

A Checkup for Health Benefit Offerings

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Managers must assess plans regularly to ensure they meet employees' needs.

Corporate layoffs may indicate softer labor markets, but demand for qualified people is still great in many areas of business. That means that quality benefit offerings still can tip the scales when prospective candidates are weighing job change decisions. What constitutes "quality benefit offerings?" And how can a company improve offerings when budgets are tighter than ever? An annual review is an important tool to ensure the company offers the maximum benefit in the most

cost-effective manner possible.

Health benefits alone offer a significant opportunity for revision and improvement. Cost increases are a given in health care and health insurance today. Health care personnel costs are increasing, malpractice insurance premiums are rising, underpayments are increasing and technology costs are spiraling upward. These constant increases lead to continual changes in insurance offerings, which means the offerings must be reviewed regularly to ensure that a company maximizes the benefits it provides.

A comprehensive review of your benefit offerings begins with assessing your employees' needs, then looking at what you offer them presently and exploring potential areas for improvement.

► **Employee needs.** Who are your employees, and what do they value? More flexible insurance coverage? Reduced costs? More covered services? It is important to understand how they view their

present package before you can determine how you can improve it. Get in touch with what employees at all levels of the organization value, and look for ways to meet their needs. Conduct a survey to determine what they want and need (see Exhibit 1). Consider not just present employees but dependents, retirees and even former employees.

► **Present plan.** Analyze the benefits presently available and look for gaps between what you offer and what employees want. Look also for overlapping benefits or redundancies. Think about not only what is offered but also the degree to which employees take advantage of what is offered. Consider the recommendations that employees and former employees make in their survey responses. Examine whether employees might value a flexible benefits approach. Look for ways to offer the same benefits for a reduced cost, such as a managed healthcare plan. Determine whether employees will better appreciate the greater flexibility of traditional healthcare versus the cost savings of a health maintenance organization (HMO)-type plan. After a broad-brush overview to identify areas for potential improvement, it is time to get out the microscope and review benefits more carefully. There may be some significant research involved in determining how your benefits stack up against other options.

► **Review.** Review the initial objectives of the plan, then compare those objectives to the plan currently in place. Review the benefits provided, individuals covered and the eligibility requirements. Health benefits in particular offer great latitude for adjustment and improvement, depending on the coverage that matters most to

NOTES

1. Watson Wyatt Worldwide and WBGH. (2000/2001). *Staying @ work: Improving workforce productivity through integrated disability management, fifth annual survey report 2000/2001*. Bethesda, MD: Author.
2. CCH, Inc. (2000, November 1). *Human resources management ideas and trends newsletter* (Issue No. 496). Riverwood, IL: Author.

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your employees. For example, medical expenses can be extended to active employees, dependents of active employees, retired former employees, dependents of retired former employees, surviving spouses and disabled employees. Health benefits must also comply with COBRA and the Family and Medical Leave Act. The company must determine who should be included in the plan, based on the objectives of the plan to meet the workforce's needs.

Options

The three options available for health benefits—indemnity, HMOs and preferred provider organizations (PPOs)—differ dramatically in benefits provided and flexibility (see Exhibit 2).

Indemnity Plans

An indemnity plan combines stand-alone utilization management programs with traditional indemnity benefits, including precertification of

**EXHIBIT 1
Sample Survey of Employee Needs**

Indicate the level of importance of the following benefits to you and your family:

	Low Importance	High Importance
Single health coverage	_____	_____
Family health coverage	_____	_____
Preventive health care	_____	_____
Flexibility in choice of physician	_____	_____
Prescription coverage	_____	_____
Vision coverage	_____	_____
Dependent care assistance	_____	_____
Educational assistance	_____	_____
Paid maternity leave	_____	_____
Disability insurance	_____	_____

Indicate any two benefits listed below that you feel can be enhanced by the company, and include a comment suggesting how:

Health care coverage	_____
Prescription coverage	_____
Vision coverage	_____
Dependent care assistance	_____
Educational assistance	_____
Maternity leave	_____
Disability insurance	_____

If the company could spend additional money on benefits, rank in order of importance (1 = most important; 7 = least important) which of the following benefits you suggest should be funded:

- _____ Health care coverage
- _____ Prescription coverage
- _____ Vision coverage
- _____ Dependent care assistance
- _____ Educational assistance
- _____ Maternity leave
- _____ Disability insurance

