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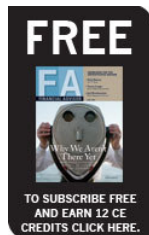
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May 2008



The Inconvenient Truth About Health Insurance
By David J. Drucker

Most of us have heard the story: In December 2007, 17-year-old Natalie Sarkisyan died just hours after CIGNA reversed its decision not to pay for a liver transplant that Sarkisyan's doctors said the girl needed.

It's difficult to hear stories like hers and not wonder if your own health carrier would render a similar decision on your behalf—or that of your clients. Dr. Steven Podnos is both a doctor and a CFP and, as the owner of Florida-based Wealth Care LLC who has also spent 17 years practicing pulmonary medicine, Podnos has insights into this phenomenon that the average financial advisor lacks: "There is no Cadillac coverage anymore. I tell clients to stick with big, known-name companies, although that doesn't ensure they won't run into trouble."

Confirming a systemic problem the rest of us only speculate about, Podnos suggests health insurance carriers are always looking for a way out. "[Denying routine claims], the insurer will say you were sent to the wrong lab, or you didn't get preapproval, or, if your doctor prescribes a certain drug different from the norm for a given condition, the insurer will only pay for the cheaper alternative—not the medicine your doctor wants you to have."

Compounding the problem of a broken health-care system, many states hinder advisors' attempts to help clients improve their coverage. Believing only licensed brokers can properly advise consumers on health insurance choices, these states make it nearly impossible for nonlicensed advisors to do their job. For example, Sean Sebold—a fee-only NAPFA member—must be licensed in life and health insurance in Illinois to provide fee-only health insurance advice to his Illinois clients. As this business moves further and further away from the sales mentality to build a profession based instead on competence and objectivity, these state requirements become more and more antiquated.

Combining the problems of a falling U.S. health-care system, outdated state regulations and client lifestyle risks we'll discuss later, you've got a potentially gaping hole in the financial planning process. The result is that many otherwise-talented advisors merely pay lip service to their clients' health insurance. Now, I haven't performed an exhaustive investigation to support this statement, but I'll share with you my "proof." First, when I was a Maryland-based, SEC-regulated, comprehensive fee-only advisor from 1981 to 1997, the state insurance commissioner permitted me to take an exam to achieve "health advisor" status that was so difficult (primarily because of arcane, whole-life insurance-related questions) as to be anti-competitive. (Let's just say the CFP curriculum's role in preparing one for such an exam would be next to useless.) Second—and here's a little insight

into the journalism process—when I e-mail planner organizations looking for knowledgeable advisors to serve as sources for stories like this, I sometimes get almost no responses because advisors fear exposing the deficiencies in their service offering.

As if the problems noted thus far aren't enough, many health-licensed financial advisors don't even sell health insurance; so they're not in the trenches with their clients dealing with insurers' frequent claim denials. Says licensed advisor Adam Sherman, president of Firstrust Financial Resources in Philadelphia, "I've been trained to think risk management first when I'm doing a client analyses, but I don't sell health insurance. I could, but it's very labor-intensive, so we outsource it to other [brokers]."

Health insurance, then, has become one more area of planning that finds itself on a growing list of risks advisors aren't adequately addressing—for whatever reason—in their clients' financial plans. (These pages have addressed two other such risks—property/casualty insurance and ID theft—both of which can be damaging to your client and your practice if you aren't proactive.) The dilemma advisors are faced with is that they must find a way to meet state advisory requirements and do a thorough analysis of their clients' health coverage, and then accept the responsibility for their recommendations. Or they must align themselves with one or more trusted agents to get the job done. Or they must avoid a health insurance review entirely. I fear too many advisors may be taking the last approach.

The question now is what do we do about it? The first step is to remember not only the necessity of having health coverage, but also to remember the many ways that not having it can undermine a financial plan. When a homeowner's policy fails to compensate a client for a devastated home because some peril was uninsured, it can derail his entire financial future. A deficient health plan can have exactly the same effect. For example, "Some clients have lifetime maximums of \$1 million, which is just not enough in today's health-care environment," says Ed Cherry, once a hospital administrator while serving in the military and now a planning associate with Diesslin & Associates Inc. in Fort Worth, Texas.

