Considerations for Selecting Your Company's Health Plans

Peter C. Savage

When a potential employee is interviewing, benefits are the second most important consideration after compensation. The benefit of primary concern for most is health-care insurance. Attracting the best people is the key to success for any business. Determining the type of health plan for your company is a crucial and complex decision. Making the right choice of a health plan is critical to the satisfaction of your employees and a productive work environment.

After World War II, veterans transitioned to civilian life and reentered the work force. Employers began offering health plans as a recruiting tool. These plans were designed to provide catastrophic coverage to address expenses that exceeded routine medical costs such as an extended hospital stay. Over many years, health-care costs have exploded for numerous reasons to include inflation and government mandates. In reaction to increased costs and competition for employees, insurers and employers began offering richer health-care plans, further driving up costs.

Today's employee demands a health-care plan that provides comprehensive benefits. In parts of the country, including Massachusetts, employees have traditionally been provided *first-dollar coverage plans* where the most basic of health care is fully covered. As we entered the twenty-first century, employers looked to insurers to become more creative in structuring plans to address the steep rise in the cost of health-care insurance. First-dollar coverage plans have become cost-prohibitive.

Implementation of the federal government's Patient Protection and Affordable Care Act and an economy that continues to be sluggish is causing employers to review the coverage and cost of their health-care insurance plan. What follows are the important elements that employers should look at during this review.

PLAN DESIGN

The first consideration is the plan design, both from a fairness and competitive perspective. There are dozens of plan types available—indemnity, preferred provider organization (PPO), point of service (POS), and health maintenance organization (HMO), to name a few. Should you select one plan or offer choices to your employees and their families?

Most employers have stopped offering indemnity plans, those in which the participants make all the choices without primary care providers (PCPs) managing care. An indemnity plan allows a covered person to be treated by any provider, and to receive services virtually without limit and without cost controls. Additionally, because indemnity plans have minimal enrollment, there are no incentives for providers to negotiate discounted payments with the insurers.

The initial indemnity plans contained a cost-sharing component. Typically, the plan contained an up-front deductible that amounted to the cost of a two-to-three-day

Published online in Wiley Online Library (wileyonlinelibrary.com). DOI 10.1002/ert.21387

in-patient hospital stay plus a 20 percent share in all costs. The assumption was that incidental illnesses or accidents were part of everyday living. Insurance was required to cover major catastrophic costs that might threaten the policy holder's financial future.

The construction of new medical facilities combined with the introduction of new medical procedures and medications have resulted in the rapid escalation of costs. These realities coupled with employer and insurance company competition led to the introduction of the new plan designs described here.

- *Preferred provider organizations* are designed to control costs by limiting the choice of providers. This encourages enrollees to use the services of the network providers with whom the carrier has contracted for advantageous pricing. An enrollee may choose to go outside the provider network at additional cost to him or her. These plans attempt to reintroduce consumerism into health plans by involving the subscriber in the decision-making process. The expectation is that additional costs will drive the use of less expensive providers.
- The *point of service* plan is an increased-control model in which a primary care provider is required to oversee care and approve all providers for subscribers. The PCP will generally refer to providers having contracts with the carrier. This model provides cost control by consolidating responsibility for the enrollees' medical care with one physician. Similar to the PPO plan, this plan allows the enrollee to go outside the network at additional cost.
- *Health maintenance organizations* evolved from the POS concept placing further restrictions on the enrollee. The enrollee chooses a PCP and is referred to network providers by the PCP. If enrollees choose to go outside the network, they are responsible for all costs. An HMO is the in-network component of the POS.

The construction of new medical facilities combined with the introduction of new medical procedures and medications have resulted in the rapid escalation of costs.

The new plan designs, unlike the old indemnity plans, cover the costs of preventive services, such as an annual physical or preventive screening. These wellness plans were intended to increase the likelihood of early diagnosis of serious illness. Treatment is then provided with the intent that more costly procedures will not be necessary. The intent is to keep people healthy and keep treatment costs under control. The reality is that with the introduction of new procedures and medications, as well as advances in technology, costs continue to rise.

This has resulted in the introduction of so called *consumer-driven plans*. These plans contain high up-front deductibles and can be offered in combination with flexible spending accounts (FSAs), health reimbursement accounts (HRAs), or health savings accounts (HSAs, which are described in the next section). Consumer-driven plans require more participation by enrollees in the decision-making process concerning their care. Additionally, the enrollee may satisfy the up-front deductible costs with pretax funds by utilizing the options listed in this paragraph.

With the recently enacted Patient Protection and Affordable Care Act, the federal government is going to introduce its influence and

control over medical coverage. Many of the coverages this act mandates, such as no limits due to pre-existing conditions, may drive up the cost of providing health-care plans.

COST

What is an acceptable cost for both the employer and the employee for health benefits? This issue will drive the decision made by an employer when choosing a health-care plan. The more benefits provided by a plan, the higher the cost. An additional major consideration is, what portion of the cost do the employer and employee accept?

