

Group needs from an insurance perspective

DIFFERENT TYPES OF WORKERS REQUIRE DIFFERENT KINDS OF MEDICAL COVERAGE.

In a perfect world, every employer would have the financial ability to provide major medical coverage to all of its employees. As a broker, however, that would limit your ability to be creative and meet the varied needs of your individual specific clients.

When selling insurance to employers with part-time and hourly employees, brokers must realize that these employees' insurance needs are much different than what you encounter when selling major medical coverage. So how does a broker evaluate a company's benefits needs from a group perspective?

Providing flexible and affordable benefits that meet the day-to-day needs of employees — whether it's major medical or limited medical — has been most successful for employers and the agents who serve them. When deciding which health insurance route might be most appropriate for a specific employer, there are many questions that must be addressed. Where do hourly and part-time employees find the most value in an insurance plan? What are the expectations of the employee and the employer? For example, with hourly and part-time workers, catastrophic coverage is not typically part of the mind-set. They are more concerned with benefits that will enable them to take their child to the doctor and receive preventative care. In addition, all benefits offered must be simple to understand and easy to use.

In order to more fully understand the mind-set of an hourly or part-time employee and the challenges he faces, consider the following:

You are an hourly employee at a convenience store and you have never been enrolled in a group health insurance program before. In your best year, you made \$39,000; you are working hard to duplicate that number. You pay rent, will finish paying off a 7-year-old car this year and have two kids. You have no assets that you concern yourself with, and you continually run out of paycheck before you run out of month.

Your employer just informed you that raises are out of the question this year. But you will be offered the opportunity to enroll in a major medical health care program. The plan has a \$1,000 deductible, with 80 percent coinsurance in-network and 60 percent coinsurance out-of-network with a \$1 million maximum. There is a 12-month pre-existing condition limitation and a \$25 co-pay for a doctor's office visit as long as you visit an in-network provider. For out-of-network doctor visits, you must satisfy the deductible first. Your employer is making this plan available to you at a reduced cost due to the 50 percent contribution the employer is making toward the individual monthly premium. Your cost will be \$135 per month, and if you want to enroll your two children, you must pay an additional \$350 monthly.

DREAMS VS. REALITY

The prospect of benefits seems exciting, but you certainly cannot afford that type of payroll deduction. You live in an area of town that is not well served by the preferred provider organization, and if something really

bad happens today, you can go to the county hospital at no charge. The proposed deductible is high and using the plan entails some amount of cash coming out of your pocket, no matter what service you seek. Besides, you don't have anything to worry about losing with no assets at risk. The plan offered by the employer does not seem to offer anything of value. It is clear that the plan could not effectively meet you where you are and therefore provide a valuable and usable solution to procuring day-to-day health care benefits.

The end result in this scenario is that you and most of your co-workers do not enroll in the plan. In fact, the employer had to drop the offering for lack of participation.

But since the issue of benefits has come up, you and your co-workers begin to kick around the topic in conversation. The talk becomes a series of "what ifs" and "if onlys" but is soon dropped because no one believes any of the ideas presented might actually be available and affordable. You and your colleagues believe that there is simply no way that a plan would successfully address situations such as:

- What if the plans did not have any medical questions? Or, if you did not have to answer a bunch of questions, will they cover you?
- If only there was a plan that would allow me to just get a physical.
- What if I could just go to the doctor when I get the flu?
- If only I could go to the emergency room and be seen more quickly.
- What if there was a plan that cov-

ered accidents, without a deductible, so I could go to the emergency room?

- If only there was a way to help buy prescription medication.
- What if you could choose any doctor and not have to worry about choosing a doctor from some list?
- If only these plans did not have such a high deductible.
- What if I could afford to enroll?
- If only I could cover my children.
- If only my employer would offer something affordable.

It was clear that there was not a plan that could effectively meet your needs and therefore provide a valuable and usable solution to procuring day-to-day health care benefits.

FROM THEORY TO REAL LIFE

While this scenario may seem far-fetched or foreign to your experience, it is a very real occurrence. Our firm is approaching 100,000 lives, many of which fall into scenarios much like the one above, successfully covered beyond limited medical plans. By working with hourly employees and their employers over the past 25 years, we have become very accustomed to serving and identifying with the needs of that marketplace. Limited medical benefit plans are one way that we meet those needs.

Employees working in an hourly environment and living paycheck to paycheck can only afford to spend about one or two hours of pay per week on benefits. When they make the choice to spend that money, they want something they can use today, something that presents real value in situations applicable to daily living.

In this case, value is determined by usability for the hourly worker.

Features such as:

- No pre-existing condition limitation
- First dollar benefits (no deductibles)
- Freedom to choose the provider
- Clear understanding of benefits before seeking service

- Guarantee issue
- Plastic ID card
- Prescription guides
- Affordability

These items all create a comfort level for hourly employees. Good limited medical programs average \$80 monthly premiums for individuals, and dependent coverage averages an additional \$100. Remember, this is a fully insured plan written by reputable carriers.

However, old habits persist. Limited medical programs are not a solution for the high cost of major medical and should never be marketed as such. Limited medical programs are gaining steam because there is a large market of underserved people who would like help with day-to-day medical coverage. This group of people wants to buy insurance through their employer and forward-thinking employers are working to give employees this opportunity.

There are some who would argue that limited medical programs do nothing to solve the problem of people being underinsured and of bill collecting for significant medical services. Those arguments have merit, but I believe those are problems of education and resources, which certainly don't call for the elimination of limited medical programs. Limited medical programs are not trying to solve those problems; they are simply and effectively meeting the needs and wants of employers and employees who are not in the market and cannot afford a major medical insurance program.

Limited medical programs provide many people with the dignity of being seen and receiving routine medical procedures and day-to-day health care services. Why should people go without anything?

BALANCING ACT

As we all know, the human resources department has a balancing act to perform. It is charged with meeting the needs of a large and diverse population of employees. Executive and salaried employees consume large amounts of

payroll and large amounts of the department's attention. It has been our experience that HR managers need to be on top of the major medical plan and its operation and services, so that executive and salaried employees stay happy. After all, the employer has a large amount of money invested in benefits. But, that often leaves the hourly employees with a small portion of the department's time. It is easy to agree that hourly employees are some of the most important individuals and may be the most visible to the public in any given company, but the fact remains, from an asset and time standpoint, HR can not afford to spend a lot of time working with the hourly employees' needs.

Therefore, successful limited medical programs must be like pack mules. If they can ease some of the burden the HR department is feeling, then you might make a long-term friend. Enrollment, eligibility, customer service and billing should all be customized to fit a specific client. The good limited medical plans have been very successful in this area. Brokers should understand how these functions can affect their clients.

Helping the employer identify its employees' needs is crucial in any benefit selling situation. In the case of limited medical, it is not an impossible identification process; it is just different than those you routinely face in the course of selling major medical programs. Find out what the difference can be for your clients, particularly those employing hourly and part-time employees. Limited medical very well might be the answer they've been seeking as a way to offer affordable yet real benefits to their part-time and hourly workers. ■

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