



ROLE OF THE HEALTH INSURANCE AGENT

in Assisting Individual Consumers and Employers Purchase Affordable Health Insurance

Region IV



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Minnesota

Short-term medical insurance has traditionally been a very affordable option in this market for families in transition. However, as a result of the changes brought on by health care reform, the largest carrier in this market will only issue single policies on a short term medical policy and only to people 18 and older. So, a family called me yesterday about her husband changing jobs. The new employer has a 90 day wait before health insurance begins. She wanted to get short term coverage for 90 days for her family, including four children, but she is no longer able to get this coverage and will instead have to pay the high cost of Cobra coverage or go without insurance for 90 days.

—*Carole Elfstrum (MN)*

One of the employers I work with provides coverage for his employees and pays the full cost of the plan. It is an excellent plan with no deductible and small co-pays for office visits and prescriptions. The employees are able to put their dependents on this plan, but the employees must pay the full cost of the coverage.

One of the employees is a single mother in her 40s with a very healthy 14-year-old daughter. On the January 1 annual renewal, the monthly premium to cover this healthy child went from \$281 to \$365 per month. This was not affordable for this single mother.

Prior to PPACA, I would have been able to provide this child with an individual plan for less than \$90 per month. Now there is not a single plan available for a child under 19 to purchase unless their parent is applying as well.

This single mother has the option of paying \$365 or having her child uninsured.

—*Heidi Michaels (MN)*

This is what I do on a day-to-day basis as a licensed health insurance agent:

- I assess clients' current level of benefits.
- I field underwrite the risk to assess what they might be eligible for.
- I present the risk to all carriers.

- I review what the group, or individual, wants in their benefit package. I define what is necessary, and what is desired.
- I present offers that meet or exceed their needs.
- I make suggestions based on my experience in the market, and with other buyers like them.
- I point out the 'pros & cons' and answer questions, until *they decide* what path to pursue.
- My staff and I complete the necessary enrollment materials, screen all applications for completeness, and forward to the carriers.
- I deliver the 'offer of coverage,' answer final questions, and have employee meetings as necessary.
- I shop for my clients. I shop in a market fraught with many pitfalls they might not realize, *until the first claim occurs!*
- I then service the products throughout the year.
- I maintain E&O insurance, adequate for my exposure.
- I maintain appointments with all "the players" (insurance carriers) in the market.
- I maintain continuing education for compliance with all states in which I'm appointed.
- I maintain membership & participation in NAHU, NAIFA, AHIA, and LUTCF.
- I'm active at the local, state and federal level.
- I'm on the Board of Directors of my State's Risk Pool (MCHA).
- I review all new plans as they become available to my clients.
- I counsel all who present themselves to me without any fee.

I'm a professional life & health insurance agent.

—*Harlan V. Johnson (MN)*

I have 175 employer-group clients, consisting mostly of groups with less than 10 employees. This subset of

employers is desperate for help in navigating through the system of providing benefits to their employees. Most of these employers wear multiple hats and have had no training in human resources. They call me with little questions that arise and it generally starts with “I have an employee that...” I am always happy to help them with the problem, no matter how small, and they are exceedingly thankful for my help. I have a very satisfying job in that respect. My clients would be very frustrated if they did not have a broker to answer their questions and keep them abreast of all current compliance changes. They just do not have the time to become experts on all the laws and regulations that consume our industry.

—*Joan Kohl (MN)*

I have been an agent for 35 years. In the past five years, I have seen my role as an agent get much more complex and more demanding. As an agent, I answer questions and meet needs for the uninsured, employer groups large and small, employees contacting me, as well as low income individuals asking for advice and seniors. I am an educator, consultant and counselor, benefits translator, a client advocate, a financier for health care and a negotiator.

I work with the government, insurance companies, and providers of health care. In the past five years, my role has increased become more complicated. I have become the point person for my clients in all areas of their health care. Being a broker in today’s market consists not just of selling the client and walking away until renewal time—it is working with all of my people on their health care insurance needs on a day-to-day basis.

