The 4 Actions A Small Business Owner Can Take To Lower Their Group Health Insurance Premium Next Month

By

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Introduction

A Lesson Learned

The year was 1999. I had been in the insurance business for 3 years. I was licensed in 1996 and sold my first health insurance policy to someone who is still a client today in 2019. I spent these initial years concentrating on health insurance, both individual and small group.

One of my clients at the time was a body shop in East Nashville. They employed about 8 workers and had been fixing dents and worse for over 20 years. In the winter, snow and especially ice storms were great for their bottom line. The business was independently owned and operated by a husband and wife team. A delightful couple in their early sixties. After they became my clients, my wife was a victim of a hit and run accident. An out of control driver sideswiped her at an intersection and then raced away, never to be seen again. When she came home, we called the police and about 10 minutes later, there was an aggressive pounding on our front door. When I opened the door, a Metro Officer greeted me in an accusatory tone, “Did you call the police regarding a hit and run”?

“No, that would be my wife.”

“Could I talk to her.”

My wife came to the door and then at his request, stepped outside. The officer spent the first few minutes with very direct questioning about her story, seeming to be trying to trap or twist her recollection of the event that happened less then 30 minutes ago. When he was satisfied that she was telling the truth, he wrote up a hit and run report.

Our insurance company would pay for the repairs, so I insisted that we give the work to the body repair shop in East Nashville. So we did, and they fixed our car to perfection. As far as I was concerned, I had a good relationship with my new clients.

In the summer of 2000, the owner of the body shop called me to ask for help regarding a recent procedure she had done at a doctor's office. The claim was relatively small (about $200) and she didn't think it was being covered the way she expected. Or at least she wanted clarification on why she was left with a $120 balance. I made a call to the insurance company and couldn't get anyone who could give me an adequate explanation. I called the doctor's office and they were not much help either. I set it aside for a few days and then tried again. More of the same was the result. I was getting the run around. To make matters worse, the company I was dealing with was not one of my favorites from an administrative viewpoint. I only had a few groups with this carrier and I had not established a strong set of contacts there. This increased my frustration level as I didn't know who to call to get this issue properly explained and ultimately settled to my client's satisfaction. "I'll call again tomorrow," I rationalized to myself. I pushed the paperwork aside on my desk and a few days went by, then a few weeks. Summer rolled into fall and as is always the case, I was busy with many other issues. It was now September and her request for service had slowly made its way to the far reaches of my mental queue, still unresolved. "She's probably forgotten about it," I thought. "She never called me again to follow up, so it most likely was not that important anyway," I justified to my receptive mind.

Their renewal date was November 1, so I called at the end of September to start work on the plan for the coming year. When I first talked to the owner, there was no mention about her claim. Yes, I did remember but didn't say anything, so I took cover in the conclusion that it wasn't really that big a deal after all.

We spent the next two weeks going over plan options. She had a lot of questions, more than usual it seemed, about coverage, deductibles and copayments. I answered all over a two week period, had two in-person meetings, reviewed spreadsheets I prepared with side by side graphics of available options and fielded numerous phone calls until we finally settled on the plan for the new year. I asked her to sign the renewal and fax (yes that's when we used to fax) to me and I would get it processed.

A few days went by and no fax. A few more days and we were closer to the deadline, so I called.

"I need the signed renewal to get the new plan in place. Can you fax to me or should I come by and pick it up?" In those days, nearly 20 years ago, very few clients could email paperwork and no insurance companies had automated renewals. I spent many hours and gallons of gasoline driving across town for a single signature. Today, there is no paperwork as nearly all processes are automated which makes my job easier, but I really did and still do enjoy a scheduled visit with my friends for a quick chat.

Her response to me about the signature page caught me off guard to say the least. Actually I was shocked speechless at first.

"I'm not going to send you the renewal," she said.

"Why not?" I asked.

"I'm switching health insurance brokers."

"You're switching brokers? Why are you doing that, may I ask?"

"Do you remember last summer, when I called you about the claim that I needed help with?"

“Yes, I do remember.”

“Well, you never got back to me. I asked for help and you never responded. So I’m switching to someone else.”

There were so many things I wanted to say, such as:

“If you made the decision to switch brokers, why did you use me to analyze all of your renewal options?

Or, “Isn’t firing me a bit extreme for one mistake?”

Or, “I’m sorry, could I have another chance?” and on and on…

But I said nothing. Once the initial confusion cleared from my brain, my first thought was, “Well played, ma’am, well played.” She asked for help and didn’t get it. She was mad and wanted to make a point. “If I ask for assistance and you don’t give it to me, there will be a price to pay,” was her message.

The only thing I said was, “Thank you very much for the opportunity to be your agent and I hope we can work again one day in the future.” We never did.

