

Employee health care benefits are one of the largest items on a firm's balance sheet. On the cost-cutting warpath, many a CFO's eyes turn to health insurance premiums. New products continue to emerge to meet this never-ending demand, yet service methods must also improve, especially given that new models of health care coverage call for an informed consumer with fiscal stake in the game.

We believe successful brokers have macro-market expertise applicable to new products, and their full-service philosophy demands complete education down through the client's entire chain of administration.

Two groups in particular—small businesses with fewer than 50 employees and employees with family coverage—are being pushed to the limit. But healthy solutions lie on the horizon.

Health Care Horizons: Product and Service Evolution



A Wholesaler's Perspective

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A Look Back

To understand the current health insurance crisis of skyrocketing costs and a string of double-digit percentage increases, we turn back the pages to the go-go '90s.

While costs were increasing rapidly, several factors kept health care numbers in check. Remember the Clinton health care reform proposal? With the Administration threatening to nationalize health care, carriers kept a tighter lid on pricing jumps. Meanwhile, the economy was flying high. Salaries and profits were up, offsetting the perception of increasing health care costs. The fruitful job market meant employers were forced to attain and pay for the best benefit packages to attract top talent. Employees weren't footing the bill and enjoyed top-tier health benefit packages.

Since the 90s, the economy has taken a dismal dive. The job market has tightened and employees are no longer in the driver's seat regarding benefits. Medical cost inflation is still raging; we've seen a double-digit percentage increase for the past three years, and the business profits that absorbed the increases have evaporated. Even as salaries are down or flat, the average portion employees pay out of pocket has risen sharply since 2000. Many employers need to find sustainable alternatives now, or risk dropping health coverage as a benefit altogether. We are near the breaking point.

HMOs Are Ailing

The health care products seeking to reverse the tide of unbearable cost are Health Reimbursement Arrangements and Health Savings Accounts. We believe this evolution comes as backlash to the past dominance of HMOs.

The original HMO notion was that one physician ought to oversee a person's total health care. The relationship

sounds reasonable, but many people felt pushed around by the HMO system. HMO patients perceived few choices and could not take an active role in their own well-being. But under an HMO, at least everything was covered.

When primary care physicians recommend a \$1,000 procedure, patients might only ask one question: "Is it covered by my co-pay?" What other major purchasing decisions do we make like this? None.

Americans love to comparison shop. Cavalier spending on the patient's part has driven up costs under the HMO and PPO models. The strong legislative push for a patients' bill of rights is further evidence of disdain for HMOs.

Some argue the HMO model is outdated. First-dollar benefits are expensive and difficult to price. The biggest problem, however, is that healthy employees perceive very little benefit from their costly coverage, yet these are the people that every broker and carrier wants to insure to more adequately spread risk over a larger population.