—*Sandra J. Neutzling (MN)*

We are an employee benefits consulting firm in Minneapolis, Minnesota. We specialize in helping small, medium, and large employers throughout the country design, implement, and administer their health and welfare plans for their employees. These employers have hired us to provide these services. Without our assistance they would simply be buying a product from an insurance carrier and paying a premium. We help our clients negotiate with the insurance carriers to customize a benefits package that works uniquely for their business model. Our clients appreciate our expertise, our ability to provide multiple insurance carrier options and communicate these benefits through meetings to the employees, handle administrative items, and more.

We are sending you several case studies of some of the clients we have worked with over the last 30 years while in business.

We believe in a private health care marketplace that facilitates competition and thus provides better results for employers and employees.

MULTI LOCATION, NON-STANDARD SOLUTION

Challenge

This company manages three- and four-star hotels in several major cities. Each hotel averages 250 employees. The central corporate staff does not maintain HR staff or training to effectively operate their complex benefit programs. Their previous health plan was self-insured and costs were out of control. Budgets were in disarray with each hotel as its own cost center. The medical benefit plan was weak, poorly understood, and not competitive with other hotels. At some of the hotels, paymasters who had not been trained in employee benefit programs were tasked to handle hotel benefits. Benefits are a secondary function with payroll being their primary responsibility, and they reported to the controller, not to the HR Director. There was no central repository for all critical forms and records. The hotels were not capturing the provider discounts available in their region, specifically for their health/dental plans. They needed experienced personnel to solve claim/billing problems with various insurers and providers. As with most hotels, high turnover of personnel presented a problem in administration. The performance of the 401(k) plan was poor, and the employees were having difficulty understanding the plan. On average, English was a second language for 60% of the employees. The CEO expected the VP of Human Resources to manage corporate HR issues and not to be tied up with benefit issues.

Solution

RAM’s work began with defining available insurers in their various locations. We determined which insurers/HMOs would deliver the best care/benefits to their employees. Detailed geo-access studies were performed to ensure proximity of providers in their residence/work areas. The self-insured plan was terminated and all employees enrolled in local managed care plans for their location. This involved using 15 different contracts with 11 insurer/HMOs for just the medical and dental plans. We were able to install first class plans with added first dollar benefits in each location. RAM continues to manage the

enrollment process by making presentations on-site each year. Presentations are currently made in English, Spanish, Polish and two Chinese dialects. Responsibilities for eligibility, enrollment, and billing functions/responsibilities were then moved to RAM. Two senior customer service coordinators (CSC) were assigned to manage the process and to handle all service-related issues. Audits are conducted periodically and premium savings have occurred through close management of the employee benefit termination process. The controllers and human resource directors now have outside help in the monitoring of premium adjustments, benefits, and insurance carrier service issues. The RAM CSC's serve as the hotel's first call for help. We added the benefits CONNECT HRIS system to centralize coverage and eligibility information. The CSC's are responsible for all updates to the system – including additions to the system, coverage changes, and terminations. The hotels each have access to view all employee information to verify any questions that they may have regarding coverage or personal changes. RAM receives payroll data feeds and submits all changes either online or via Electronic Data Interchange (EDI). The 401(k)-plan administrator was replaced and new account options were installed. RAM has the primary role in improved employee communications to satisfy IRC Sec 404c exemption requirements. RAM hosts all recordkeeping functions, and we have a duplicate set offsite. The corporate headquarters has not had to add any staff, and RAM has become their outsourced HR department for all employee benefits.

Results

RAM was able to document savings of one million dollars in each of the first two years, which equates to a 21% savings. Through skillful marketing and negotiations, RAM has been able to keep the hotel's cost at the low end of the market while delivering the highest quality benefits possible. Budgets are now more predictable and RAM's forecasts have been within 5% of actual renewal rates. We've streamlined the benefits administration process for each hotel; reducing the time it takes for them to manage employee eligibility, enrollment, and billing. Employee satisfaction is very high. Accor management resources are now free to concentrate on other essential functions. All of this has been accomplished at no direct cost to the company or the hotels.

