The Healthcare Crisis: How to Solve it and Prosper
by Mark Reynolds, RHU
October 2009

The healthcare crisis affects every business today, especially employers with two to 50 employees. One solution is for consumers to accept responsibility for their health and make better choices. But, retraining consumer behavior cannot be achieved overnight, at least not in time to make a substantial impact on the current healthcare crisis. We must also rethink our benefit plans and the role that employers play in its delivery.

One of the most common solutions for a small employer is to try to lower costs by downgrading benefits. This is an unfortunate circumstance because everyone ends up paying more and those who need the plan the most, end up getting less.

As an example, let's look at some cost-saving alternatives for a 40-life group that enrolled with us in 2000. When this group enrolled, it had a traditional plan with $0 deductible, $20 office visit co-pay, and 80% coinsurance. The medical premium was $15,364 per month. We compared the very same group with identical census information for an October 1, 2009 effective date.

What if we decreased the benefits using the type of plan that many employers downgrade to including a $500 deductible, $40 office visit co-pay and 60% coinsurance? The employer's medical premium would increase to $28,491 per month with lower benefits from the $15,364 they had in 2000. Benefits would drop dramatically while the cost would increase just as dramatically. If brokers present no other alternative, this is a situation employers are accepting.

The second typical solution is to implement a health savings account (HSA). It seems like a reasonable way to lower costs while maintaining a healthy benefit package. However, we would run into a couple of obstacles:

- HSA premiums have been increasing by as much as 40% or more in some instances.
- Employers are reducing funding or are unwilling to continue funding HSAs.
- Healthy employees are stockpiling funds in the HSA account while their employer may be fighting to keep its business running.
- Unhealthy employees may not have any HSA funds left in their account when they need healthcare services.
- Providers are not getting paid.
- Many members don't know how the HSA works and do not recognize its value as a new way of financing healthcare.

I could write a whole article just on the bullet points listed above, but I would like to point out the two main flaws with HSA plans as they have been marketed. An employer that is funding the HSA may not be lowering costs on the health plan after all. If the employer is not funding the HSA, the employee who uses the plan is left with only catastrophic coverage because one cannot depend on the employees to fund the account. This is why providers are not getting paid.

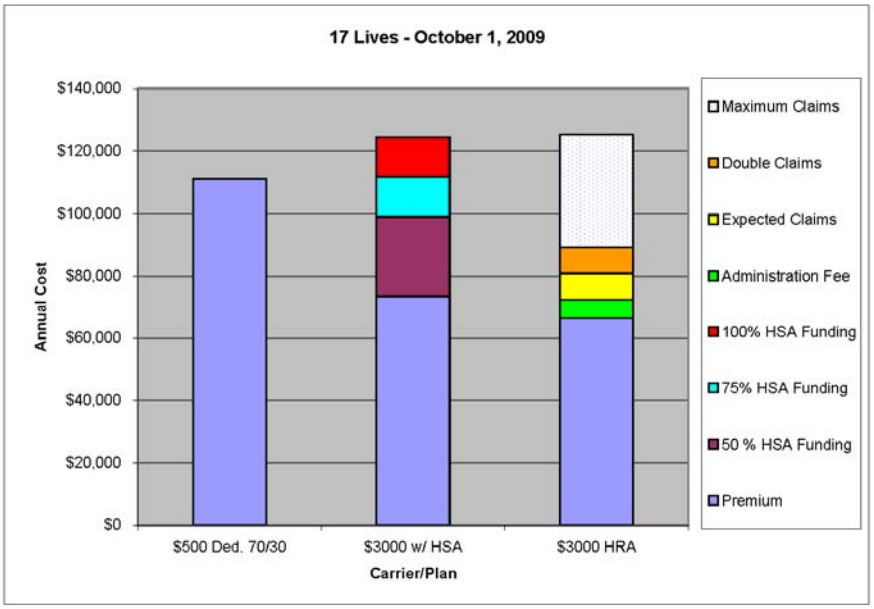
A more recent solution is the health reimbursement arrangement (HRA) or medical expense reimbursement plan (MERP). Medical expense reimbursement plans are tax deductible for the employer and unused funds stay with the employer. The employer has more flexibility in plan design and more control over how the plan performs. The biggest advantage for employees is that the plan's reimbursement payments are not considered taxable income and plan designs usually improve benefits.

The chart below compares one employer's options as mentioned. The first bar represents what many in our industry consider to be today's traditional plan. The second bar represents an HSA, which the employer funds at different levels. The third bar represents the HRA/MERP plan.

In the traditional plan, represented by the first bar, the employer's options are limited; there is no plan design flexibility and costs are set.

The HSA, represented in the second bar, allows a little more flexibility. The employer has no control over the carrier premium, but can control the amount of funding it provides. An employer that only funds 50% will see some cost savings.

The HRA/MERP plan, represented by third bar, is where the employer's cost are reduced most significantly. The carrier premium is a little less. (I have added in full service administration fees for third party administration and outlined the expected claims.) It is important to note that the expected claims are based on the statistics that 5% of the members will maximize the carrier deductible, 20% will utilize $800 and 30% will use $400 in healthcare expenses annually. Every year, clients come within 20% of the expected savings projections based on these figures.



But, let's say we've missed the projections by a mile. Even if we doubled the projections for claims utilization, we would still be saving this employer more than $20,000 in annual healthcare costs.

The only way the employer would end up spending more, while enrolled in an HRA/MERP in any given year, is if every deductible risk unit (including the member and dependent) maximized the carrier deductible in one year. If this happened, the employer would have larger business problems to face than the cost of their health plan.

