

Health Insurance Guidebook for Small Businesses

March, 2003



**WAUSAU/MARATHON COUNTY
CHAMBER OF COMMERCE**

Basic Information on Health Care Plans

Introduction:

Increasing health care costs have led to increased premiums for employers offering health benefits to their employees. Employers have been forced to seek alternatives to mitigate the impact of these increases. The objective of this booklet is to help employers understand the problems and provide strategies to address them.

Average Annual Premium:

The average annual premium for single coverage in Wisconsin for 1999 (the most recent data available) was \$2,502. Family premiums averaged \$5,750.

The health care trend has continued to increase since these figures were reported, with today's family premiums averaging \$900 - \$1,200 per month. While employers have absorbed a major portion of these increases, they have been forced to pass on a portion to their employees through actual monthly payroll deductions or increased deductibles and coinsurance.

According to a December 2002 survey by the Milliman USA consulting firm, the average cost of health care rose 18 percent during 2002. This increase comes on the heels of an 11.1 percent increase in 2001. Projected increases for 2003 are in excess of 17 percent.

Employees' Share of Premium:

Forty-three percent of employers polled in a recent survey indicated they increased employee cost sharing in 2002 through increased deductibles, co-pays, co-insurance and premium contributions. Additional cost sharing alternatives are planned for 2003.

Benefit Plan Choices:

Large employers generally offer their employees multiple benefit options through annual enrollment periods. Employees make specific plan choices based on their medical needs, benefit designs, provider panels and monthly contribution levels. Small employers generally only offer one benefit option.

Extension of Coverage After Termination of Employment:

If employees terminate employment, they have the option of maintaining medical coverage for 18 months under COBRA. COBRA is the Consolidated Omnibus Budget Reconciliation Act of 1985. This law applies to insured plans and self-funded, employer-sponsored plans. It does not apply to church plans, plans covering fewer than 20 employees and those covering federal employees. It is administered through the existing group health insurance carrier.

The terminating employee is required to pay the full cost of the extended coverage under COBRA. Employees can also use COBRA if their work hours are reduced and they no longer qualify for a company's medical plan. If an employee terminates because of a disability, or becomes disabled during the first 60 days under COBRA, the COBRA

coverage can be extended for 11 additional months up to a total of 29 months (which is the waiting period for Medicare disability coverage).

Individuals who stay on COBRA until it runs out cannot be denied the ability to buy a private health care policy. Also, the insurance company cannot make an individual prove insurability or require a pre-existing condition exclusion period.

Wisconsin Continuation- Applies to Wisconsin employers with 19 or fewer employees.

Wisconsin insurance regulations require a continuation program very similar to COBRA for small employers.

Health Insurance Is Not Legally Required:

The State of Wisconsin provides review and oversight of health insurance companies, through the Department of Insurance, but there is no law requiring firms to provide employees with health insurance coverage (worker's compensation coverage is mandated by the state). However, many businesses believe that offering medical coverage is required to attract and retain the best employees. Firms that offer medical insurance generally limit eligibility to those employees working 30 hours per week or more.

Other Sources for Medical Coverage:

In addition to employer-provided coverage, sources for health insurance include professional, trade or membership associations, unions, fraternal organizations or other groups. When considering individual plans, buy a policy that will cover major expenses and pay those expenses to the highest maximum level. In some instances it might be a good idea to pay a higher premium for a lower deductible plan. This can prevent the stress associated with finding cash to pay the deductible during an illness.

If you are turned down, don't give up. Wisconsin offers a high-risk insurance pool for people who cannot obtain conventional coverage. The Wisconsin Health Insurance Risk Sharing Plan (HIRSP) offers health insurance to Wisconsin residents who, because of medical conditions, are unable to find adequate health insurance coverage in the private market. Information on HIRSP can be obtained by contacting:

HIRSP
6406 Bridge Road, Suite 18
Madison, WI 53784-0018
(800) 828-4777 or
(608) 221-4551
www.dhfs.state.wi.us/hirsp/index.htm

Tax Deductibility:

Health insurance premiums paid by a C corporation are generally fully tax deductible to the company. If a group health insurance plan satisfies certain anti-discrimination restrictions, premiums paid will not be included as income to the employee. A self-employed individual can deduct 100 percent of health insurance premiums paid, effective January 1, 2003 (the deduction is for 70 percent of the premiums for 2002). Partners or 2

percent shareholders in a corporation which elects to be taxed under Sub Chapter S of the Internal Revenue Code can deduct health insurance premiums but they must also include premiums paid for their coverage as taxable income. See your tax advisor and insurance consultant for details on this subject.