EXHIBIT 2
Comparison of Plan Features

Plan Feature	Coverage		
	Indemnity	HMO	PPO
Deductible	Applies	None	May be waived for certain services
Provider choices	Any	Options provided by HMO	Can be in network or out of network
Copayment	None	Minimal; typically \$10 to \$15	Minimal; typically \$10 to \$15
Cost to sponsor	Highest	Lowest	Moderate
Cost to participant	Highest	Lowest	Moderate
Flexibility to participant	High	Low	Moderate

inpatient medical, surgical and some other admissions; concurrent review of ongoing confinements for medical necessity and discharge planning to encourage alternative treatment, such as precertification for selected outpatient surgical and diagnostic testing procedures (whether performed in a physicians office, hospital outpatient center or ambulatory facility), second surgical opinions and case management for high-dollar cases.

In an indemnity plan, deductibles should be linked to inflationary increases. Low deductibles do not necessarily increase the use of the health system. If the deductible is not increased, the plan sponsor's costs will most likely increase. Under a standard indemnity plan, virtually all expenses are subject to a deductible. Certain benefits may be paid at 100% if they are an alternative to inpatient hospital care. Most comprehensive plans have a maximum out-of-pocket payment. Special daily limitations and annual maximum and lifetime caps usually apply.

A typical 90/10 plan may look something like the following: Benefits are paid at 90%, subject to the deductible, for inpatient room and board, maternity and newborn care, administration of radiation and chemotherapy, inpatient surgical services, physician office visits, chiropractic care, anesthesia, outpatient hospitalization services, emergency accident and medical emergency expenses, prescription drugs, private duty nursing, preadmission hospital testing, skilled nursing facility care, hospice care, respite care and physical and respiratory therapy. Benefits may be paid at 100% for outpatient diagnostic tests, x-rays, lab exams, outpatient surgery, home health care and second surgical opinions for specific procedures.

Managed Care Plans

A HMO's intent is to maintain the participant's health; the plan is geared toward health maintenance and not treatment of illness. As such, HMOs typically provide richer preventative benefits. Financial incentives and cost controls are structured differently. HMOs usually have no copayments or modest copayments for routine physician visits. Most plans offer broader health care coverage, especially in the areas of wellness and preventive care, such as routine physical exams, preventive screenings and diagnostic tests for early detection of certain diseases, prenatal and well-baby care, immunizations for prevention of diseases, vision and dental checkups and allowances for health care memberships. The critical difference, however, is the highly controlled way in which the individual accesses the delivery of care.

PPOs

With PPOs, medical providers usually offer discounted pricing because of the volume of business received from the contracting organizations. The medical providers are reimbursed on a fee-for-service basis, but the fees are lower than with a traditional plan because of the negotiated discounts. The benefit of a PPO is that it can perform as the sole source of medical care for an employee group or the PPO can be positioned as a choice among several medical plans the employer offers. In addition, the PPO may provide an in-network benefit for a point-of-service program (POS).

Understanding the Options

Under a POS, the participant can decide whether to remain in network and receive a higher level of

coverage or alternatively select a medical provider who is out of network and assume personal responsibility for a larger share of the care cost. This is attractive to participants who do not want to be restricted to receiving medical care only from network providers but still would like to receive the same coverage and wellness benefits provided through a managed care system. This also works well for medical providers who are willing to join the PPO and provide medical services for discounted fees but are unwilling to assume the financial risks of HMO participation, in which a monthly fee is often paid to the doctor for each member regardless of the frequency of visits and the care provided.

PPO plans offer members some flexibility in choosing providers because they can see any provider within the network without a prior referral through a primary care physician (PCP). A neutral level of benefits (80%) typically applies for those services when a network provider is unavailable or if the network does not offer a specific type of medical services so as not to penalize or reward the member for something that is outside the member's control.

In designing a PPO, plan sponsors should determine which of the following approaches meets the needs of the participants.

► **Incentive approach.** Under the incentive approach, the plan sponsor's primary objective is to introduce managed care with the least amount of disruption for employees. Participants receive preferred benefits while maintaining existing benefit levels for nonpreferred benefits. Compared with a standard comprehensive medical plan, which may pay 80% for covered services, an incentive approach would pay, for example, 100% for preferred expenses, whereas nonpreferred expenses would be maintained at the prior 80% benefit level. From an employer perspective, the premiums will likely increase because of higher benefit payments unless provider arrangements are negotiated up front and the impact of utilization controls is large enough to offset the benefit increase and additional administrative expenses.

