Consumer-Driven Recovery: Whose Move Is It?

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We've heard it before. New health products often cause a stir, but many smart brokers know that the newest products, while well-marketed, are usually administration headaches and a distraction from the tried-and-true solutions.

We all want happy clients, so do we give them what they want (the new plan, the one they called to ask about) or do we give them what they need? The shiny new plan in the front window or the old standard? Neither one is perfect.

The old standard, a low-deductible HMO or PPO plan, will keep your client covered and appeased for a year, maybe two. But try to renew for a third year—say the price tag out loud and it's going to be followed by a door slam or a dial tone.

The real answer is both. If you want a stable book of clients who are happy to renew and create the fewest claim and administration problems, you've got to give them what they want *and* what they need.

The consumer-driven model in essence is the wave of the future. The newest consumer-driven plans may or may not offer efficient solutions, but the revolution has started. Hang one lantern or hang two; either way the consumers are coming!

Color me Jerry McGuire, but our industry will suffer this revolution with or without our participation. Smart brokers will think long term and realize that a book of satisfied, healthier clients is more manageable and more profitable overall. A one-time large fee is a sad substitute for a happy repeat client who refers you to everyone but the Pope. A broker can handle more business when the end user is better educated (fewer questions and complaints) and the product starts having the positive effects of better self-health management.

After payroll, health benefits are often the biggest item on the books. Double-digit percentage cost increases cannot continue, or be assured the government will come knocking in one form or another and put all health brokers out of business.

Using new products and the excitement surrounding them just to get in the door and sell the same products as last year is irresponsible and will destabilize your client list in the long run. Sow the seeds of stability in your business now, and recommend solutions that put consumers in charge. Educate the CEO, the human resources administrator, as well as each insured, and you'll win their trust and referrals.

Consumer-Driven Model: Nuts and Bolts

What is the right weapon of choice: flexible spending accounts (FSAs), health savings accounts (HSAs), health reimbursement arrangements (HRAs) or medical savings accounts (MSAs)? MSAs were replaced by HSAs as of January 1, 2004. MSAs are no longer offered but may exist with older plans.

Rather than a seminar on the details of every plan, it's easier to first concentrate on

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the important points of variance. All of the above are some variation of high deductible plans that allow employees or employers to set aside pre-tax dollars for employees to spend on medical care. The value grows tax-free in an account. In general, the plans are akin to individual retirement accounts (IRAs) for healthcare dollars. The value is more portable and flexible than a set of health benefits which may or may not be utilized or appreciated by the healthy plan member in a given year. Because the employee shares in the contribution, consumer consciousness is brought back into the equation.

Flexible Spending Accounts

FSAs are also known as cafeteria plans or 125 plans (IRS Section 125). Employers set up these plans for employees to deduct payroll money on a pre-tax basis for specific medical costs (as defined by the IRS) which are either not fully covered or are excluded by the employee health insurance. There is no upper limit to the contribution employees can make to these accounts, but it is a matter of use-it-or-lose-it. Value is not transferred year-to-year and reverts to the employer. For the medical portion of the FSA, the full account balance must be available to the employee as of the plan's start date.

There are no mandated plan designs and no plan maximums for FSAs. However, the plans are set up to be funded evenly over the plan year's pay periods, meaning if the employee gets paid once per week, the balance is accrued from each paycheck, in 52 installments. While reversion of all ending plan-year balances to the employer is beneficial, the employer is also liable for any FSA balance that may have been spent by an employee who was then terminated before the full account election had been accrued during the plan year. As stated above, there is no IRS-regulated plan maximum, but employers might want to initially approach the limits conservatively to limit their exposure—especially if they have a particular employee clamoring for benefits.

FSAs are useful to pay for child care, but this component of the plan must be set up separately from a medical FSA, and benefits are only distributed as they are actually deducted from the employees' checks, so there is no liability in this component to the employer, and this component does carry an annual limit of $5,000.

Health Reimbursement Arrangements (or Accounts)

These accounts are built by pre-tax dollars from the employer. Note that this pre-tax feature applies only to non-shareholders of S-corporations or non-members of limited liability corporations. The deductible might be set at $1,000 (or higher) for an individual, and the employer sets aside money that employees can use to meet those costs until full coverage kicks in above the deductible. HRAs are also a use-it-or-lose-it account from the employee's perspective, but employers can (but are not required to) account for the money on a year-to-year basis in the employee's name if they elect this option.

Although the law states that all qualified medical expenses are eligible for HRAs, most employers limit the coverage to expenses that are eligible under the medical plan. Essentially, these plans carry great premium savings potential, with a rather small amount of risk. HRAs allow employers to share the plan savings with employee groups that have good performance; however, if groups have a bad year, the employer's liability is limited to the reimbursement level or exposure of the specific employees that are incurring the claims ($1,000 per employee in this example). HRAs carry no upper limit on contribution amounts and there are no legislative requirements pertaining to plan design.

