INSURANCE SERVICES, INC.
PROTECTING YOUR HEALTH & WEALTH

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INSURANCE SERVICES, INC.
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Greetings to Our Clients and Friends

Happy Easter to those who celebrate! And best wishes for a sunny spring to all of our clients and friends.

We are disappointed to report on the April 1st court-ordered liquidation of Universal Health Care, a St. Petersburg based company serving nearly 150,000 Medicare beneficiaries through its Medicare Advantage (MA) Health Plans. Universal offered MA plans in 18 states and the District of Columbia; and the company had received a Three-year National Committee for Quality Assurance (NCQA) accreditation for its Universal Masterpiece HMO (valid through 2014). While Universal had filed for bankruptcy protection and found a potential buyer, that plan was negated on March 21st when a Leon County, FL judge ruled to close and liquidate the company. Approximately 800 employees of Universal, rated One of the Best Workplaces in Tampa Bay for the past two years, are now without a job.

On a different front, many of my readers know that I make every effort to purchase organic foods produced using humane treatment of animals and trade practices that are fair to local farmers who must compete against the giant agri-business companies that have vertically integrated nearly all aspects of the food production chain. Always, I try to avoid genetically modified foods (GMOs) in my diet, but that is becoming increasingly difficult.

Recently, I became a supporter of a movement hosted online at ProOrganic.org. Funds are needed to finalize the website, which will spread the message and help us organize efforts to put pressure on elected officials to create responsible food policy legislation.

As many are aware, Monsanto (a Fortune 500 company headquartered in St. Louis) has been leading the charge to ban mandatory GMO labeling in the U.S. Labeling would at least inform consumers that the food products they are buying are experimental plants or animals genetically engineered in a laboratory with DNA from other plants, animals and viruses. If GMOs are so safe, why would Monsanto oppose their labeling?

While railing against Monsanto or the Food and Drug Administration is an understandable reaction for consumers who are concerned about food safety, over time it has proven to be ineffective. The new motto is "we have to move beyond opposition towards proposition."

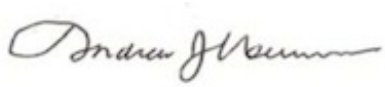
Please support us with your contribution (there is a link to donate at ProOrganic.org).

ARTICLES IN THIS ISSUE:

- **Medicare Advantage (Part C) Program - Is it Doomed?**
- **Health Care Reform Update.**
- **On the lighter side, Jessica Goodman is "checking up from jolly ol' England" where she currently is studying at the University of Nottingham. Jessica provides an interesting update, along with her opinion on how the U.K. health care delivery system compares to our system in the good ol' U.S.A.**