► **Disincentive approach.** Under the disincentive approach, the plan sponsor's primary objective is cost savings, with preferred benefits equal to the prior plan and nonpreferred benefits significantly reduced. Compared with the standard indemnity plan, preferred benefits remain at 80% after the deductible, and nonpreferred benefits are paid at 60%, with a higher calendar-

year deductible. Savings are maximized because plan design differentials, negotiated prices and utilization management controls more than offset the administrative expense of operating the managed care plan.

► **Combination approach.** The combination approach is for the plan sponsor who wants to introduce managed care with some improvement in benefits but also wants to save money. Using the presumed current 80% standard indemnity plan, the preferred benefits are set at a slightly higher level, for example, 90%, and the nonpreferred benefits at a lower level, for example, 70%. Deductibles also would be adjusted accordingly to match the higher and lower coinsurance benefit levels.

Under a POS plan, participants can use the network of preferred providers when they need health care, and they can use other medical

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providers, but they may incur additional expense in the form of greater deductibles and copayments. This allows plan sponsors to enjoy more cost control than PPO plans offer but provide employees with greater provider choice than in HMO plans. POS plans were initially intended as full replacement products to all other health plans offered but are now commonly offered as one option among several.

Under a POS, there is generally no deductible and 100% coverage after a small office visit copay for care rendered through the selected PCP. Preventive services are typically covered when obtained through the member's PCP, and it is the PCP who directs medical care and obtains necessary precertification for hospital confinements and referral care. For self-referred nonpreferred services, the member is responsible for obtaining

any required precertification and handling any other utilization management requirements.

POS plans can use incentive, disincentive or combination approaches to plan design, but there must be a greater differential (30%) between preferred and nonpreferred benefits than in a standard PPO. Inadequate steerage works against the objectives of controlling health care delivery and costs through the PCP, in which quality of care is best coordinated and monitored.

POS participants generally appreciate that they can make their own decisions about whether to remain in the network and receive a higher level of coverage or select a medical provider who is not in the network and take personal responsibility for a larger share of the cost of care. It is attractive to the delivery system for participants who do not want to be restricted to receiving medical care only from network providers but still would like to receive the same coverage and wellness benefits provided through a managed care system. If an employer moves from a standard indemnity plan to managed care, savings will reflect the initial cost reductions from transitioning membership from a traditional indemnity plan to managed care, as well as the level of provider discounts, the change in benefits and the degree of utilization control included in the new managed care plan.

Other Options

In addition to health coverage, employers should review their other health-related benefit offerings. Skyrocketing prescription drug costs have made prescription drug coverage popular with employees. Dental coverage and vision coverage also may be valued in a given workplace, depending on employees' needs.

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Prescription Drug Plans

These may or may not be a component of the basic health plan. Prescription drug benefit programs can be designed under the indemnity plan or under managed care. Under the indemnity

plan, the employee would need to meet the annual deductible and then is subject to coinsurance, typically at 20%. The participant would pay for the prescription and then file a claim. Under managed care, a fixed cost is associated with the prescription; for example, the individual may pay \$12 per prescription drug, regardless of the retail price.

Dental Plans

Under indemnity dental plans, the expenses are submitted to the insurer for payment after the procedure is performed. If the expense is covered, the payment is typically made to the covered employee, unless the employee directs payment to the provider. Under a preferred provider arrangement, benefits are paid directly to the dentist, according to a contract that is between the dentist and the provider. Under a group practice or HMO-type arrangement, a certain range of dental services is provided to eligible participants, generally in return for fixed payments. Services are provided by dentists practicing in practice groups or through affiliations.

Dental plans normally include preventive and diagnostic expenses, which are typically covered at 100%. Minor restorative procedures can include restoration, endodontics, periodontics and oral surgery. Typically, these amounts are covered at 80% or 90%. Prosthodontics, which is major restorative work, may be covered at a lesser percentage, such as 70%. Orthodontics may also be covered at a lesser percentage.

There are primarily two types of dental plans—scheduled and nonscheduled. There also are variations of both of these. A scheduled plan contains a fixed allowance for specific procedures. There may be deductibles, although these are typically small and may be calculated on a lifetime basis.

Cost control is a major advantage to the sponsor of the scheduled plan because benefit levels are fixed. On the downside, however, the benefit levels on scheduled plans must be reviewed regularly, as reimbursement levels must be adjusted for different geographic areas.

