA – Key Note**
- **Texas Facility Managers (Nursing Home Association) – Training**
- **Clark County (Las Vegas) Health Underwriters – Speaker**
- **East Coast Consortium of Home Health Agencies – Key Note Speaker**
- **Michigan Grocery Store Owners – Annual Meeting, Key Note Speaker**

In addition to his public appearances, Mr. Hammett has been widely published in such notable national trade publications as **HIU Magazine, California Brokers, and Benefits Selling,** along with numerous local, new, and business journals.

Over a period from 1998 to 2015, Hammett (HMG Benefit Services) facilitated plan enrollment to over 100,000 employees (mostly low to moderate income hourly) and continues (2015 name change to Hammett Insurance Services Inc.) to produce new strategies for the distribution of ever more innovative products to these underserved markets.

Brokers:

Let Us Be Your Silent Partner

William Hammett

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Direct 619-301-7460

Services are 100% FREE with NO Strings Attached

Hammett Insurance SERVICES INC.

HOURLY WORK BENEFITS

HWB

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