Group Coverage

Group health insurance is one policy covering a group of people. The insurance company agrees to insure *all* participants. The most common users of group policies are corporations, however, health insurance plans are not limited to employers. Many times clubs, organizations, special interest groups, trade associations and religious groups organize health care for their members. Group plans have a number of advantages:

- After the initial setup cost, group plans are generally less expensive for the employer and participant.
- Many employers cover part or all of the insurance premiums.
- There are no physical exams required.

Limited choice of program design is the major drawback to group health policies. New enrollees in an already established group plan have no voice as to what type of policy - HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) - would serve their purpose or what amount of premium, deductible and maximum lifetime coverage would fit their budget.

Choosing health insurance coverage can be a confusing and time consuming process. Coverage and quotes can differ from company to company, but there are many good health insurance policies available. Before selecting any insurance group plan, be sure to research the policy to determine if it is right for you and your employees.

The first point to consider when evaluating health insurance coverage is the type of plan for your firm. There are two levels of coverage: standard and catastrophic. Standard coverage benefit designs have many options including combinations of co-pays, deductibles, co-insurance and optional benefits such as physical exams and prescription drug cards. Standard coverage often includes benefits for doctor visits and wellness services. The catastrophic plan is designed to protect the insured from the expense of a major illness or injury that could be financially devastating without insurance coverage, after meeting a deductible of \$2,500 or more.

When considering health insurance coverage, you should also think about what type of managed health care system you prefer, HMO or PPO. Most insurance companies offer HMOs and PPOs on group and individual policies.

Another important health insurance coverage issue is cost. Premiums and deductibles will determine the level of coverage you can afford, and depending on your health status and finances it may save you money to pay a lower premium with a higher front-end

deductible. Careful calculation of each plan will determine the exact cost-savings for each level of coverage. Co-payments, out-of-pocket maximums and lifetime benefit ceilings should also play an important role in your insurance decision, as they can affect your assets should a catastrophic event occur.

Unfortunately, small business in the United States bears the weight of heavy expenses when it comes to health insurance for employees. It *is* possible and fairly easy for small businesses to obtain health insurance for their employees, but it can be costly. Insurance companies often penalize small business with higher premiums because small firms are unable to spread the risk among a large number of employees. The State of Wisconsin has specific regulations for the health insurers that work with small business. These regulations cover employers with two to 50 employees.

There are several options for small business health insurance from the local level to the national level. The first option is group insurance purchased directly from the insurance company. Group insurance quotes can be obtained by calling an insurance carrier, an insurance agent/broker or via the Internet. You'll need only a small amount of information about your employees to get started, including their full name, date of birth and home zip code. **Keep in mind that final rates will be dependent on the health statements completed by each member to be covered by the health plan.**

If your local resources don't offer what you are looking for, the next step is your state insurance department. It is the state insurance department's job to provide information regarding local and state purchasing pools, which may offer less expensive options for small businesses.

A third alternative is the National Federation of Independent Business (NFIB). The NFIB is a national lobbying group that is currently petitioning Congress to amend the Patient Bill of Rights to make more affordable health insurance available to small companies.

The NFIB is pushing for Association Health Plans, similar to local purchasing pools, which would allow small businesses to obtain health insurance as a large group and at a lower rate. At this time, the NFIB has information on local pools in each state that will assist small companies in finding affordable health insurance. You can find the NFIB at www.nfib.com or call (202) 554-9000.

Plan Structure:

Considerations when selecting a health plan include deductibles, choice of physicians and hospitals, limits on benefits, as well as coverage for pre-existing conditions.

There are two basic kinds of coverage: **fee-for-service** (also called traditional or indemnity) and **managed care**. Fee-for-service plans tend to be more expensive in terms of premium, primarily because they offer no cost control features. Managed care plans operate by negotiating discounts with doctors and hospitals. They control which providers a patient may see and, in some instances, how frequently a patient may see a

particular provider. There are two main types of managed care plans: the HMO and the PPO. Each of these controls access to the health system. Managed care plans have become the most common among the plans offered in the north central Wisconsin market.