Until next quarter,

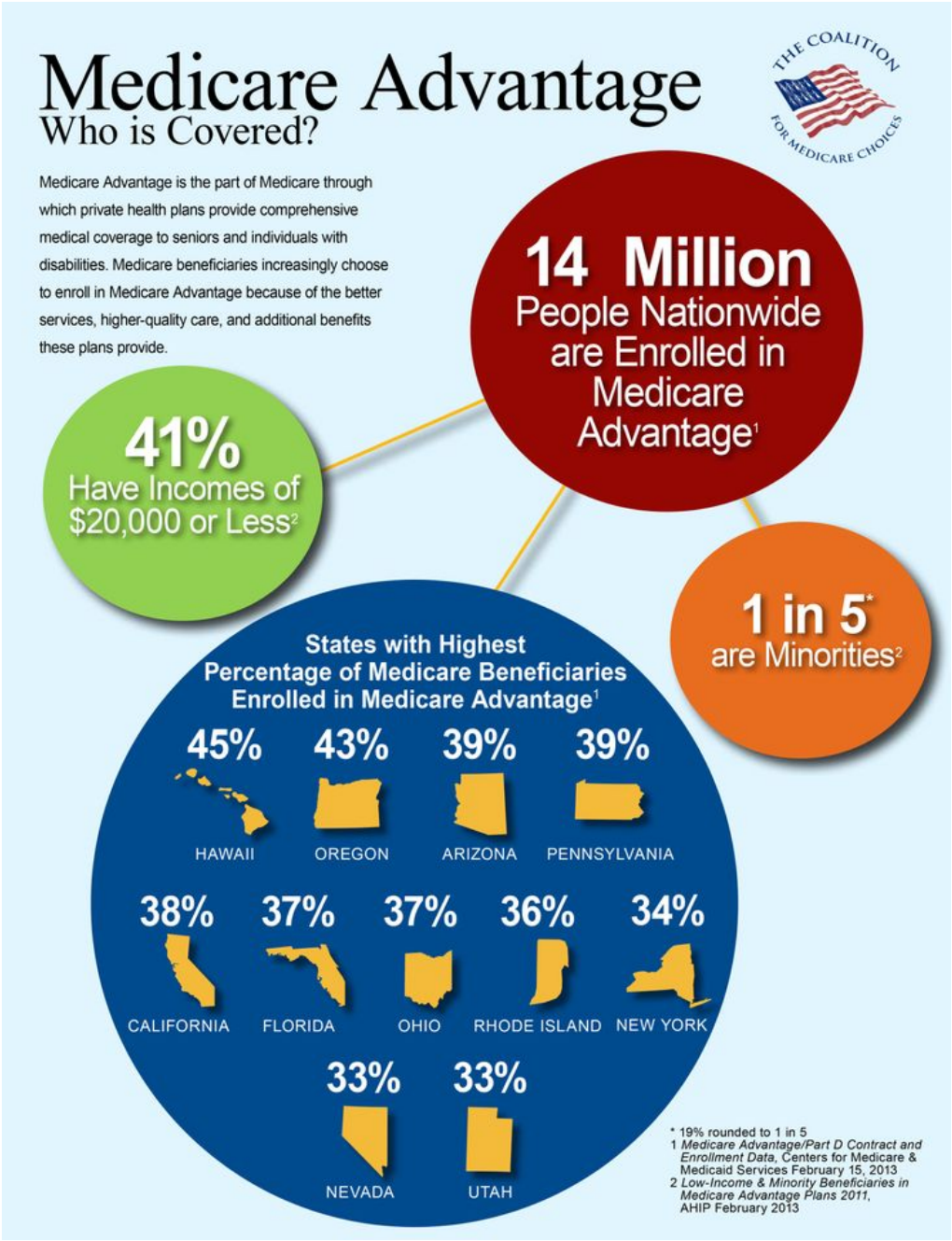
Andrew Herman, President



Quarterly Quotation

"Washington cannot tax and cut Medicare Advantage this much and not expect seniors to be harmed. These changes will disrupt coverage for Medicare Advantage beneficiaries at a time when evidence clearly demonstrates that Medicare Advantage provides higher-quality care than the fee-for-service part of Medicare."

- Karen Ignagni, President of America's Health Insurance Plans
(February 2013 Press Release)



Medicare Advantage (Part C) Program - Is It Doomed?

Proposed 2014 payment cuts would be devastating

In light of recent proposals for 2014 Medicare Advantage (MA) payment cuts, actuaries at Oliver Wyman have assessed the impact of cumulative reductions for MA beneficiaries. This response, commissioned by America's Health Insurance Plans (AHIP), predicts how the decreased reimbursement to Medicare Advantage Organizations will affect MA beneficiary premiums and benefits, and MA enrollments and viability.

With an estimated 6.9% -7.8% decrease in reimbursement to Medicare Advantage Organizations, the actuaries at Oliver Wyman predict negative effects for all Medicare Advantage recipients- to varying degrees.