For most employers, deciding on the overall cost is quite simple: they must determine the percentage of company income they are willing to spend on health care. What is purchased with that amount is a bit more complicated. If the employer believes in providing coverage at low cost to the employee, the result may be a plan offering fewer benefits. If the employer believes in a shared-cost model, then the plan can offer more benefits, with the cost shared by the employee.

The trend today seems to be toward the consumer-driven plans. In this case, the company would offer a fairly rich PPO or HMO containing a substantial up-front deductible—for example, $2,000 for individuals and $4,000 for families. After the deductible is satisfied, the plan would provide full coverage.

The IRS has approved several types of accounts that subscribers can utilize to fund the deductibles and copays with pre-tax dollars. The three most common are:

1. *Flexible Spending Accounts:* An FSA enables the subscriber to have a fixed amount deducted from his or her compensation before taxes to be placed in an account from which he or she can be reimbursed for allowable medical costs. The downside to this option is that if the withheld money is not used for allowable medical expenses, it reverts to the employer. Employees must be counseled to be conservative in setting the amount of money that will be deducted to fund the account.
2. *Health Reimbursement Accounts:* An HRA is funded entirely by the employer. The employer sets the parameters for the account from which the subscriber is reimbursed for medical expenses not covered by the health-care plan. The advantage here is that it is a "promise to pay" by the employer up to established limits. The employer keeps any unused funds.

For most employers, deciding on the overall cost is quite simple: they must determine the percentage of company income they are willing to spend on health care. What is purchased with that amount is a bit more complicated.

3. *Health Savings Accounts:* An HSA enables the subscriber to build an account of pre-tax funds that can grow through investment. The funds must be used to pay for medical costs not covered by the health-care plan. Unlike the FSA or HRA, both the subscriber and the employer may contribute to an HSA. The goal of offering a high-deductible health-care plan in combination with an HSA is to involve the employee in his or her health-care decisions, resulting in choosing lower-cost options to help the overall experience of the plan. An HSA belongs to the employee and will follow him or her into retirement. After the employee retires, funds

may be withdrawn without being taxed to pay medical costs. An HSA may only be offered in combination with a high-deductible health-care plan.

CONTRIBUTION RATIOS

A significant consideration for employers is determining the portion of the cost of the health-care plan that is to be paid by the employee. If the company assumes a large percentage of the cost, it may be forced to offer a plan with fewer benefits.

Larger employers can offer several plans that have different contribution ratios based on benefits and plan design. In this way, the company is able to offer a choice of plans at different cost levels.

Larger employers can offer several plans that have different contribution ratios based on benefits and plan design. In this way, the company is able to offer a choice of plans at different cost levels.

FUNDING TYPE

Companies with 150 or fewer employees will in most cases provide health-care insurance on a premium-pay basis. This involves the insurer paying all the claims and generally results in high premiums.

Larger companies may opt to self-insure their health plans. Utilizing the self-insure model requires the company to assume the risk rather than the insurer. The risk is mitigated through the purchase of reinsurance. There are two types of reinsurance that are generally used in this model, *specific coverage* and *aggregate coverage*. Companies may also choose to partially self-insure their health-care plan.

SOLICIT INPUT FROM BENEFIT PROVIDERS AND EMPLOYEES

Choosing a company health-care plan is a complex decision with long-term ramifications. Government mandates and oversight will continue to add to the cost of these plans.

Employers must consider the following issues:

- ❏ What type of plan should be offered?
- ❏ How comprehensive should the benefits be?
- ❏ Should a single plan or multiple plans be offered?
- ❏ What can the company afford?
- ❏ Should the company consider self-funding the plan?

Change is difficult, and altering a health-care plan is many times seen as a benefit reduction. Educating employees is a key element in the implementation of plan change. Employee inclusion in decision making throughout the review process of new plan designs is essential. Soliciting employee input will lessen anxiety and ease the introduction of new plans. This is particularly important today, as employees will be required to be more involved with consumer-driven plans.

Whether a company is modifying plans or introducing new benefits, holding an annual health fair is a productive way to remind employees of all the benefits a company offers. Bringing benefit providers together in a central location and encouraging employees to meet with them will lead to better understanding of the benefits the company offers. Vendors are eager to participate in these fairs as they provide the opportunity to speak directly with clients

and to enroll them in new programs such as group life, long-term disability, or catastrophic illness plans.

In determining how to proceed, every company large or small should consider engaging the services of a health-care consultant or a broker. These professionals are prepared to help businesses navigate through the process by providing the information required to make the correct decision.

Regardless of what health-care plan is ultimately chosen, making the right choice will pay dividends in sustaining a healthy and successful workforce.

Peter C. Savage *is senior executive vice president with Cook and Company Insurance Services, Inc. (www.cookandcompany.com), based in Marshfield, Massachusetts. He has been with Cook for the last 30 years and heads up the company's Health Benefits Division. He may be contacted at psavage@cookandcompany.com.*