HOW TO PROCURE HEALTH INSURANCE BENEFITS

by Colin McNeese

HEALTH INSURANCE is an essential component of any full-time professional compensation package. Organizations that offer health insurance tend to retain their talent base for longer periods of time. Health insurance is also expensive, and could easily be an organization's second largest expense next to salaries. So, there lies the core issue for anyone purchasing health insurance: balancing benefit value against benefit cost.

SMALL GROUP OR LARGE GROUP: WHY DOES IT MATTER?

The number of employees participating in a plan has a material impact on the types of products available, underwriting, and funding options available to a group. Most states have strict underwriting guidelines for "Small Groups," which typically are defined as those with fewer than 50 participating employees. These guidelines were introduced to prevent insurance carriers from denying high-risk groups as well as limiting their maximum rate setting authority. Each state may have a slightly different statutory definition and underwriting guidelines. Groups with more than 50 employees tend to have more plan design options available and more negotiation leverage with insurance carriers.

Larger groups, in excess of 150 employees, can reasonably consider "self-funding" health insurance, where the organization accepts a portion of the risk in exchange for the potential reduction of annual costs. Debating appropriate funding strategies, self-funded vs. fully-insured, is a lengthy subject. This article will focus strictly on fully-insured health insurance.

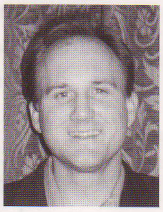
PLAN DESIGNS AND AVAILABLE NETWORK OPTIONS

The Preferred Provider Organization (PPO) has emerged as the dominating product in recent years. HMO's can still offer excellent benefits and value in regional markets; however, that is an exception to trends in the industry.

A very brief description of three common products is provided below.

Some carriers have recently begun offering special PPO networks that offer deeper discounts than their traditional

PRODUCT	DESCRIPTION
PPO	Preferred Provider Organizations (PPO) give incentives for using preferred providers and reduced benefit for using non-preferred providers. PPOs are the most popular plans due to the balance of provider choice and cost reduction. The plan includes a mix of copays, deductibles, and coinsurance.
POS/HMO	Point of Service (POS) or Health Maintenance Organizations (HMO) provide a smaller network than a PPO in exchange for a cost reduction. National popularity for these kinds of plans is waning due to shrinking cost advantages; however, some regional plans still provide excellent value. These plans are driven by copay.
Indemnity	The most expensive insurance plan option is Indemnity. It has limited network restrictions or cost savings opportunities. The plan option is based on a deductible with a coinsurance.



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PPO contracts that are more similar to HMO's discounting. These networks are smaller, have greater managed care capability, and are often referenced as "high performance networks." If these networks provide access to the hospitals and doctors providing services to your employees, you ought to consider this option at renewal.

Fully-insured health insurance options vary greatly by region. Available carriers, plan designs, network options, and cost vary depending on where plan participants live. This is an important fact to understand, especially if you have a decentralized population spread over many states.

- Fully insured health insurance is regulated at the state level, so a plan offered by a national carrier will be slightly different between various states depending on state mandated coverage options. Differences in these mandates and premium taxes could account for as much as a 10% (or higher) difference in cost.
- Network provider accessibility and discount strength varies greatly by region.
- Average inpatient and outpatient procedural costs vary by region.
- Hospital billing and reimbursement practices vary by region.
- Incidents of disease and utilization vary by region due to demographics and other factors unique to a given area.
- National carriers and plan designs are gravitating towards the PPO product plan design. Regional health plans tend to offer the best HMO options.
- Hospital systems and health insurance carriers continue to merge which reduces the number of options available each year.

The type and quality of health insurance options available depends entirely on the location of your main office and employees. An article in the local San Antonio, Texas, newspaper describing the average cost and trends of the most popular plan options may be completely irrelevant to those prevalent in Boston, Massachusetts. This seems obvious, but it is likely that at some time in your career, your boss or an influential member of the benefit committee is going to provide errant advice or undeserved criticism based upon a local article read while traveling through an entirely different market.