Health Savings Accounts

As with HRAs, there are two components to the total health package: an insurance component and the health savings account component, usually set up through a bank. HSAs are the newest and most popular option for many, as these plans seem to plug the gaping holes the previously highlighted plans carry. Deposits made into an employee account are owned outright, and employees are fully vested in that deposit. Unlike HRAs, employers and employees may share in the contributions to an HSA, and the balance must be carried over year-to-year in the employees' personal bank accounts. Additionally, shareholders of an S-corporation or members of a limited liability corporation can appreciate the full deductibility of the HSA. The money becomes available at age 65 or a beneficiary receives the sum in the event of death.

Most insurance companies do not have anything to do with the HSA; carriers provide a plan that is "HSA compliant" only. It is important to note that HSAs are different from the other plans mentioned above in that there are mandates on plan designs to make them HSA compliant. Those mandates are as follows: a minimum plan deductible of $1,000 per single employee (the family deductible is two times that of the individual). It is also important to note that the definition of a family and how the family deductible is accrued is different from most industry standards.

The family is defined as any employee plus one or more dependents, meaning an employee and spouse or an employee and one child will have to meet the full family deductible. Legally, the family deductible must be met before any benefits will be paid in family coverage.

In family coverage situations, the family deductible can be met by one person or a collection of family units. For 2004, the deductions are scheduled to be the lesser of 100 percent of the deductible or $2,600 for single coverage and $5,150 for family coverage.

The beauty of the HSA is that it rewards and facilitates consumerism in employee healthcare and its mechanism allows plan designs that are appreciated by heavy plan utilizers (comparatively lower premiums) and the healthy employee alike (cash balances in the HSA).

Note: The now-retired MSAs share many features with HSAs, except MSAs had a larger penalty on withdrawal before age 65, and MSAs were only for companies with 50 or fewer employees, while HSAs are available to all size groups.

Whose Move Is It?

A wait-and-see attitude is a popular and perhaps a prudent one, but the changes are coming, and those who wait too long will be left behind.

The long term savings on the new high-deductible plans ought to grab your client's attention. The consumer-driven model keys into the philosophy and success of re-

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nowned Japanese fitness programs which are part of Japan's corporate culture. If you think corporate leadership doesn't have one eye on the bottom line while planning and paying for these programs, think again.

Fitness is a two-way street of benefits. Employees get reduced-cost access to exercise facilities which they see as a real benefit (as opposed to coverage that is idle until the employee is hurt or ill). The secondary benefits of exercise are what really make employers happy. The boss gets workers who handle stress better, sleep soundly, are more alert, have more energy and are less prone to illness. If that's not a productivity boost, nothing is.

Consumer-driven plans encourage a healthy lifestyle. Your clients will have you to thank for their awakening and for their savings.

Excellent Service Creates Confidence

Once you've agreed on the right plan for your client, ask if you can sit in on the first round of administration and enrollment—the human resources person gets to have you there as a coach. You'll also get down to where the rubber meets the road and hear the types of questions non-industry people have about coverage. You just may impress the employees enough that soon you'll be writing their individual life, property/casualty and disability business.

So Who Educates the Brokers?

Your wholesaler does. Select a wholesaler with macro-market knowledge, one who sees every type of plan in the market and knows the differences, the trade-offs, and why one plan is right for one firm but wrong for another. The carriers are developing wonderful plans, but a selection from all of them will find a better match than exclusivity.

Are you taking a one-in-six chance that you've already picked the right carrier at the outset? Select a source who can arm you with every option, teach you to use each one properly and spot optimum prospects for each type of plan design. You should seek a resource that will compare and contrast the carriers/products for you as opposed to a single-source outlet which will attempt to sell their option for all your prospects (whether it fits or not; that is all they have to sell). If your client is asking for a product that your carrier doesn't offer, where will you turn for an answer? Where will your client turn? Your *former* client will find a broker who offers that plan.

Select educational seminars that focus on market issues and a broad range of health insurance tools. Product-specific sales seminars only tell a small part of the story.

The most successful brokers know that a client visit after the sale speaks volumes about their commitment to service. Visit and explain the logistics of the plan—not just to your golf buddy contact, not just to the owner, but down the complete chain of policy administration. These are the brokers who keep clients and win referrals. Good service is paramount to selling and delivering the consumer-driven, fully integrated health products of today and tomorrow.

Progress, Not Pontification

Our industry faces a fork in the road: socialized health care lies down one path; cost-reduction, healthier lifestyles and consumer-driven coverage lie down the second path. The first course of action is to educate yourself and educate your clients. HIPPA was signed in 1996 and there are still compliance deadlines approaching. Your instinctive hesitations about new products are well-founded on your years of experience in this business. Don't ignore your instincts—apply them to demanding more for your clients and advise them how to weather the changes as the consumer-driven model takes hold.

The health of our industry and the health of our clients depend on our expertise and commitment to the best sustainable coverage for everyone. ❑

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