Title:
The 1st Step Toward Consumer Driven Health Plans - Why supplemental benefits make the transition easier

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Summary:
Helpful hints for employers considering restructuring employee insurance plans to save money and include supplemental benefits and HSAs

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Article Body:
Part of the reason that I initially got my insurance license, was that as a business consultant focused on change management, nearly every business owner, CFO and HR director that I spoke to asked me what I could do about the rising cost of their healthcare benefits. Up until recently, with regard to their major medical plan costs rising at double-digit rates every year, there was little I could recommend aside from biting the bullet and accepting that it would be a painful process of micro re-examination of plan costs nearly every year. Many decision makers are being forced to shift costs to their employees or do away with certain benefits altogether. Fortunately, now there is finally a sensible way to reduce costs (and taxes, by the way), give employees more choice, more security and believe it or not, keep them from storming the castle with rakes and torches when you ask them to contribute more out of their own pockets. These plans are aptly called “Consumer Driven Health Plans” (or CDHPs) because the policyholder makes as many choices about their health benefit plans as their employer.

Two key components of CDHPs have been receiving a lot of press. The first is the Health Savings Account (HSA), which must be used in conjunction with the second, a High Deductible Health Plan (HDHP). Without going into great detail about the restrictions, the whole idea is that by enrolling in a major medical health insurance plan with a significantly higher deductible ($1000 or more), the company (and/or the employee) can dramatically reduce the premium cost. In addition, by replacing Flexible Spending Accounts (FSAs require the participants

to use the tax free money contributed during the plan year or lose it) with HSAs (that allow the participants to accumulate money in their account tax free BUT the money rolls over from year to year) eventually, the deductible is covered with tax-free dollars.

The only downside to this plan is that FSAs make the elected amount available on day one of the plan, whereas HSAs allow only the amount that has been funded to date to be made available. In other words, for most folks, the first year of such a plan puts them at risk for substantial out of pocket expense related to the deductible.

The way to avoid this risk is to implement a third key component of the plan, Supplemental Benefits. Most often via a new or existing Cafeteria (Section 125) plan.

For several reasons, supplemental benefits should be the first step in any HDHP/HSA plan. First is that they introduce employees to employee funded, 100% voluntary plans so employees come to feel comfortable with contributing to their own financial security. Second is that supplemental plans cover deductibles and co-pays, so employees realize that by participating, they reduce their own out of pocket expense should the unthinkable happen. Thirdly, they learn the value of pre-tax dollars. And last, more choice lends itself to better education in just what those choices are. In other words, employees take more interest in learning how their overall plan fits together and what the best choices are for their family.

When Supplemental plans are introduced first, employees feel empowered by the fact that the company is giving them options to better protect their family without changing anything else. Then when the HDHP/HSA changeover is eventually made, far fewer employees will feel like they're getting the short end of the stick.

So what makes up a good Supplemental plan?

While many of the plans are similar in benefits and structure, the providers vary widely in how they work and what they actually provide in terms of customer service. Your employees trust you to select high quality benefit providers that give them financial stability and control when they need it most. As more and more players enter the game, every insurance provider will be touting their respective accolades. Just be aware that many small, unproven operations hide beneath the veil of a well-known brand. In some cases, insurance conglomerates are simply an affiliation of unrelated subsidiaries that were acquired for a specific strategic purpose; in this case, to enter the voluntary benefits

market. Like the Wizard of Oz, you may find that a parent company's financial and marketing statistics give a misleading view of the size and capabilities of the business unit that actually does the product design, underwriting, and servicing.

Nobody likes surprises. Especially, related to financial security. And the last thing anyone wants to hear from an employee who has claims issues and thought they signed up for a policy with BIG Insurance Company (whose slick marketing reps touted gazillions in financial backing and years of experience), is that they've now found out that the policy they were counting on to protect their family was really underwritten by the National United Smoke and Mirrors Insurance Company of Hoboken, NJ., which did strictly Property and Casualty insurance until last year. So pay attention to the man behind the curtain.

If you ask the right questions of potential providers, you'll be doing your company and your employees a big favor by picking the best provider for their needs.

Here are some suggestions:

Who is really underwriting the policy and how long have they been doing it? Experience has its strength, and in the guaranteed renewable (supplemental) market, size does matter. What is the company's history and track record? You want a company that has the depth to handle any adverse selection, and a track record of satisfied clients across industries.

