ARE YOU LEAVING HEALTH INSURANCE MONEY ON THE TABLE? . .

. . . Top 10 money-wasters for Group Health Insurance Benefits.

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As an employer or a participant you might be leaving money on the table by not properly taking advantage of certain features and benefits of your company's health insurance. As a licensed Consultant and Group Benefits Brokerage company, with clients across the country, we are successful in reducing group benefit expenses because of our experience and our intimate knowledge of the factors used in determining pricing. This top 10 list should be helpful in increasing your insurance knowledge, maximizing your plan benefits and possibly reducing your company's expenses.

Background and Overview:

For most companies, group benefit plans, specifically medical benefits, are among the highest non-producing company expenses. Unlike other expenses, medical benefits hits home since it affects our employees and our families personally. Therefore, it is of paramount concern that the CFO and Director of Human Resources take into consideration the needs of their employees, the needs of their employees' families, pricing, and specific benefits being offered.

The ability for an employee or an employee's family member to use a favorite physician such as a Pediatrician or an OB/GYN is often affected by this decision. The ability for employees and their families to use specialized treatment centers in the event of a catastrophic medical situation also lies in the balance of the Health Benefits decision. Quality and access to medical care varies from insurance carrier to insurance carrier.

Staffing and Retention:

The primary purpose of Group Benefits as a whole as it relates to employers is to attract and retain employees. It goes without saying that the broader the benefits, the easier it would be to attract and retain a higher quality workforce.

As a reciprocal, industries that utilize high turn-over positions with minimum-wage

employees may not necessarily choose to utilize the highest quality insurance policies to attract and retain employees. Employee pools may be abundant and the bottom-line total expenses may be more important than the quality and level of care offered.

With that said, let us share with you some money-saving ideas and under-utilized features of your medical benefits. Keep in mind that some items may relate to your current coverage while others suggest a change in coverage or a change in features of your plans.

The following represents our list of the top 10 frequently made mistakes as it relates to Group Health Insurance. This list is in no particular order. Each item may or may not apply to your current situation.

Top 10 Medical Benefits Mistakes:

1. Not Catching Medical Problems Early

To use a few cliché's, "a stitch in time saves nine" or "prevention is the best medicine", or "kill the monster while it is tiny." I am not sure if the last one is a main-stream cliché but it does hammer home the point that prevention is often the best medicine. Early detection is the second best course of treatment. Many doctors argue that colon cancer is extremely treatable if it is caught in the earliest stages. If the cancer is not detected early there is a risk of the cancer getting more aggressive and spreading through the body. Every person should take the time to get regular exams. Every person should be aware of key medical indicators such as weight, blood pressure, and cholesterol levels. As a person gets to certain recommended ages, mammograms and other early detection tests should be done regularly. Just because you never went for a cholesterol check does not mean your cholesterol levels are zero. That is as foolish as driving around in an automobile without a gas gauge and assuming you don't need to put gas in it since there is no indication of the level. The life you save with early detection could be your own or someone who you love.

Depending on the size of your group and which state your business is located in, early detection means fewer large insurance claims which translates into lower premiums for your company.

2. Not Using the "Value Added Benefits"

Many times, when you think of medical benefits you only think about doctor visits and drug plans. Often, employers and employees do not realize that their insurance carrier might also include services known as "Value Added Benefits".

Health Insurance Carriers offer these Value Added Services to encourage healthy lifestyles. Healthy lifestyles would yield healthy employees which keeps insurance claims down.

It is important to understand your value added benefits for several reasons. First you, your family, and the employees you work with can benefit from these services. Second, your management or human resources department might come off as heroes just by telling employees about these value added benefits. The benefits are already included so you might as well tell people about them.