POOR SERVICE WITH AN ONGOING LARGE CLAIM

Challenge

Buffalo Wild Wings was self-insured with a vendor that had high fixed costs and underwent a claim office conversion. As a result of the conversion, people would be randomly dropped from the plan, or people would just show up on the plan. Others would have to be entered several times. Compounding the problem of finding a new vendor to pay their claims was the fact that there was a major ongoing claim that caused stop-loss carriers to decline to offer coverage.

Solution

After a complete marketing, RAM Benefits did the financial analysis and determined that if we could convince a quality carrier to quote stop-loss and exclude this claim, the financial savings due to lowering the fixed costs would more than cover the expected costs for the large claim. We then negotiated directly with the underwriter of a major stop-loss company. They agreed to exclude the first \$35,000 in claims over the specific stop-loss level on this individual even though it is against their policy. All future claims would not be subject to this type of exclusion.

Result

Buffalo Wild Wings was able to move to a new third party administrator, solve their eligibility issues, continue to offer the same networks to their employees, and save well over \$150,000 in fixed costs. In addition, their maximum claim liability went down by another \$150,000. Fortunately, the claim liability was not an issue because their claims went down when they changed vendors.

SIGNIFICANT ACQUISITION

Challenge

Christensen Family Farms, a family-owned business in the pork production industry, recently acquired another smaller business. As a standard practice, they would absorb all of the new company's employees into their plans. However, if these new people were to be rolled into their medical plan, their current medical insurance vendor would have the ability to re-rate the entire medical plan. This would be a problem since the losses in the current year would cause a very significant increase.

Solution

RAM Benefits did an overall analysis of the benefits as part of the due diligence process. While the plan of the acquired plan was not exactly the same as that of

Christensen Family Farms, it did pass a comparability test. That test states that if the plans are actuarially similar, there is not a discrimination issue. Therefore, we recommended that Christensen Family Farms keep both plans until the main plan renewed. At that time, a cost evaluation will show whether it makes sense to merge the two plans.

Result

By taking their time and not using the quick and easy solution, Christensen Family Farms saved more than \$500,000 between January and July.

NETWORKS AND THEIR DISCOUNTS

Challenge

Douglas Machine, like many large employers, experienced a large increase in their medical claims. They were very happy with their current vendor but had not undergone a major marketing analysis in several years. The projected cost increase was \$435,000.

Solution

RAM Benefits did a thorough marketing analysis of the networks available to the employees of Douglas Machine. We found that the marketplace for networks had changed drastically since Douglas Machine had last looked. While their current network had reasonable discounts, HMO's had developed 10% larger discounts and had almost all of the local doctors and the local hospital in their networks. We then brought our conclusions from the marketing analysis to management. After that meeting, we had two more meetings with the benefits committee. Once a decision was made, RAM Benefits developed a presentation and explained all of their benefits in a series of mandatory meetings with the employees of Douglas Machine.

Result

The savings from changing to a HMO network was worth \$144,000. Douglas Machine also modified their plan, made a very modest change to employee contributions, and increased their corporate contribution by \$195,000. Because of the involvement of the benefits committee and the investment in communication to the employees, the plan changes were well received.

CONNECT SETUP FOR: BIOMEDICAL COMPANY – 200 EMPLOYEES

Challenge

We were introduced to this biotechnology client in 2002. Our first meeting was with the Human Resources Director and Manager. The challenge was they had multiple medical, dental, life, disability, 401(k), flex, etc. benefit plans and had to fill out multiple forms for new hires, any carrier/plan changes for open enrollment, life-events and more. Payroll was being processed through ADP, but they were not tracking benefit deductions very accurately because of the lag in time between HR forms processing and payroll changes. The company was faxing forms, emailing data (un-secure PHI), and going online to multiple carriers to enter employee data. The HR department was staffed with two highly compensated HR people and two HR administrative staff to manage a 200 employee company. The CEO, CFO, and management team wanted a solution to reduce the HR department or paper-based enrollment and go to a web-based system. Finally, management thought the HR department and the company as a whole had too many management personnel so 25 managers, including the two senior HR managers, were fired three days before our benefits CONNECT system was completely installed and ready to go live.