A nonscheduled plan is sometimes called a comprehensive plan. These plans usually cover a certain percentage, for example 90%, of the reasonable and customary charge. They also include a deductible, and procedures may be reimbursed at different levels. Nonscheduled plans offer the benefit of setting a uniform reimbursement level because the total cost reimbursement is the same regardless of geographic area. In addition, the

rates automatically adjust for inflation. During certain periods, however, these rate adjustments can be dramatic, presenting a cost-control challenge. Nonscheduled plans also can be difficult to change once in place, and the prices for services may not be known until the services actually are rendered.

Depending on the needs of the employees and the employer, a cross between these plans may be feasible. Some plans provide preventive and diagnostic coverage on a nonscheduled basis, whereas other procedures may be covered on a scheduled basis. This allows for better cost control, and it emphasizes preventive care. Because most dental problems get worse as they progress, it is wise to have prevention stressed in the plan to keep costs down.

When designing the dental plan, remember that age and general health play a factor in costs. Older individuals have a greater need for more expensive dental care, and costs are typically higher for women. Location also is a factor in dental service. Different geographic areas have higher reimbursement levels. The plan sponsor must keep in mind that having employees contribute to the plan does not always increase participation. Combining dental plan participation with medical plan participation tends to even out the participation issue, however.

The company may also help stabilize costs by limiting the enrollment periods, requiring dental checkups prior to enrollment in the plan and requiring participants to remain in the plan for certain time periods before dropping out. On an annual basis, the employer should review the plan to determine whether it is meeting the intended objectives. If the sponsor is not satisfied with the providers from a service or cost standpoint, it may be prudent to enlist an insurance broker in the process of selecting a new provider. The company should also take this opportunity to see if the employees are satisfied with their coverage. An employee survey can achieve this and may boost morale at the same time.

When seeking a new provider, the employer should consider the following:

- Who are the providers in the network, and what type of quality standards do they observe?
- What types of utilization review procedures are maintained?
- What enrollment processes does the company require? What assistance is given to help employees understand the plan provisions?

EXHIBIT 3

Selecting a Health Care Provider

The following are some key considerations in assessing whether a new health care insurer can offer a more meaningful benefit to a specific workforce:

- **Enrollment**—How does the insurer enroll new members? How does the proposed new plan change the benefits presently provided to existing participants?
- **Education**—How much education does the insurer provide to help employees understand their benefits?
- **Inquiries**—How does the insurer handle employee inquiries regarding coverage and claims?
- **Claims**—How does the insurer process claims? How much support does the insurer provide to employees to simplify or facilitate claims processing?
- **Precertification**—Is it required for certain procedures? If so, who is responsible for precertifying? What are the penalties for failure to precertify?
- **Primary care physicians**—Does the plan require patients to select a primary care physician? If so, will employees welcome the system?
- **Accreditations**—What accreditations does the network have?
- **Billing**—How is it handled? How well is it geared toward participants' understanding of charges?
- **Unnecessary procedures**—How are these defined by the insurer? Who bears responsibility for payment?
- **Explanation of benefits**—Do participants receive regular statements?

- How is open enrollment handled?
- How are inquiries regarding billing procedures and claims processing answered?

Vision Plans

Employers must consider this benefit in their overall benefit strategy. If they choose to offer vision coverage, benefits generally include a vision examination, lenses and frames. Some may also cover contact lenses. When designing the plan, the employer can use frequency limits to help stabilize costs. By establishing frequency limits, the employer can control unnecessary use and keep administrative costs down. These intervals usually are 12 or 24 months.

Under a schedule-of-benefits approach, a plan provides a maximum allowance for each service and material and a limit on the frequency of use. For example, a fee would set be for the examination, lenses and frames. The schedules are usually based on a national or regional range of usual and customary charges. This type of plan is user

friendly, creates no provider restrictions and allows employees to shop around for the best prices. The administration is simpler because the fee caps are determined in advance.

Revise Accordingly

Insurers are keenly aware that you can take your business to a competitor, so it pays to continual-

ly shop the market and investigate different insurance offerings. (See Exhibit 3.) Armed with solid information on what your employees value, meet periodically with your insurance provider to determine whether your company is offering the best possible benefit for the best possible price. The results inevitably will be a healthier bottom line and a more satisfied workforce.

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