Examples of Value Added Benefits Include:

a. **Vision** – some carriers have pre-negotiated discounts for vision care such as eye exams and eyeglasses.
b. **Nutrition and Supplementation** – Certain carriers provide discounts or reimbursements for nutritional supplements. Supplementation might keep employees healthier and prevent certain diseases. Some employees are often already paying out-of-pocket for supplements so any discounts become bottom-line savings for the employee.
c. **Quit Smoking -** Employees may be entitled to discounts on programs that relate to quitting smoking. Without going into a lecture as it relates to the dangers of smoking, let's just say that when an employee is ready to quit, it is easier to do it with the help of professional programs. In the event that the Surgeon General is right about the dangers of smoking, healthier employees are happier and more reliable as an employee. This could also avoid future hospital visits and catastrophic treatments as well as delay premature death.
d. **Weight Management** – Employees may take advantage of weight management programs. In some cases employees might already be using well known programs such as Weight Watchers™ or Jenny Craig™. Many scientific medical studies directly relate disease and health risk to an individual's weight. Once again, a healthy employee calls in sick less often, is more productive, and on a selfish side, is likely to minimize the number of claims against your Insurance Policy. Certain company sizes in certain states may be rated and premiums are charged based on the claims filed against the insurance carrier.
e. **Gym Membership** – Discounts and reimbursements may be available for health club membership.
f. **Hearing -** Certain hearing centers may have pre-negotiated discounts with your insurance carrier.
g. **Bicycle Helmets -** Safety equipment such as bicycle helmets may be available at a discount with specific insurance companies and retailers. Certain states mandate that children under a specified age are required to wear a helmet while riding bicycles, skateboarding, or roller skating. Even if helmets are not mandated, it is alarming how many serious injuries might have been prevented with the proper head protection. If you need or want a helmet anyway, you might as well get a discount on it.
h. **Store Discounts -** Various retailers may have a pre-negotiated incentive worked out with your insurance company such as baby stores or

household goods. This is good for the store from a marketing prospective and it is good for the consumer to get a discount.

i. **Security Improvements** – Security companies my provide discount services for your home protection and safety additions.
j. **Stress and Alcohol Management** - Different services may exist for stress management and alcohol rehabilitation and treatment programs.
k. **Mail Order Discounts** – Certain carriers offer additional discounts for mail order prescriptions. This is especially useful for drugs prescribed for the long-term such as heart medicine or cholesterol drugs. You know you need it any way so you might as well stock up by mail.

3. Not Getting a Second Opinion:

Different Insurance professionals have different experiences and abilities. Some Brokers are only Brokers while others are also Licensed Insurance Consultants. Some Brokers specialize in Property and Casualty or Life Insurance while others specialize in Group Health. If you are concerned with your Health Insurance rates and services, perhaps a specialist is what your company really needs.

Speaking as an insurance professional, we of all people, respect and appreciate client loyalty based on past service and existing relationships. On the other hand, how do you really know that you have the most appropriate policy and features if you do not get a second opinion from a different Broker or Consultant? If the relationship with your Broker is that solid, it would not be difficult for your Broker to keep your business. If your Broker's skills are not current and sharp as it relates to your company, his/her complacency might be costing your company tens of thousands, if not hundreds of thousands, of dollars.

Oftentimes, an insurance professional might become complacent with existing clients. This may be due to increased workload, understaffing, or the fact that they are too busy finding new clients. They may not be focusing on your bottom line.

A second opinion introduces a fresh perspective regarding your company's health insurance needs and options. It keeps your broker honest and reminds them that they need to continue to service and provide creative solutions if they wish to keep your business.

Make sure the carrier alternatives are of "like kind and quality". That simply means they are an apples-to-apples comparison.

Mix it up a little. Find out what the increase (or decrease) in premiums might be if you increase (or decrease) the co-pay, deductibles, in-network deductibles, and co-insurance. Look at different options with the drug plan as well.

Sometimes it pays to self-insure a portion in order to reduce premiums. Look at the total exposure, have your broker figure out worst cases scenarios, and contemplate

the probability that the scenario could come true. This dovetails with mistakes #4, #5, and #6 coming up.