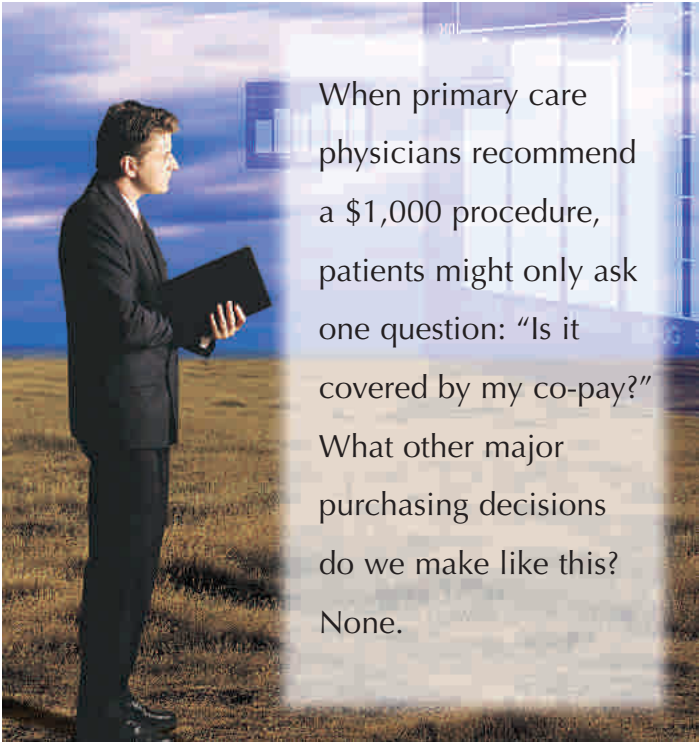
Incentives for the Prudent

The solution is to require some employee skin in the game and encourage active participation in their health maintenance. HRAs have provisions that let employees save their health care dollars. When employees spend less than their full allotment, money can roll over from year to year (or the employer can choose to retain the savings). Preventive care and healthful life choices are financially encouraged. Under an HRA-friendly plan, mindful and healthy employees are rewarded instead of taxed.

Let's review the marketplace as most employers see it today. The typical, extremely costly PPO health plans offered have a low deductible and are loaded with token co-payments (covering doctors' office visits, prescriptions, even emergency room visits). Employees pay virtually nothing at the point of sale. These plans create disengaged consumers who have far less concern for which services are being rendered and how much the services cost. The industry has set up a system where the patients are involved only from a consumption point of view! Under this model, if the insured does not use health care services, they don't perceive any given benefits.

New plans have employers offering a higher-deductible, comprehensive, major-medical PPO plan. These plans usually start with a minimum \$2,000 deductible, 100% co-insurance medical plan, with no doctor's office co-payments. The plans also provide a cash allowance for the first \$1,000 toward medical care, then the second \$1,000 is paid by the employees out of pocket. Above the second \$1,000, the insurer covers all costs.

If the initial \$1,000 is not spent, it can (but is not required to) accumulate and roll over for use in the next year. This structure encourages employees to carefully budget their health care spending, electing for preventative care and regular checkups to stave off major illnesses that will cost them real money. The model also encourages healthful life choices such as smoking cessation, regular exercise and maintaining an ideal weight.



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Ironically, under these new options, the premium savings from switching to a high-deductible health plan can adequately fund the HRA. Premium savings can be upward of 30% off the old-style premium plans, and the new monthly premium for which future renewals will be based is much less as well. It's basic math: 20% of \$7,000 (a sample HRA premium) is a lot less in future years than 20% of \$10,000 (a sample rate of a current PPO plan).

HSAs Take HRAs a Step Further

HSAs differ from HRAs in several important ways.

HRAs are an agreement by the employer to pay claims of the employee up to a set amount. However, the arrangement is essentially a non-funded liability. The employer only needs to come up with funds in the event claims are incurred. As touched on above, the HRA legislation is explicit that the funds need to be exclusively employer money; employees cannot contribute, therefore the employer retains complete ownership of the HRA funds. The HRA legislation does not require rollovers of unused funds although the employer can elect to offer that option. HRA legislation also declares that partners or shareholders of an S-corporation or LLC members (otherwise known as shareholders or partners of the LLC) cannot take the same tax benefits of the HRA provisions that rank-and-file employees can enjoy.

While HRAs do an effective job of treating the symptom (the high initial cost and renewals of present PPO health insurance premiums), they are not an ideal long-term solution. Under an HRA model, because the employee is still spending someone else's money (the employer's instead of the insurance company's), true consumerism is not likely to take hold, nor should we expect any significant behavioral modification.

Compare the HRA source of payment with an HSA, where the employee is accumulating money in his own name, whether he incurs medical claims or not. The HSA stores value, it grows tax-free, is fully portable and can be utilized for expenses not normally covered by an insurance contract (e.g., eyeglasses, dental work, long-term care insurance premiums, etc.) or saved until age 65 and used for retirement, simply taxed as ordinary income. Informed employees will aim for healthy lifestyles and frugal health care consumption patterns to maximize the benefits of an HSA, which can lower cost to the employer and employee drastically.