I hung up the phone, sat back in my chair and after a few moments of reflection, all I could conclude from this poor start to the workday was that I deserved it. Yes, I deserved to be fired. This was also a moment that changed my professional protocol for good. I learned on that day, something I would have said I already knew, but apparently did not. That you don’t earn loyalty from customers when they sign an application. You don’t build any goodwill by doing what any other salesperson will do, which is to take your money and earn a commission. You earn your paycheck by providing service that you are not getting directly paid to do. Returning phone calls right away, not giving up on

any task until it is completed to your client's satisfaction. Never thinking you helped someone by giving them a phone number to call so they can ask someone else the question they are asking you. Never responding to a phone call for help by emailing an overload of information that contains an answer deep in the attachments that the client is expected to wade through. Business people can easily spot someone who goes the extra mile and someone who doesn't.

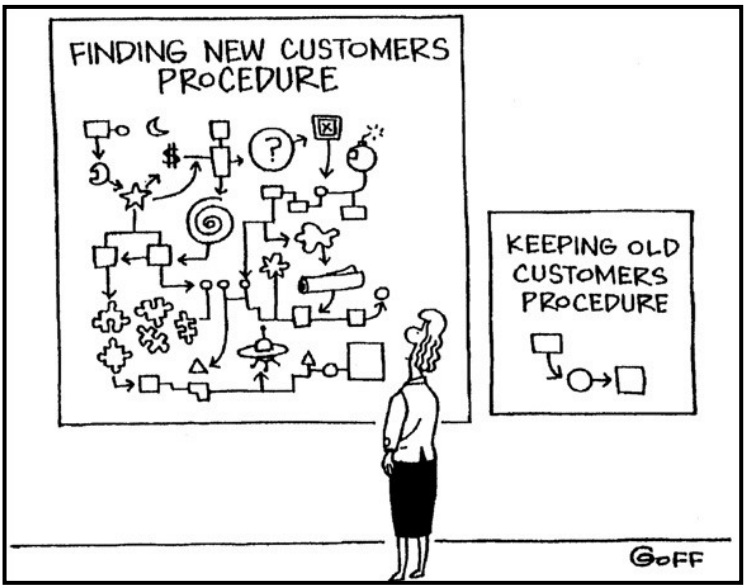
Since that day 20 years ago, I have never left a client's question hanging for any reason.

In 2005, I got a call from one of my loyal groups that the owner had been in a motorcycle accident and nearly killed. This was a man who flew a private airplane, took adventurous vacations all over the world and would routinely ride his motorcycle from Nashville, TN to Los Angeles or even Canada to check on his other business locations. He lived life to the fullest to say the least. At age 52, he was sitting at a blinking red light in Metro Center in Nashville at 10:00 at night when a vehicle ran their blinking red light and basically ran him over while he was sitting still at the light on his bike. He was badly injured and barely survived. By the time I was called, he had been moved to a rehabilitation facility. The concern he had was that this provider was not going to accept his insurance for therapy in full. His share of the bill would be in the multi-thousands, easily exceeding $20,000. He needed to know where he should be transferred. I spent the next two days on the phone with Blue Cross and several providers for hours going back and forth on what treatment he was going to need and how it would be covered. We got it straightened out and he was transferred to another facility and spent the next year in therapy. He is fully recovered today, but one leg is two inches shorter than the other, so he walks with a bit of a hitch in his getty-up. He resumed riding motorcycles until another accident on Granny White Pike in South Nashville in 2015 (not as serious, just a few

broken ribs) convinced him to stop riding and he began the painful process of parting ways with his nine motorcycles. He still has three that sit idle today.

I've had hundreds of calls for help since. Every call or request that comes to me today gets answered and continuously followed up on, no matter how long it takes or how frustrating the insurance company's layers of bureaucracy can be. Twenty years ago I would have said the same thing. My heart was in the right place, I just could get distracted I guess, if more pressing matters made their way to the forefront. But I learned an invaluable lesson from my client at the body shop. I learned it the hard way, but in the long run, sometimes that can be the best way.

Have you ever felt that some companies operate on the



Chapter 1

Action 1 - To Lower Your Group Health Insurance Premiums Next Month

Buy the Most Efficient Plan Available

This sounds like stating the obvious, right? Like something that everybody would be inclined to do, one would think. But when group health insurance is purchased by an employer, they're not buying coverage for themselves, they are buying it for their employees. So there is a very different dynamic at play when you are purchasing coverage that you are then going to present to employees as benefits. When recruiting a new employee, you might be asked, "What type of health benefits do you offer?" You will want to respond with something impressive, right?

Another thing that muddies the waters on which benefit design employees' will be most impressed with is, who is paying the premium? When a premium is paid in full or in part by a third party (the employer), the end user (the employee), chooses their coverage by benefit line. What I mean by this is, employees will ask, "how much is the doctor copay?" Or, "how much is the prescription copay?" They will not be interested in how much premium these benefits add if they are not paying the bill themselves. So when a business owner looks at available options, there is a lot more at play than simply determining what is the most efficient plan available.

Last year I met with an employer that had been offering the same plan for years to his 8 employees. It was a rich PPO benefit design with a low deductible ($1500) and copays for doctor visits and prescriptions. The total premium for the entire group was about $61,000 per year. I had tried over the years to prod him to look at what would be the most efficient plan for his group, but

he wasn't interested. He was adamant about providing what he perceived to be the best coverage available. On their 2017 renewal date, he finally said to me, "Rick, the cost of my health plan has just gotten too high, what can we do about it?"