What is the financial standing of the company?
Regardless of whether you use A.M Best, Moody's, Fitch, Standard and Poors or some other rating system, make sure you choose one of the highest rated companies. There are several. A is better than B, + is better than -, and so on.

How is the company recognized?
Accolades and industry market share are some indicators, but what you're really looking for is long-term satisfaction by clients. Long-term relationships with companies like your own are good indicators. More importantly, what is the actual operating unit that provides the underwriting classified as? A life insurance company? A property and casualty company, or a liability company? And what are its individual ratings?

Are voluntary benefits the insurance provider's top priority?
Are supplemental/voluntary plans the company's only focus or are they a sidelight meant to be a means to open a door to other relationships? What

percent does the insurance being offered represent of the parent company's overall premium base? Who you choose can have a lot to do with whether you want to put all your eggs in one basket…or not.

Is representation national?
Do they have a physical presence in all 50 states or just an 800# that goes to a central office? Do they have dedicated agents in your geographic locale or is it a loosely tied, affiliation of middlemen spotted across the map? For companies with one or two local branches, this is not an issue. However, even for companies with many locations in a single state, how consistent your message is conveyed and how well your employees are serviced depends on how well the company's representatives are trained across the geography. What is the depth and quality of backup?

How often do the rates go up? And what are the circumstances that cause rate hikes?
Some companies guarantee rates for policyholders for a period of time (usually two or three years). Do some due diligence as to how often and how high those rates increase over time. Require a written history. Past practices are a good predictor of future trends. The industry leader has never raised its rates for existing policyholders, but is still one of the top selling insurance stocks. It doesn't make sense to get a great low rate, if in only a few years it becomes a high rate.

How complicated is the underwriting?
How far back does the underwriting go for critical illness plans? Are any disclosure documents required outside of the application? How many questions are asked during a typical enrollment and what do they require for information on pre-existing conditions? What you're looking for is as little underwriting as possible. Guaranteed Issue is uncommon unless the group is very large, and in many cases not available at all from even the best companies. Understand what the parameters are for “knock-out” questions. Make sure they seem reasonable.

How strict is the company's definition of disability?
In some insurance policies' definition of disability, the insured must be entirely unable to perform each and every duty of his/her job, as well as other specific requirements. Other companies are more liberal in their definition of “total disability” before benefits are paid, often requiring that the insured only be unable to perform “material and substantial” duties before they are deemed disabled. This is one of those areas that vary widely so understand what defines “disabled” by seeing documented examples. Less stringent is better.

What is the company's loss ratio?

Loss ratio is defined by incurred claims over the life of the average policy divided by earned premium. Meaning what is the average payout versus what the policyholder pays in? Higher is better.

How quickly does the company pay claims?
Unfortunately the landscape varies widely in this key factor. Faster is better. Less hassle is better. Do your homework on this one. Some companies have been nailed in recent years for having internal policies relating to nonpayment of legitimate claims. It's been uncovered as common practice in other companies to deny legitimate claims pending certain documents that seem to become less and less relevant, stringing you along for months hoping that you'll give up. Look very closely at procedures and ask for statistics on both common and uncommon claims.

Do benefits require coordination with other coverage before payment is issued?
Some companies offer plans that sound great, but if coverages overlap, all the benefits are not paid. Other providers pay over and above any other insurance the policy holder has, regardless of type or amount or to whom the benefit is payable.

How are benefits paid?
Are they paid directly to the policyholder? To the doctor or hospital? Or some combination of both? Since more choice is better than less choice, the preferable payment is directly to the policyholder who then determines where the money goes.

Does the company encourage preventive care as part of its policies?
Many companies encourage preventative care as part of their base policies and incent policyholders to seek common precautionary screenings in an effort to reduce claims. It makes good sense all around since early-detected conditions usually result in more effective treatment and less time off work. Look for companies that make such benefits a real part of the plan, not riders or options.

Are the policies offered portable?
Portability means that the policy is owned by the policyholder and not the company. So if the policyholder leaves the company for any reason, the policyholder retains coverage at the same levels. True portability means at the same rate as well. Some companies confuse convertibility with portability, making policies truly portable only under certain circumstances. Convertibility means that the policy converts from one form to another, usually a change in benefits offered or rates.