Industry experts predict that 40 million new HSA accounts will be opened in the next 10 years. HSAs are a popular new product with both employees and employers because of the pre-tax benefits and consumer-driven aspects of the care delivered. Selling an HSA plan can be easy because it appears to be a revolution against the high-cost, low-benefit coverage companies have had as their only option for so long.

Are HSAs working?

As with anything new, there is a learning curve. Additionally, most carriers were slightly delayed in unveiling marketing materials explaining the new legislation, and it took some time for them to release new plan designs that take full advantage of the enhancements in the HSA law. As each month goes by and more marketing materials hit the street, the interest and activity increases and brokers are becoming more comfortable with how to sell and administer the new products. Clearly, people are talking about them, but some brokers may simply be talking about them to differentiate themselves or get a foot in the door, rather than talking about the new plans with the intention to sell!

HSAs are the next step in solving the health care delivery system quagmire, not only by lowering the insured premium portion of the plan costs, but also by bringing the employee into the health care delivery system.

The bottom line is insurance companies will continue to sell first-dollar coverage as long as the marketplace demands it. My concern is that we are on the cusp of a marketplace either not able or willing to buy these high-priced, high-

cost benefits. The industry must establish alternatives to provide to the conscientious consumer. Without affordable private-sector alternatives, we might as well all throw up our arms and start pushing for nationalized health care!

Under HRAs and HSAs, the first-dollar benefits will be paid out of the insured's pocket. If the new plans take off, down the road the industry should see multiple good results: lower health insurance premiums and lower renewal cost increases (because renewal costs are figured on the new lower premiums). Industry participants can only hope the changes will also create a healthier, more-informed American insured population.

What about Administration Headaches?

Third-party administrators are another element of the new cost-effective products. Nationally (in states where the carriers are filed to do business), Assurant Health and Starmark have established cost-effective relationships and seamless electronic data transfer to TPAs to great effect. In Illinois, some carriers are effectively administering it all under one roof.

Destiny Health, a pioneer of the consumer-driven health care model, offers consumer-driven plans exclusively. Its whole portfolio is made up of variations on the fully integrated, consumer-driven model (Destiny has plans for firms from two employees up to several hundred employees). BlueEdge is a new product from Blue Cross/Blue Shield of Illinois (BCBS of IL) for 50-plus-employee groups, and is a fully integrated consumer-driven product.

Can Financial Incentives Alone Curb Medical Inflation?

The answer is an emphatic no. An uninformed consumer is a dangerous creation. In addition to providing financial incentives, a plan must provide members easy access to education about health conditions and treatment options, and must raise awareness of the impact and importance of healthy lifestyles. Destiny Health provides health information and additional financial incentives through the "Vitality Program." BCBS of Illinois has taken its own progressive steps with a program called "BlueAccess for Members," a partnership with the Mayo Clinic to provide employees relevant, real-time medical information that assists them in their own medical management. BCBS of IL has also introduced a program distributing significantly discounted pedometers to employees, encouraging them to be mindful of their physical activity.

The Needs of the Many...

While the evolution of health products affects everyone, small business, specifically those in the 2-50 employee range, are taking the biggest hit with rising costs. Also suffering are employees with families to insure.

In many states, the 2-50 lives category is heavily regulated. Once a firm rises above 50 total employees, health coverage is generally a non-regulated business; an insurer can rate coverage specific to the risks of the firm. Smaller

firms are taking the biggest hit because most states have small-group reform laws relating to how new business rates and renewal actions can be dispensed on 2-50 employee-sized businesses. It's more expensive for the carriers to operate in a regulated environment, but they simply build the cost into their rates based on the added risks for this marketplace size.

Families are also increasingly expensive to insure. One way employers are covering their costs is to increase required contributions for dependent coverage. Under older plans, the employer might cover 80% of the employee's monthly premium but only 50% of dependent premiums. For example, the employee might pay only \$60 of a \$300 premium.

Whereas a full family will cost \$1,300 a month, the employer only pays 50% of the dependents' share of the premiums, leaving \$560 (\$300 at 20% plus 50% of the remaining \$1,000) for the employee to pay to insure himself and his family. Clearly this model is becoming unaffordable and the industry needs to change dramatically.