What factors into this 6.9% - 7.8% decrease for Medicare Advantage Organizations? Beginning in 2014 under the Affordable Care Act (ACA), there will be an annual fee on

the health insurance sector; this extends to private plans participating in public programs- including MA plans. The fee in 2014 will be approximately $8 billion, and will increase steadily until it is almost double in 2018. The National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) is projected to be -2.3% for 2014. Benchmark reimbursement based on per-capita fee-for-service spending is estimated to reduce MA plan payment by a further 2.5%. The Centers for Medicare and Medicaid Services (CMS) has also already reduced payments by approximately 3.41% as a "coding intensity adjustment". This "coding intensity adjustment" is projected to decrease payments by a further 1.5% in 2014. Although some of these drawbacks are offset by bonus payments to Medicare Advantage Organizations for highly-rated plans, there will still be a decrease in payments in 2014, and at a time that medical costs are projected to increase by 3%.

What impact will this decrease have for MA beneficiaries? It is probable that Medicare Advantage Organizations will partially make up for this loss by reducing benefits. It is possible that service areas will be reduced (and possibly even dropped), provider networks will be reduced, and benefits will be more limited.

Furthermore, monthly premiums will have to be raised by between $50 and $90 per member, and there will likely be increased beneficiary cost-sharing. However, the impacts presented by Oliver Wyman are estimated averages; these cuts may impact individuals and people in different locations to varying degrees. It is projected that those with the lowest income and those who utilize the most services will be most adversely affected.

Floridians will be greatly impacted by this change, since many Florida seniors opt for MA plans in lieu of taking original Medicare Parts A & B and an optional standalone Part D Prescription Drug Plan. Oliver Wyman has predicted that due to decreasing values of MA plans, many seniors will choose to return to traditional Medicare plans; and that those enrolling for the first time in 2014 will be less likely to opt for MA plans.

While the Medicare Part C program appears to be in jeopardy, I remain hopeful that cooler heads will prevail and prevent these dramatic cuts from taking place.

For more information, click on the following links:

- February 2013 Oliver Wyman Report
- AH Insurance Services March 24th Blog Post - Will CMS Reconsider 2014 Payment Cuts to Medicare Advantage?

Health Care Reform Update

Regulatory Guidance Has Been Released by Dept. of Health and Human Services

During the first quarter of this year, the Department of Health and Human Services

(HHS) and other federal agencies released several regulations containing details critical to the implementation of the health care reform law. Highlights include:

Proposed rule on health insurance tax

One provision of the health reform law that is particularly important to the health insurance industry is the premium tax - also known as the health insurance tax or the health insurance providers fee. The tax will be assessed as a lump sum to the insurance industry: $8 billion in 2014, rising to $14.3 billion by 2018, and indexed to premium growth after that. Each year's premium tax bill will be divvied up among insurers, generally according to market share. The proposed rule confirms that the annual fee is not tax-deductible.

Final rule on essential health benefits, actuarial value and accreditation

The health reform law requires that health plans in the individual and small-group markets include a core package of essential benefits and services. The final rule lists the "benchmark" plans for each state, the District of Columbia and all U.S. territories, which are generally based on one of the state's three largest small-group plans. If states want to mandate additional benefits, they may, but they must pay for them. Also, plans must cover at least one drug per category and class - and more, if the benchmark plan contains more. The final rule applies to policy years beginning on or after January 1, 2014.

Final rule on market reforms and rate review

The health reform law says insurers cannot charge higher rates based on health, gender or occupation. However, rates may vary based on age and tobacco use, and this regulation finalizes details on how. Tobacco users, for instance, can be charged 50 percent more than non-users, but the rule gives an exemption for those who are participating in a cessation program. The final rule also includes updates to the rate review program standards, and requires the reporting of all rate increases beginning in 2014.

Final notice of benefit and payment parameters

This is a highly technical set of final rules, nearly 400 pages long, focusing primarily on the 3 Rs - risk adjustment, reinsurance and risk corridors - as well as federally facilitated exchange rules and medical loss ratio refinements. Together, the 3 Rs are intended to stabilize and support health plan premiums as the insurance market adjusts to the host of new requirements under the health reform law, including having to provide coverage to all regardless of health experience and limiting the ability to vary rates based on health and risk profiles. The rules also lay out fees to be assessed on health plans to finance the federally facilitated exchanges, the three-year temporary reinsurance program and the permanent risk adjustment program. Of interest, HHS outlines that the reinsurance program fee will be $5.25 per enrollee per month, and that the federally facilitated exchanges can charge participating health plans a user fee of up to 3.5 percent.