Solution

The company hired RAM Benefits to implement the Benefits CONNECT system after three meetings and an online demonstration with senior management. The solution to their problem was straightforward. First, we gathered all the employee demographic and benefit data by extracting this data from their ADP PC/Payroll system then uploaded the data via a 500 report into the benefits CONNECT system. Second, we gathered all of their benefit plan contracts, plan designs, summary data and built the plans in the system. We then attached all of the benefits to the employees and entered in all dependent data and added all the medical, dental, life, disability, etc. forms into the system. We tested this data for all scenarios. We built a company-specific open enrollment and new-hire guide for employees to follow step-by-step for their "required" online open enrollment. Then we performed four training sessions (one virtual via the internet) for the employees to show them how to use the system.

Results

Our client had all employees enrolled for their benefits online within a three-week period. As mentioned above, the HR staff was cut from four to two employees within days of our client going live on benefits CONNECT, and open enrollment. This posed

a major problem initially, but was quickly resolved by RAM performing in-depth advanced training sessions for the remaining two HR staff to complete open enrollment and manage the system going forward. The client is now able to run their HR department efficiently with two staff instead of four which equated to a savings of \$160,000 per year in salaries alone. Also, since the employees are doing all of their own demographic and benefits changes via benefits CONNECT the managers are able to perform other duties. This employee self-service (ESS) has made the company's Return-On-Investment (ROI) a reality since the setup charge was \$5,000 and the PEPM (Per Employee Per Month) charge was \$2/PEPM. The time saved in the HR department through more efficient HR and benefits practices equated to dollars savings due to less staff needed to complete the work. Also, employees are now able to answer most of their own questions, thus creating more time for HR to do other tasks. This client has been using benefits CONNECT for 2+ years to date. Future technology goals are to set up Electronic Data Interchange (EDI) to the medical and dental carriers, as well as set up a payroll interface to the company ADP payroll system.

COST INCREASES AND CONTRIBUTIONS

Challenge

Company R, a large company with approximately 2,000 full-time employees whose primary business is meatpacking, was facing large health care cost increases and their prescription drug costs were rapidly rising. In addition, a large percentage of the employees were working in the U.S. via their green cards and did not highly value their benefits, even though the employee cost per paycheck was less than 5% of the total cost. Some of the employees paid nothing for insurance. However, if the contributions were drastically increased or benefits significantly decreased, the fallout from the management and office staff could have disrupted business. Another challenge was the political ramifications of being the main employer in several smaller towns. If an employee could not afford coverage and had large claims, the employer could be viewed in a negative light.

Solution

Through a series of meetings, RAM Benefits was able to help develop a series of benefit and contribution changes. Then, a team from Company R and RAM Benefits toured the various plants and held mandatory meetings explaining national trends, industry trends, and the new benefit structure. The benefit changes included implementing two medical plans (vs. the previous singular plan) and changing the prescription drug co-pay from a flat dollar amount to a percentage co-pay. The lower plan of benefits continued to have a very nominal weekly contribution. In addition, the dental plan enrollment was no longer tied to participation in the medical plan. Salary adjustments were made to office staff on a one-time basis to account for the increased contributions.

Results

Participation in the health plan continues to be high, with the lower compensated employees migrating to the lower cost plan. Salaried employees continue to purchase the higher cost plan, but now have a better understanding of the true cost of the benefits. Prescription drug costs decreased by over 20% and in two years still have not returned to previous highs. The medical claims went down minimally and over two years have remained flat. The benefits adjustments have been well received and have helped Company R remain competitive with their competitors.

— Scott Haskins (MN)

Nebraska

Surprisingly, I would say the vast majority of people inside of the health insurance industry are appalled by the expansion of dependent eligibility to age 26. In addition, the universal health insurance industry reaction of ceasing to offer child-only coverage due to the removal of preexisting condition limitations has proven to be very detrimental to the marketplace. In short, parents are forced to either pay for child coverage at higher costs through their employer plan, apply for individual coverage themselves in order to get their children covered on an individual policy, or cease to cover their children altogether.