- **Common Plan Features:**
- **Deductible** - This is the amount of the covered expense that you must pay each year before the insurer will begin paying. Deductibles can range from \$100 to \$1,000. Most plans will offer a family deductible, which is an accumulation of covered expenses for all covered family members. Once the family deductible is reached the insurer will begin paying covered expenses for all family members.
- **Co-insurance** - This is the portion of the covered medical expense that you pay. It is designed to discourage overuse of the medical system by requiring the insured to pay part of the cost, generally 20 percent. (This is not the same as “co-pay,” which is a flat fee paid by HMO members for medical services.)
- **Reasonable and Customary Fee** (fee schedule) - Insurers have schedules of fees for professional services and will not pay more than the maximum on that schedule. If a medical provider charges more than the “reasonable and customary fee,” the patient must pay the difference. In a managed care plan the providers agree not to bill the patient for amounts exceeding the reasonable and customary amount.
- **Covered Services** - Group insurance policies typically exclude services that are not directly related to an illness or injury. Examples include cosmetic surgery and experimental medical procedures.
- **Lifetime Limit** - This is the maximum amount paid by the insurance plan for an individual. This usually ranges from \$250,000 to \$1,000,000.
- **Out of Pocket Maximum** - Once an individual’s or family’s expenses reach a certain amount in a calendar year, the insurer will pay the remaining charges in full.

Additional Resources for Information:

- The Office of the Commissioner of Insurance provides an excellent resource on health insurers in Wisconsin and frequently asked group health insurance questions:
www.oci.wi.gov/consinfo.htm
- Life and Health Insurance Foundation for Education’s discussion of basic forms of health insurance and a checklist to compare plans:

www.life-line.org/health/bottom.html

- Health Insurance Resource Center's glossary, consumer tips and answers to common questions:
www.healthinsurance.org
- AARP's discussion of managed care and traditional insurance:
www.aarp.org/indexes/health.html#insurance
- National Partnership for Women & Families' Guide to HIPPA:
www.nationalpartnership.org
- RING! Online's tips on how to check and organize your medical bills:
www.ring.com/health/medbill/medbill.htm
- Health Insurance Association of America's discussion of health insurance:
www.hiaa.org/consumer
- A resource for a general idea of price range and benefits for many different health insurance provider companies. Before committing to any policy, be sure to research thoroughly and ask questions:
www.eHealthInsurance.com

Trends in Plan Design

As medical plan costs have continued to increase, employers and insurance carriers have sought means to reduce premiums and the use of plans. The following are some of the methods being used:

Increase Cost Sharing by Employees:

A number of different approaches are being taken to shift more of the premium to employees, including:

- Paying 100 percent of the premium for the employee and a lesser percentage for family coverage. In some situations the employee is asked to pay 100 percent for family coverage.
- Requiring employees to pay some fixed percentage of total premium ranging from 15 percent to 40 percent.
- Increasing employee contributions annually by the percentage increase in medical plan expenses. This "indexing" of premiums will hold the employer's expenses at a fixed amount.
- Offering "defined contribution" plans. In the most modest version of defined contribution the employer provides a fixed amount of money for the employee to purchase medical coverage directly from an insurance carrier. This approach transfers responsibility for securing coverage to the employee. Other versions of

defined contribution are integrated into “flexible spending plans” as outlined below.

- Offering a cash incentive for employees who waive coverage. Many times when a husband and wife are both employed, they will each have medical coverage through their employer. Since this dual coverage is expensive, firms will offer cash payment for the employee to waive coverage. Generally the employer will require proof of coverage by another plan before allowing the cash-out.

Allow Employees to Pay for Health Premiums with Tax-Free Dollars:

A firm can lessen the burden of premium increases by establishing a Section 125 (Internal Revenue Code) "flexible spending account," which allows employees to pay both their share of health insurance premiums and non reimbursed health care expenses with pre-tax dollars. This can save employees between 20 and 35 cents on the dollar because federal and state income taxes are not imposed on the spending account funds. Moreover, the company saves by reducing the employee's base salary on which it pays Social Security and other taxes. A benefit consultant should be used to help the company set up this program.

Reduce Benefit Coverage Levels:

Cost reduction can be realized by lowering the benefits provided by your medical plan. While this amounts to another cost shift from the company to the employee, such changes help to conserve the medical benefit plan for the future.