Powerful New Tools Require Capable Hands

As much as innovative new products can help a client meet demand for sustainable alternatives to the current health insurance plans, the next-generation products are nothing without the excellent service of a knowledgeable broker. Service methods must evolve along with these policies to bring the full benefits to your clients and reap the rewards of a happy customer: referrals. Brokers must first be educated themselves, then not only concentrate on the sale, but also on after-sale service, ensuring that the education regarding administration of the plan is complete down through the chain to the HR clerk who will actually administer the staff's insurance coverage.

Brokers who have concentrated solely on their relationship with a client CEO or owner soon learn their mistake. We have found that the communication chain breaks down if a broker only knows the principals at a client company. A top-heavy relationship with the client leaves the HR department, whoever that might be, in the dark about simple tasks such as how to delete an employee from coverage—a mistake that can cost your client money. Poor communication also leaves the HR department seeking answers and may open the door for them to select an alternate broker whom they know better.

A broker who fails to complete the chain of client education can be assured that either he will hear the complaints loud and clear when they come back up the chain and the CEO announces that his administrators don't understand the complicated product, or the plan will not be administered properly and cost the company in wasted administrator time, lost benefits and disgruntled, unhealthy employees. And it is not unusual that the CEO or owner may get a personal introduction to a new broker whom the firm's HR person would rather utilize.

Go to the Source: How to Choose a Wholesaler

We think it's important for a front-line agent or broker

to select a wholesaler that understands the macro-market. Many wholesalers and carrier representatives claim to be consumer-driven specialists and may understand HRA products to a degree, but often they do not understand the health insurance market as a whole. There is a big difference between being a product specialist and a market specialist—product specialists will sell their product simply because they understand it. More important, it may be the only thing they have to sell!

A direct carrier rep or a one-product wholesaler inevitably wears blinders to all but their own products. A true expert can see whether a plan is really right for a client or not. You should select a carrier-neutral (independent) wholesaler with a full menu of varied products, one that can offer price and benefit comparisons across the board.

Agents need to select a wholesaler that helps effect education down the entire administrative chain. Health plans can be complicated, but they are not rocket science. The best wholesalers can help you describe the benefits and logistics of administration to clients in plain English.

Good wholesalers will also provide brokers with efficient communications regarding changes to the particular products a broker sells. If you prefer to receive information by e-mail, fax, mail or PDA-friendly messages, ask if your wholesaler will adapt to serve your needs. Brokers need these updates to properly assess the right product for a client. Product changes affect client compatibility: you don't need to know about those changes two weeks after the sale, you need to know before they go into effect. Find a wholesaler that understands technology without losing the personal touch.

Assess a wholesaler's educational seminars. Are the programs simply product-specific sales seminars, or are they state-endorsed programs providing continuing education credit and teaching the marketplace, not just the products?

Determine if all associates at the wholesaler are licensed, or if it's just the one or two people whose names are on the door.

Good Service Yields More Business

Referrals will come when a client perceives excellent service, ample coverage at affordable prices and ethical practices. If a wholesaler has armed a broker properly, the broker will not get caught trying to fit a square peg into a round hole. A company that can administer its plan efficiently and keep employees happy and healthy will refer you over and over again.

Macro-market knowledge is a must. If your client already has the right coverage, why jostle them just to make your commission? You will only destroy a chance at future sales. Honesty goes farther.

The same applies if a client needs a product that you don't sell. Admitting that you don't carry it and recommending a friend who does is worth far more than the one-time profit and a headache down the road. Your wholesaler must back you up with knowledge and adhere to these same principles.

See the Whole Picture

Our most successful brokers are those who visit a client after the sale and explain the logistics of the plan—not just to the owner, but all the way down the chain—explaining the nuts and bolts of the administration process at each step. These are the agents who aren't afraid to get down to where the rubber meets the road to retain clients and gain referrals. Good service is essential to providing your health insurance clients with sustainable alternatives today, and constant education is crucial to selling the consumer-driven, fully integrated health products of tomorrow. ■



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