—*Scott M. Stevens (NE)*

As an independent broker serving self-employed professionals and tradesmen, I broker for many of the major individual health insurers, each with a group of products, and with each company having a different set of underwriting challenges. I consider myself an expert field underwriter who presents the product most fitted to the client.

The benefit I bring to the client is that I assist each client through the challenges of their relative underwriting, and bring them price efficiency. That efficiency generates rewards for the positive choices they make regarding their health. Examples of that reward include low relative bodyweight and a non-smoking status. My active analysis of the deductible/premium ratio assures them that they do not need to pay excessive premiums to achieve a low deductible.

The result of my efforts is that these individual plans are more affordable than group plans of similar content. That is just because the group plans have premium up-charges for tobacco and obesity built in for all insured.

In summary, the insurance policies I present can reward the insured for his accountability and actuarial advantage with lower premiums, and an attitude of not insuring what is not important to the client.

—*Tom Hanthorn (NE)*

Two years ago, I received a phone call from a 32-year-old woman. I could hear the desperation in her voice from the onset of our conversation. She was quick to explain to me that her husband had been laid off and their COBRA was running out in 30 days. This was a major issue because she was on Medicare through disability. This poor young lady had a terrible kidney disease, and was receiving dialysis regularly. She was also legally blind, due to complications with her disease. As her COBRA period was ending, she'd tried frantically to find a coverage solution for herself and her family. She had been in contact with all of the state and federal agencies she could think of, including HHS, CMS and SHIP, a volunteer coverage explanation agency for Medicare recipients. All of these resource points told her she had no coverage options outside of her husband getting new group insurance. That was not happening fast enough, and may not have happened at all. The client couldn't accept this. She found my name via the Nebraska Association of Health Underwriters website and called for help. Upon reviewing her case, I found that one company had filed their Medicare Advantage plan in NE to accept participants under the age of 65, on social security, disability and Medicare. Since I was not licensed to sell this product, I put her in touch with the right people at the company offering this product. After some joint explanation of her scenario, and how they filed their product, she was successfully enrolled. Through all of the heated exchanges and tears, I realized the vast holes in the administration of our safety net programs. I took it upon myself to assist a fellow human being in need. I should add, although it makes little difference, as I acted out of principal, neither my firm nor myself made a single dollar on her case. However, I was proud to use my skills to better someone's position in life. I am becoming concerned that this scenario will become more commonplace, and ultimately unsustainable, if the agent is crowded out of the solution side of health care reform.

—*Brian Urban (NE)*

Wisconsin

There are numerous ways in which our agency assists clients beyond the initial sale. Here are a few examples:

Individual clients—when they contact us with any questions or concerns about their policy, such as provider network changes, benefit changes or claim questions, our agency handles the inquiry. We work with the insured, the carrier and the provider (if needed) to resolve the question. Also, when I receive a renewal on an individual client I check with the other carriers I work with to see if we might be able to match benefits at a lesser cost to the insured. Each year I contact them to discuss their options.

Employer clients—prior to each group renewal I request basic census information and go to the market to get base quotes. By the time I receive the renewal, I have enough information for the client to make an informed decision on whether or not to go to the next step of applications. If a client goes to application, our agency assists with every step of the process to ensure accuracy and privacy of information required. I then meet with the client once the final rates are determined to discuss the pros/cons of each carrier. We also hold employee meetings to discuss the benefits, how to manage their out of pocket costs, etc.

Another service we provide is mailings to our clients on issues that impact their benefits. An example of that is in regard to the COBRA subsidy rules. I've sent my clients information on the subsidy rules, forms, etc., and encourage them to contact me with any questions so I can help walk them through this process. I've also attended several meetings on the COBRA subsidy to make sure I have accurate and up to date information.

I have also worked with the provider community to provide education for my clients on wellness. One of our providers will do health assessments for a small fee based on level of participation. Based on the results of the assessment, we then tailor our wellness presentations to topics that impact the majority of the employees.