And lifetime maximums are just the start. How about the risk that an employer will cancel the health insurance it voluntarily provides your retired client? Maybe your client is unaware that his policy no longer covers his 20-something daughter because she's an out-of-state student. Perhaps your client is the main breadwinner—the one with access to employer-provided health insurance—and he gets laid off. Or he isn't aware that his HMO provides little coverage when he travels. The list goes on and on, but these things are only familiar to those advisors who stay on top of the subject—whether or not their compensation structure allows them to be paid for their counsel.

Don Whalen, an advisor with Versailles Financial LLC in Alpharetta, Ga., had a client who was tired of the corporate grind and recently retired at the age of 50. "One year prior," Whalen says, "I insisted he take out a private health insurance plan for him and his family. Even though he didn't know the exact date he would retire, and even though it would mean paying for two policies at the same time, I insisted that doing anything else would be irresponsible. After all, what if—a year later—he had to leave his job to avoid severe health consequences, such as a heart attack? Imagine the precarious situation he would be putting his family in if any of them were to become uninsurable from the time he contemplated leaving until the time he actually flipped the retirement switch?"

The client didn't like the cost of this strategy (Whalen minimized it with an HSA), but he agreed it was the right thing to do. "My client has been retired for a year now and is enjoying every minute of it. I like to think he sleeps well at night knowing that his health-related expenses, though not insignificant, were contained within affordable limits in the event of a catastrophic illness," adds Whalen.

Of course, the greatest risk of all is that a client goes without health insurance altogether. While this may be a relatively rare occurrence among

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typical financial planning clients, it's not unheard of. Does it mean people don't want the insurance, or that they can't afford it? Most likely it is the latter, or at least that's what they think in Oregon. In early March, the state began drawing names from a one-of-a-kind lottery for people who want health insurance and aren't poor enough for Medicaid, but who are too poor to buy their own policy. According to the Oregon Department of Human Services, approximately 600,000 residents (about 15%-20% of the state) meet that definition.

So how did we get into this mess, anyway? "The first thing advisors need to understand," says Podnos, "is that there's been a big shift in the market away from employer-provided health insurance towards individual family insurance, much like the retirement plan portability we now have. Now, the government lets employers essentially give their employees the money to buy their own insurance through tax-favored plans, like health reimbursement accounts."

Most clients will be choosing between HMOs, PPOs and HSAs, say sources, but the role of each is shifting. HMOs and PPOs both came into their own in the 1980s as alternatives to straight indemnity plans. Says Podnos, as recently as five years ago, "most HMOs were very restrictive, employing a 'gatekeeper' physician, a limited panel of referral specialists and a limited drug formulary. Now, when you look at most HMOs, there's often no gatekeeper position and the number of physicians and drugs has expanded, such that there's almost no difference now between HMO and PPOs."

Leon Rousso of Leon Rousso Inc. in Ventura, Calif., a financial advisor and licensed health broker who actually sells the stuff, says that the hospitals and insurance companies are singularly profit-motivated and the consumer is likewise greedy, wanting more and more for his premium dollar, which is another cause of rising health costs. "The main problem is that premiums have gotten out of hand because benefits have been liberalized. When MRIs came out 15 to 20 years ago, they were seldom covered; yet now they are. AIDS was once excluded but now is covered by most plans." In other words, he says, as medicine becomes more technically advanced, making possible more benefits, health-care costs inevitably rise.

How are doctors part of the problem? Those working in hospitals want to be altruistic, but they're operating within profit-motivated institutions. Those outside the hospital may discount their services 20% to 30% to qualify for inclusion in PPO plans, but then they look for ways to make it back, defeating the PPO's attempt to bring down costs. Explains Rousso, "If you get lab tests done, for example, it used to be the doctor would call you with the results, but now they want you to come back to see them in their office again so they can charge you for two office visits."

Obviously, the growing complexity in the U.S. health-care system as it makes careful attention to clients' health needs all the more important. So what does a really thorough analysis of their coverage look like?

Linda Campbell, a senior financial advisor with Budros, Ruhlin & Roe Inc. in Columbus, Ohio, reviews new clients' health insurance when they sign with her and periodically thereafter. "First, we discuss the current health of all family members by asking rather probing questions." Good questions to start the health discussion, says Campbell, are those like, "Have you or your family members been treated for any chronic or recurring condition?" or "Have you or your family members ever been denied coverage?" or "What is the status of the health of your parents and siblings?"

Second, Campbell reviews and summarizes the client's existing health-care coverage, not only to scrutinize routine features like deductibles, exclusions and co-pays, but to highlight the features (or lack thereof) that suggest coverage failures, like the insurance company's ratings and their history of premium increases; the lifetime maximums included in the client's plan; and whether the client's regular prescriptions are covered by the carrier's formulary. She also reviews the client's actual medical expenses incurred in the previous and current years.