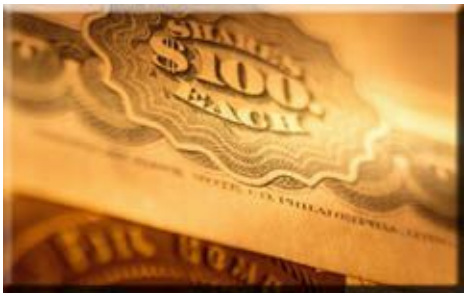
4. Not Looking at the Big Picture of Total Costs

Very often, companies only look at the monthly premiums associated with their healthcare coverage. This is not the only variable when it comes to insurance rates. It is important to look at the total picture which includes:

a. Co-pay amounts
b. In-Network and Out-of-Network Deductibles
c. In-Network and Out-of-Network Co-Insurance Levels
d. In-Network and Out-of-Network out-of-pocket expenses
e. Out-Of-Network Reasonable and customary reimbursement levels
f. Gated or Non-Gated
g. Drug coverage co-pays, co-insurance and deductibles
h. Disease Management and Wellness Programs
i. Employer/Employee Contributions
j. Network Accessibility
k. Disruption Analysis
l. Monthly Premiums
m. Maximum Exposure
n. Maximum Benefits
o. Tax Treatment (See #9)
p. Quality of Coverage
l. Introduced deductibles on drugs
m. Generic and non-formulary drug discounts

Each of the above can be a topic unto itself. We can offer a free consultation to look at your coverage and suggest ways to maximize cost savings and improvements. Please see the "About the Author" section at the bottom of this article for more details.

Paying 100% for Employees



If you pay 100%, by law, employees cannot "waive out" of the insurance plan. Participation must be 100%. By paying less than 100% of the benefits you are able to "create consideration". This gives you flexibility.

What is so bad about having to take advantage of benefits if you are paying all of it? The fact is, certain employees would not be able to use a spouse's insurance plan if they had to use yours. The spouse might offer better quality coverage with more options and better quality doctors.

Do you really want to have to pay for everyone's insurance if they do not want insurance or prefer to waive coverage and go on their spouse's plan? That means paying higher expenses for something that will likely never get used by certain people.

5. Not Listed as the Right Group Size (or Perhaps a Different Stated Size) Is There Common Ownership?

Depending on your circumstances, such as what state that you do business in, you may or may not benefit by being classified as a small group or as a large group. By simply classifying clients in the most appropriate group size we have saved clients thousands of dollars.

Generally speaking, small groups are considered to be groups consisting of between 2 and 50 full time eligible employees and large groups are considered to be groups consisting of 51+ full-time eligible employees. A full-time eligible employee is not the same as an employee that may be covered under the benefits. For example, a group can have 55 employees, with 40 employees on the group health plan, and be classified as a large group.

Depending on your employee population it could be either advantageous or disadvantageous to be considered a 2-50 sized group. Read #6 of this list for more information.

Is There Common Ownership?

In certain situations some companies have common ownership with other companies. Depending upon the percentage of ownership, in certain cases it makes sense to insure the companies separately, while in other cases it might pay to combine the employees and consider it a larger group.

6. Not Knowing Your Employee Population or Offering Different Plans

Similar to #5 in classifying the group size, money can also be saved by having an overall understanding of the demographics that makes up your group. Typically, younger people are healthier and can often afford to take certain medical risks that older employees cannot afford to take. If you realize that your company is mostly made up of younger people who are healthy, it might be a good idea to utilize a high-deductible tax qualified plan with a Health Savings Account (HSA). A high deductible plan is essentially betting on the fact that claims will be minimal throughout the year, so why not pay the lowest premiums available, and at the same time accumulate cash in the Health Savings Account (HSA)?

A high deductible plan does not necessarily mean that you intend to pass on the increased deductibles to your employees. Your company can be willing to pay the deductible (or a portion) through a Health Reimbursement Account (HRA).

Not Offering Different Plans for Different People

More recently than not, the market has been trending towards companies offering multiple insurance plan options. The company may provide a base contribution allowing the employees to choose between "a base", "a buy-up", or "an HSA plan".

In addition, companies can offer a plan based upon employee classification. For example, "Class 1" employees can consist of executives and managers and "Class 2" employees may consist of all others.

7. Not Comparing your Coverage to Your Peers:

The trick is to be competitive without giving away the shop. Typically, to generalize for a moment, law firms might offer the best insurance available for the money while assembly line workers might be given average benefits for manufacturing. But what is average and how do you find out what is standard and customary?