- **Increase Eligibility Periods** – This is the waiting period that a new employee must meet before being eligible for medical plan participation. The eligibility period can be increased to limit the exposure to large claims from new workers.
- **Increase Deductibles** – Likely the most common current trend is to increase deductibles from \$100 per calendar year to \$400 or \$500 per calendar year (some as high as \$2,000). According to the William Mercer study cited earlier, most small employers have raised the annual deductibles from \$250 to \$500. Deductibles over \$1,000 per year are offered by 17 percent of the survey respondents.
- **Increase Co-insurance** – Medical plans with 100 percent coverage are now rare. The standard co-insurance amount is 80 percent paid by the plan. Some HMO and PPO plans provide lower coinsurance (70 percent or less) when a plan member uses out-of-network medical providers.
- **Prescription Drugs** – With prescription drug costs rising at a rate of 18 percent per year, plans are moving away from prescription drugs reimbursed at 80 percent. Many plans now offer a three-tiered deductible plan such as the following example:
 - \$5 for generics
 - \$15 for formulary (a list of drugs approved by the insurance company)
 - \$30 for non-formulary

Switch to a Narrow Network Managed Care Plan:

Managed care plans (HMOs and PPOs) attempt to hold down costs by placing controls on the use of medical services. New generation managed care plans offer an additional

smaller provider network within their participating provider panel. Members utilizing the providers in the reduced panel enjoy the highest level of benefits and lower premiums.

Narrow network plans will expand as new providers make a presence in the community. Carefully evaluate your patterns of care and determine if you are buying a wider network of doctors than you really need.

Additionally, there are several plans offering higher deductible options in conjunction with a savings alternative. These come in many forms including medical savings accounts (MSAs), medical expense reimbursement plans (MERPS), personal health accounts (PHAs), and flexible spending accounts (FSAs). Each of these has a unique use but essentially accomplish the same goal - giving the consumer a larger stake in the purchasing of health care.

Small Group Health Insurance Checklist

The following checklist will help you compare policies presented to you by your insurance agent.

Plan:

1. What medical services are covered?
2. Are benefits for medical services limited or excluded?
3. Do certain medical procedures or services require pre-approval by the insurance company?
4. How are pre-existing conditions covered?
5. How long is the insurance rate guarantee?
6. Does it offer a health care certification program to review quality and cost effectiveness?
7. In comparing managed care plans, evaluate policy provisions for out-of-area coverage (medical emergencies and students living away from home).
8. Determine if your favorite doctor and/or hospital is included in the “network” offered by the insurance plan (out-of-network providers are sometimes covered at lower benefit levels).
9. Does it offer a catastrophic case management program?
10. What is the policy's lifetime maximum amount of coverage?
11. What does the policy cost?

Insurance Company:

1. How long has the company been in the small group market?
2. What is the company's financial rating?

Service:

1. Who will administer the program?
2. Is customer service easily accessible? Is there a local office? Is there a toll free number?
3. What type of claims processing system is used?
4. How long will it take for an application to be processed?
5. How long will it take to process a claim?
6. How often is the company billed?

Local Resources

The following is a listing of Chamber members who work as medical insurance plan insurance brokers:

American Family Insurance

Heather L. Bresnahan
715-842-9608

The Boller Group

Richard C. Boller
715-845-6088

**American Family Insurance
Jeff Canniff Agency Inc.**

Jeff Canniff
715-842-5262

Clint West – Insurance Agency

James C. West
715-845-7039

American Family Insurance

Jamie Thomas
715-359-2400

The Jabas Group Inc.

James A. Berry
715-355-5310

Bankers Life & Casualty

De Well R. Clay
715-842-0497

Helke/Corsten Insurance Group

Donovan Helke
715-849-9922

Benefit Concepts of Wausau LLC

Sarah Niesl
715-845-3557

The Insurance Center

Sue Buettner Duginske
715-845-3184

Benefit Partners LLC

Matt Kolling
715-693-2100

Manson Insurance

Dan Meschefske
715-845-4371

**Blue Cross & Blue Shield United of WI
Ginger Wolf**

888-223-9579

Marcell Insurance Agency Inc.

David Marcell, Gordon Schalow
715-359-9330

Security Health Plan of Wisconsin Inc.

Steve Brenner
800-472-2363

WPS/NCHPP

Matt Young
715-843-2773

Virchow Krause Employee Benefits

Dave Haylett
715-845-2540

Wausau Insurance Companies

Mark Meeks
715-847-8120

Wayne Syring Insurance Agency

Brad Lantzer
715-842-3464

The following insurance carriers are underwriting small employer group plans in our market area:

American Medical Security
Avemco
Blue Cross & Blue Shield United of WI
CBSA
Fortis
Golden Rule
Humana
MetLife
Midwest Security
Pekin Insurance
Principal Financial
Security Health Plan of WI Inc.
Starmark
Trustmark
Wisconsin Physician Service (WPS NCHPP)

Notes

Please call the Chamber of Commerce at 715-845-6231 if you have any questions or comments about the information contained in this booklet.