Next, she determines the adequacy of the client's current coverage to address his or her family's specific future needs, such as surgeries or special procedures they've been putting off or exposures they might have to familywide health issues. "If it appears their [existing] policy may not be the best fit for them, we typically work with the client's health insurance agent, or a local broker, to look at their options. If both spouses work and have options through their employers, we compare the two to determine the best primary or combined family coverage," says Campbell.

Finally, she says, the analysis comes down to an estimate of net out-of-pocket costs under the various plans—everything else being equal. While decent health coverage is what we all want for clients, the questions and probing conducted along the way ensure that the critical risks have been anticipated and that the coverage chosen truly fits. The questions Campbell asks to uncover those risks include:

- Do you plan to have more children?
- Do you travel overseas frequently?
- Do you spend part of the year in another state or outside of your PPO network?
- Do you plan to move to another state in the near future?

What these questions have in common is that they are about lifestyle, not health—another indication that our industry is moving toward a life planning model. If you don't look at the client as a person and plan for him and his family holistically, you will miss your intended target. By asking revealing questions like these, Campbell may find her client is exposed to the risk of a coverage gap. "Many clients between the ages of 55 and 64 have difficulty obtaining an individual policy if they leave their group coverage due to certain health conditions," she says.

What if the client moves to a different state before Medicare age—a state in which his present carrier doesn't write coverage? Or what if the client doesn't understand the coverage she has and fails to use it efficiently? Campbell recalls one of her clients, a physician, who was filling his prescriptions through his hospital's pharmacy, because he found he spent less, per prescription, than he would paying retail. "However, we discovered he would have paid less over the course of a year, once his prescription deductible was met, had he filled the prescriptions through a network retail pharmacy using his existing health insurance. The client believed he was benefiting from the tax deduction for the prescriptions and, although he did itemize them on his tax return, any deduction was entirely phased out by the AGI limitations."

Can all advisors perform the kind of thorough analysis Campbell's firm does? Yes and no. It depends not just on an advisor's own familiarity with health insurance or on life planning skills, but on business considerations as well, like, "Have I built enough room into my fee schedule to justify spending the time required to do a proper health analysis?"

One way out is to recommend a certain type of health plan—one in which you have complete faith—to most of your clients. Says Rousso, "HSAs are really all advisors need to know about today. They're the HMO/PPO of our time, and they will endure." Rousso explains HSAs this way: "Let's say your health plan is a car, catastrophic insurance is analogous to a long road trip, and an HSA is like a car with just fifth gear. The client has to push the car for a while to get it started since he pays for everything between \$0 and his deductible (first through fourth gears). However, because HSAs have only fifth gear, the car costs you half as much to buy, and, if it stays garaged for ten years, that savings belongs to you. I know people paying \$2,000 per month for health insurance; if I can cut their premiums in half, that's substantial." With an HSA, the client thinks twice about taking that "road trip" since he'll have to push the car part of the way. Instead, he accepts generic instead of brand-name drugs and perhaps takes antibiotics rather than going under the knife.

The question is, do HSAs fit all clients, and most advisors will answer "no." Rousso, however, says he can tailor an HSA to fit almost any client—but that's the subject of another article.

What do the rest of us do who can't give the client's health program the thorough review it demands? We seek qualified outside help, says Marcy Burton, chief marketing officer for Partnervest Financial Group LLC, a company offering broker-dealer, RIA and insurance services to 70 advisors with \$1.5 billion in assets. Burton describes how Partnervest helps its affiliated advisors help their clients: "About 85% to 90% of our advisors are insurance-licensed, and most do comprehensive financial planning, but we don't want them all to be experts in health insurance." Partnervest attracts or partners with a variety of specialists, such as CPAs, employee benefits experts and property-casualty insurance specialists. "We are proponents of a team approach, so if a client comes in with a health issue, the advisor calls the specialist in his geographic area and sits in on that person's presentation."

Ultimately, she says, "There are only maybe three carriers—Healthnet, BCBS and Aetna—that are really involved in the business. You have to trust they're going to follow through, and you have to monitor them constantly." And the best way to do that, says Burton, is to partner with an employee benefits specialist or other trusted professional.

And that, in the end, is what most full-service, conscientious professionals will do. □

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