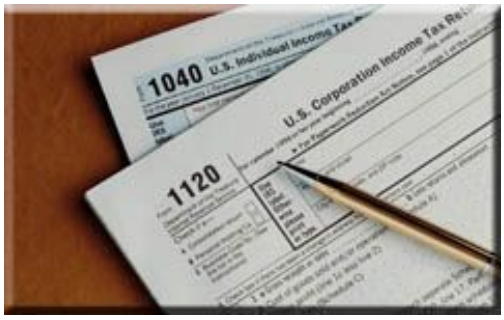
A "Benchmark Analysis" is a report that can be ordered to get statistics and trends about comparable companies in your industry, company size, and/or in your region. Although these reports often cost some money, the information provided could be valuable in attracting and retaining qualified employees without giving away all of the profits.

8. Blindly Auto-Renewing

Even if you love your Broker, it is a mistake in not treating each renewal period as an opportunity to find out what policies or other insurance companies are more competitive or appropriate for your company. Each renewal period should be treated just like you are looking for insurance companies for the first time.

With our clients this step is invisible to them. We always look at the renewal numbers and compare them to other carriers or to other policies within the same carrier. Over the years it became obvious that the only constant in life is change. Based on the insurance company's desire to increase or decrease market share, they often choose to increase or decrease their risk tolerance and policies. A renewal period is a great opportunity to make sure you have the right coverage for your circumstances.

9. Not Using the Right Tax Treatment for Your Company



Although we encounter this particular "money-waster" often, we are not an accounting firm and suggest that you speak with your tax advisor, accountant, or CPA before doing anything.

Pre-Tax or After-Tax Dollars:

Typically speaking, health insurance premiums are tax deductible with pre-tax dollars, while co-pays, deductibles, co-insurance, and prescription co-pays are usually paid with after-tax dollars. It might be a good idea for your accountant to work with your broker to come up with a tax strategy that works well with your human resources and health benefits objectives.

Employee Tax Treatment

Are the employees paying for their portion of the health insurance premium through the use of a "Section 125" premium only plan? This will allow employees to pay the health insurance premium on a pre-tax basis thereby reducing the employer payroll taxes.

You may want to consider offering a Flexible Savings Account (FSA). An FSA allows employees to pay for a portion of their un-reimbursed medical expenses on a tax-free basis.

10. Losing Money Due to Poor Administration.

We hear about it almost every day. Due to poor administration, employers neglect to advise the insurance carriers of newly terminated or newly eligible employees.

In many cases, the guidelines are rigid and clear. A simple mistake with administration may cause your company to either pay insurance on someone who is no longer with the company or it may open yourself up to liability. Had an employee been eligible for benefits, but somebody forgot to do the paperwork, your company could be liable for claims.

Liability of not setting out corporate notices

Notices may need to be communicated due to changes in coverage or policy changes. Once again, in many cases the burden of proof might be on you. If you do not notify employees of the changes you might be held accountable for the lack of notifications.

COBRA Notifications

Last but not least, in many circumstances an employee has a legal right to be notified if they are eligible to participate in the COBRA insurance program post termination. COBRA is the Consolidated Omnibus Budget Reconciliation Act. This gives employees the right to continue health insurance given certain qualifications. By not properly notifying the employee, your company is in violation of federal law and can perhaps be held accountable for claims and medical expenses incurred by the employee. By properly notifying the employee, the liability lies in the hands of the employee and the insurance company if they choose to continue coverage.

So What is Your Next Step?

It's great that you made it this far into the article and that by itself gives you plenty of things to look at in deciding if you are making any of the above mistakes. In some cases you can change your behaviors midstream. For example, you can find out from your current carrier if there are any Value Added Benefits that you may not be aware of. You can also make sure that your company has an accurate list of employees who should be on the policy or need to be added.

Once again, Group Health Insurance is one of the largest non-producing expenses for most businesses. It is up to the business as well as their employees to maintain an active role with wellness, routine exams, and disease management programs. Insurance might be considered an expense, but when it comes down to it, health and lives are at risk.

DISCLAIMER: Information is intended as a general nature. Always consult a licensed professional before implementing anything.

ABOUT THE AUTHOR:

John R. Klimchak has been in the insurance field for over 20 years. He is a licensed Insurance Consultant and a Licensed Insurance Broker. Mr. Klimchak is also the President of Economic Evaluation Group, Inc. (www.eegroup.com), a firm specializing in Group Health benefits and other related services. For a free consultation call (516) 338-2800 and reference the "Top 10 Mistakes Article".