We take our client relationships very seriously and pride ourselves on doing what is best for each client's individual needs.

—*Kate Ludwigson (WI)*

Without the help of brokers, small business would be lost in regards to group health insurance, employee benefits and related legislation. A prime example is the ARRA COBRA legislation that was recently passed. I have spent all week explaining to my clients how to comply and how to get reimbursed for the subsidy through their 941 payroll forms. Most small business wouldn't even know about state continuation of COBRA if we were not there to tell them about it, much less explain it to them and administer much of it for them.

Many small businesses have no human resources personnel. We are their HR office. I deal with new employees and also work with those who are leaving by setting them up on state continuation or COBRA or I try to find less expensive options with individual plans to make things more affordable. Our relationships with our clients are ongoing since they have no time to deal with everything we do. All my clients' employees are given my business card and they call me with questions or issues with things such as healthcare claims, provider questions, coverage questions or any other issues that arise. After I have written a new policy for a new client, that is where the real work begins.

Brokers are the gatekeepers to the health insurance world. We know which carriers are good and we know which are a right fit for the needs of our clients. It is with the broker that competition is at its best. If insurance companies don't make our grade, they don't get sold. If their rates are too high or their coverage is lacking, I let them know. PPO, POS, HMO, HSA, HRA, and FSA are just a few acronyms our clients wouldn't understand without our help. We have to continually analyze our client's changing needs. I just returned from a small business client who needed my help setting up multiple plans. My client's workforce became more diverse and thus we wanted to offer more than one health plan and let the employees choose the plan that best fit their needs. In this case, we offered three plans, a \$500, \$1500 and a \$2000 deductible HSA plan.

We are ongoing consultants for our clients who would otherwise be uninformed simply because they have no time to spare to learn the ins and outs of the health insurance industry. They have all their focus on keeping their businesses successful. I work with basically every health insurance company and HMO

contracted to do business in my state. It would be impossible for business owners to know every coverage difference between them unless they did this for a living. For example, I have a client whose child was born without a lower right leg. There are only a couple insurance companies in my state that do not limit coverage on prosthetics. Most limits on durable medical equipment and prosthetics range from \$2500 to \$5000 coverage per year per person. My client's son's costs were \$25,000. That would be money he would have lost if we were not there to fit him with the right insurance company.

I could write for hours on everything I do, but most of my time is spent servicing my existing clients (free of charge) and, I might add, very little is spent searching for new ones. I've been a broker for 15 years and prior to that I was a group health underwriter for six years. The payer system is not broken in the private sector; in fact, it is alive and well thanks to competition. The healthcare delivery system is broken, along with Medicare, Medicaid and the state-run programs.

—Robert Jandrain (WI)

I am an insurance agent specializing in the small-group market. On a daily basis, we help our clients wade through the process of deciding which insurance plans will suit their budget and employee needs. We apprise them of the variety of products available and how these plans, such as health reimbursement arrangements and health savings accounts, may be better options than their current traditional plan with deductibles and co-pays. Many

employers don't really understand the nuances between all these plans and how they may help or harm them. We discuss the pros and cons between having a group plan and not.

I have helped a number of clients resolve complicated claims issues. Without my assistance, they most likely would have just given up and paid significantly more in claims than they were obligated to pay. While insurance carriers strive to pay claims correctly, many times, I find it is the provider who made the error. The insurance carrier is merely paying based on what they receive. Without the experienced agent reviewing this information, it may go unnoticed.

The recent COBRA subsidy is just the newest issue to review with clients. Many have looked to me for guidance and explanation of what their responsibilities are. Even though this is an employer compliance law, many employers don't truly know what they are supposed to do. The smaller the group becomes, the more likely it is they may overlook this important aspect and put themselves and their company in serious trouble.

I hope this helps explain in an abbreviated way, how important the insurance broker is in the process of selling group and individual insurance. My clients turn to me for guidance, problem solving and support. Many have told me how much they value my service and would be lost without it. For the small business owner, I am their human resource department in regards to the insurance benefits.

—Laura Bagin (WI)