UNDERWRITING AND PLAN RATING

Underwriting is the process of accessing plan cost in order to set appropriate premiums. Carriers take into consideration factors such as location, average age, gender, and number of dependents to calculate average cost in order to set premiums. Carriers will request any medical claims experience or rate history that is available in order best to predict future claims liability. Of course, providing any information that depicts your group as a favorable risk (such as the group's last two renewals were less than 5%) will produce a more competitive quote.

- Note that underwriting for "Small Groups" is partially or entirely controlled by the pooling of average risks in a given area. That simply means the demographics and average costs of your region may dictate your plan rates more than your group's specific demographics. This is one disadvantage to being a "Small Group."
- Another disadvantage is that the carrier's initial quote is subject to individual review of plan participants' claims history in order to adjust the rates according to the disclosed conditions. This typically means the final rates in the contract are higher than anticipated by the plan sponsor. "Large Groups" still provide claims history at time of enrollment, however, questions are less comprehensive and competition tends to limit major rate changes after enrollment.

REQUESTING QUOTES AND EVALUATING PLAN OPTIONS

Now that we have identified some of the key issues regarding health insurance options, we are ready to prepare an action plan to purchase the best plan for our group:

1. Identify the plan design options and anticipated budget most suitable to the organization's compensation and benefit strategy. This is an important step to ensure the final medical insurance solution is consistent with the organization's compensation philosophy.
2. Prepare an underwriting census, requested plan design and any supporting claims, enrollment and rate history. Write a short summary of your organization's history and objectives in order to promote the image of a "good client." Make them want to work with you.

HEALTH INSURANCE IS A VITAL PART OF YOUR ORGANIZATION'S BENEFIT PACKAGE AND IT REQUIRES CONSIDERABLE DUE DILIGENCE TO NEGOTIATE THE BEST SOLUTION.

FULLY-INSURED HEALTH INSURANCE OPTIONS VARY GREATLY BY REGION. AVAILABLE CARRIERS, PLAN DESIGNS, NETWORK OPTIONS, AND COST VARY DEPENDING ON WHERE PLAN PARTICIPANTS LIVE.

3. Identify the insurance carriers that provide plan options in your area most similar to current or desired plan design.

4. Provide the information to the target insurance carriers and give them two weeks to respond.

5. Begin evaluating your options. Some carriers may decline to quote if they feel they are not competitive. Hopefully, three or four carriers with multiple plan options appear as viable candidates in your analysis. Use the following key criteria to select the best options:

   - Does the proposed plan design match the requested plan design? Carriers don't always initially match the requested plan design.

   - Does the network provide maximum provider accessibility for plan participants? Double check that key hospitals and providers most frequented by your organization are included. Vendors can include a basic network accessibility analysis upon request.

     – Some carriers offer multiple networks, so make absolutely sure you know the exact name of the quoted networks for analysis.

     – Consider any "high performance" networks.

   - Does the carrier provide excellent customer service and resources to both the plan sponsor and participant? Carriers are now including new services and attractive "added value" benefits that may influence your decision.

     – Enrollment support resources

     – Engaging communication support

     – Informational and transactional internet resources

     – Wellness and Disease Management initiatives

     – Health club discounts

   - Cost is obviously important. The top candidates should be very competitive. Request the average cost increase their plans experienced during the current renewal cycle to determine the carrier's historical rate stability.

   - Interview the sales representative and proposed account executive for the top two carriers. Look for both professional experience and personal dedication to support the ongoing success of your plan.

   - Select the insurance carrier and plan option that achieves your objectives. Allow time and be prepared to request additional options from the finalists.

     – Ensure rates are guaranteed for 12 months.

     – The selected vendor should maintain "continuation of care" for current plan participants receiving critical treatments who potentially could be negatively impacted by a change in networks.

CLOSING COMMENTS

Health insurance is a vital part of your organization's benefit package and it requires considerable due diligence to negotiate the best solution. Note that during the underwriting process, the plan administrator may learn of sensitive health information, so take extra precautions to protect employee privacy. You may want to consider using a benefits professional to identify the best health insurance carriers for your organization, select the best plan design to meet your budget and to ensure the selected vendor performs to your expectations throughout the entire contract.