There are many different administrators and models in the HRA/MERP arena. A more recent model is a simple reimbursement for lower administration fees. What a great concept to lower the employer's cost even more. However, what many don't realize is that the employer's up-front savings, through simple reimbursement plans, are eaten up and exceeded in the back end due to limited plan capabilities. As a simple reimbursement administrator, the main goal is to set up a plan with very little customization (for example, no co-pays, coinsurance or Rx benefits) and send payment back to the member for each claim incurred. If there is a prescription claim, the member must pay in full up front and wait for reimbursement.

This takes us back to the expectations we have placed on our consumers, also known as "members." Based on today's statistics, employers fear that their employee member is not going to pay the provider. In fact, most employers expect their employees to cash the check and use the money for gas or rent. An employer that is not able to build cost sharing into the plan, through employee co-pays, coinsurance,

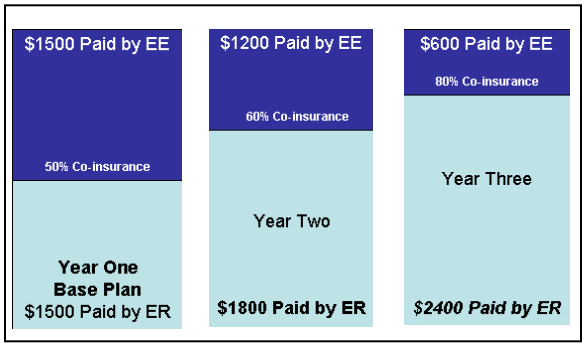
and individual deductibles, will spend more than is necessary. These are just a couple of the issues to consider before presenting a simple reimbursement plan. Overall, the financial impact is that the employer has a higher plan cost, which will continue to cost more until the employer requests more flexibility in plan design.

The HRA market is quickly gaining in popularity and confidence. Carriers are designing products specifically for HRA plans and more and more employers are gravitating toward this concept for many reasons including the following:

- HRA premiums are beginning to stabilize, which is reflected in lower premium increases.
- Employers are reducing their overall plan costs by as much as 40% with HRA plans.
- Healthy employees are seeing their plan contributions reduced.
- Unhealthy employees are seeing benefits improve.
- Providers are getting paid.
- Through education, employers, employees, and agents are growing comfortable with the benefits and results of the plan.

Let's take it a step further. What if you could take the HRA and implement an integrated wellness program that would benefit employees for changing their behavior? You could easily identify areas for improvement that would lower healthcare costs significantly and designate rewards in the form of benefits through annual health assessments. For instance, an overweight employee would have to lose 10% of their body weight in order to gain an additional 10% in coinsurance. Smoking cessation could take an employee from 60% to 70% coverage. Reaching a healthy cholesterol level could reward 5% more in coinsurance. You could take this all the way to a 100% benefit level. By identifying the desired employee effort and placing a benefit reward, you put the responsibility and accountability back in the hands of those who need it the most.

The kicker is that the employer rarely pays claims out on behalf employees who benefit from 100% coverage because they are the ones who have made healthy lifestyle changes.



As lifestyles change, benefits increase; as benefits increase, costs decrease. You can clearly see how this integrated wellness plan can reverse the healthcare crisis we face today.

Several major corporations have instituted wellness programs with positive results. Coca-Cola's physical fitness program recouped $500 per year per employee even though only 60% of their staff was enrolled.

Coors Brewing Company's worksite wellness plan saved $5.50 in healthcare costs for every $1 it spent on physical fitness, with member absenteeism dropping by 18%. Large employers give proof that it is the right direction, but it also applies to small employers with fewer than 50 employees.

Agents need to put serious consideration into how wellness can be incorporated into the small group market. These kinds of programs could create the perfect partnership among the employer, carrier, agent, and third party administrator (TPA). A wise insurance carrier could limit an employer's funding to 50% and help the employer implement a wellness program, with measured results, which would increase co-insurance levels and lower co-pays for employees thus resulting in healthier lifestyles and improved results overall.

Reforming healthcare can be simple if we start with the goal of reforming healthcare financing. When we look at the past, we need to look at what we are facing and move forward with solutions, such as the following:

- Making health insurance premiums tax deductible for anyone who pays it.
- Making all plans guarantee issue to one life with reasonable pre-ex period (two years for individuals and families).
- Allowing carriers reasonable corridor for risk adjustment factors (30%)
- Passing tort reform: The loser pays or fixed fee for attorneys.
- Allowing carriers to sell across state lines.
- Having no new benefit mandates for five years.
- Allowing HSAs, HRAs, FSAs, and MERPs to be permissible and available on all plans.
- Requiring all providers and insurers to publish outcome statistics and experience data.
- Providing universal enrollment forms for employer/employees, individuals/families.
- Setting health plan commissions at 7%, which does not increase as premium increases.

In conclusion, lifestyle habits have been ingrained in consumers for more than a quarter of a century. Retraining consumers to take responsibility for negotiating their way through the access and financing of their healthcare in a short period of time is unreasonable. Expecting consumers to exercise, stop smoking and eliminate frivolous malpractice lawsuits is unreasonable.

What is reasonable is to identify the efforts that are needed and the parties involved in order to create the solution. This will set into motion a way of re-educating employees on how to evaluate their own healthcare needs, ultimately helping to further control the cost of healthcare. Lower costs, improved benefits, re-education, and accountability are powerful reasons to work with our employers to implement new concepts into a stagnant market plagued with increasing rates, decreasing benefits, and uninformed consumers.

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