Proposed rule on the Small Business Health Options Program (SHOP)

The health reform law requires states to establish a Small Business Health Options Program, or SHOP exchange, to help small employers and their workers obtain qualified health coverage beginning in 2014. The rule proposes changes to the special

enrollment periods within the SHOP exchanges, along with a transitional policy regarding employees' choice of qualified health plans. The rule also proposes to delay until 2015 the requirement that federally facilitated SHOP exchanges provide employers with a monthly bill identifying the employer and employee contributions, as well as the total amount that is due to the qualified health plan from the employer. The proposed rule allows for a 30-day comment period.

Final rule on the Multi-State Plan Program

The Office of Personnel Management (OPM) recently released a final rule for the health reform law's Multi-State Plan Program (MSPP). The law directs OPM to contract with health insurers to offer at least two multi-state plans on the exchanges beginning in 2014 (at least one of which must be for-profit and another not-for-profit). The rule sets standards for the MSPP, with OPM determining which health plans are qualified to become multi-state plans offered on the exchanges.

We will keep you posted about the new health insurance exchanges, as further information becomes available this year.

Update from Jessica Goodman at the University of Nottingham

Dear readers,

I am now checking up from jolly ol' England, where I am spending a semester abroad at the University of Nottingham. I am taking classes in Philosophy of Mind, Philosophy of Religion, Underwater Archaeology, Introduction to Judaism, and Origins and Rise of Aegean Civilisation (with a "s" instead of a "z"). Classes are fun and challenging simultaneously… and of course stressful. I think the differences in how classes are operated are what I find most stressful. To begin with, the final grades for most of my classes are based on only two things: either one essay and one essay-format exam or two essays. In Underwater Archaeology, the entire class grade is based on one exam. Also, a grade of 70 or above is essentially an A+. I am working hard, doing my best, and can only hope from here that I get good results.

However, I find life here more interesting than the classes. I cannot count how many times I almost got run over the first week I was here in Nottingham because I looked the wrong way to see if cars were coming. Whenever I drive somewhere with anyone else, I feel like I should be driving, sitting on the left side. My new friends found it ridiculous how excited I was the first time I sat on the top of a double-decker bus. Most people in the U.S. drive to the supermarket for groceries; I and most other people I've met walk there. Transportation is amazing here; bus routes seem to go everywhere, and one can travel (fairly inexpensively) almost anywhere in England by train. I find it quite amusing when my friends mention how far one place is from another, and I point out that my state is bigger than their country.

I have not yet travelled anywhere outside of Nottinghamshire, but soon will. I will soon visit a friend who lives near Birmingham, and together, she and I will hopefully also go to Cardiff and/or York. I also intend to go to London, Paris, and maybe Madrid after exams end.

Favorite things about England: public transportation, tea selections, accessibility of stores, accents, lack of poisonous animals, more affordable Nutella, socialized medicine

Least favorite things: differences in spelling, unpredictable weather, lack of good Mexican food, dollar-to-pound exchange rate, confusing word switches

One of the things I do like about the U.K. is the fact that it has socialized medicine (although only being here for a few months, I cannot take advantage of it). Universal healthcare is a very controversial issue in the United States, but having been here for two months now, I do not find it nearly as bad as many think it to be. Regarding standard doctor's appointments, nobody I have met has ever had a problem getting one. From what my friends say, necessary operations are not wait-listed; they take priority and are done as soon as possible. In general, it seems good that people get treatment without deductibles, and can get prescription medications either for free or for small fixed fees. One need not worry about whether or not a doctor is in-network. I personally find it logical and preferable to our current healthcare situation with a multitude of insurance companies and private doctors.

I hope to be able to give another update at the conclusion of my trip!

Sincerely,

Jessica Goodman
Guest writer, AH Insurance Services

If you have any questions for Jessica, you may email her here.