"Finally," I thought to myself, "He's ready to take a hard look at his plan."

It kills me sometimes when I know business owners are overpaying, but I can't get them to take action. Employers are sometimes more worried about how their plan is perceived by their employees and this complicates a true analysis like they would apply to other financial decisions. I fully understand this concern in the competitive market for hiring and retaining a workforce, but my experience is that if you properly explain a plan to employees and structure employer subsidies the right way, employees will understand that they are not only being offered top quality coverage, but they are not going to be able to get something better from another employer.

When I explained in detail the much more efficient plan to this employer, his eyes were wide open. We took his total premium down to $32,000. A $29,000 cost reduction is a big deal for almost any small business. When we explained the new plan to his employees, they were thanking their boss for being so committed to their best interest.

What is the Most Efficient Plan?

Always keep in mind, that in the small group market (2-50 employees) all plans have the same underlying medical coverage. Whether you choose a Bronze, Silver, Gold or Platinum plan, they all cover the same things. The difference is how much you pay upfront before the insurance company starts to pay. With a Bronze plan you might have a $5000 deductible, and with a Platinum it could be $1000. The Platinum is the better plan,

right? It sure might look that way to an employee if those two options were offered.

Let's assume you are buying a health plan for yourself. In that case, you would surely need to look at not only the deductibles and copayments, but also the premium. I would argue that today, since all plans cover the same things, the premium is the single most important item to consider.

Take the following example:

On page 16 we will compare two plans. One plan that is a Health Savings Account (HSA) qualified and one more traditional PPO plan with doctor and prescription copays. If we compare plans with doctor copays, prescription copays and a relatively low deductible against a High Deductible Health Plan (HDHP) where all medical expenses are subject to your deductible, but we also factor in the premium, what will we find? In every scenario that I have run, both theoretical and real world results from actual premiums, the HDHP plan is always more efficient when you factor in the full premium paid.

We'll analyze a single employee (male age 45) with no claims for the year, and then also that employee hitting their out of pocket max for the year. We'll also run the same scenarios for a full family (male age 45, female 40, two kids.) We'll assume the marginal tax rate for this employee is 22%.

HSA Plan - Deductible $3,000, out of pocket Max $4,500
PPO Plan - Deductible $2,500, out of pocket Max $3,500. PPO plan also has doctor, prescription and emergency room copays.

Let's look at the total spent on healthcare and premiums for the year.

Example 1, Single employee, no claims for the year.

	Annual Premium	Premium After Tax	Out of Pocket Max	HSA Tax Savings	Total Expenses
HSA	$4,483	$3,496			$3,496
PPO	$6,534	$5,096			$5,096
				Difference	**$1,600**

Example 2, Single employee, maximum claims (out of pocket) for the year.

	Annual Premium	Premium After Tax	Out of Pocket Max	HSA Tax Savings	Total Expenses
HSA	$4,483	$3,496	$4,000	$770	$6,726
PPO	$6,534	$5,096	$3,500	$0	$8,596
				Difference	**$1,870**

Example 3, Family, no claims for the year.

	Annual Premium	Premium After Tax	Out of Pocket Max	HSA Tax Savings	Total Expenses
HSA	$13,200	$10,296			$10,296
PPO	$19,239	$15,006			$15,006
				Difference	**$4,710**

Example 4, Family, maximum claims (out of pocket) for the year.

	Annual Premium	Premium After Tax	Out of Pocket Max	HSA Tax Savings	Total Expenses
HSA	$13,200	$10,296	$8,000	1540	$16,756
PPO	$19,239	$15,006	$7,000	$0	$22,006
				Difference	**$5,250**

What does this mean? Buying more first dollar coverage so that the benefit package that you offer to your employees will look more attractive does not result in you purchasing the most efficient plan.

Being able to recognize this inefficiency is difficult in the employer sponsored health insurance world. Why? Because when an employer is subsidizing a plan, either somewhat (50%) or in full, the full cost of the plan is hidden from the end user (employee). But in reality, if your employee had a $20,000 claim and they were covered under a rich copay plan, you could have purchased the same payment from the insurance company in example one for $1870 less. In example 4, with family coverage, that same claim payment could have been purchased for $5250 less. Add these types of numbers up for 5, 10 or 50 employees, and you will get a staggering realization of how much you might be overpaying for the same potential payments.

My Sister Thought My Plan was Terrible

In a discussion with my sister a few years ago, when I still had my grandfathered individual plan, we were informally comparing our health insurance coverage. Due to her husband's employment, she was covered under a plan for employees of the federal government and about $300 per month was being deducted from his paycheck for his share of the health insurance premium. I had an individual HSA plan. I told her my deductible was $5000, and she said her deductible was $0. I told her that I didn't have a doctor copay, which meant I had to pay the doctor visit in full if I hadn't yet met my deductible.

"What kind of plan is that?" she said sarcastically, "What about prescriptions?"

"Same thing, I pay the cost of the prescription until I meet my deductible and then the insurance company pays 100%."

“That’s an awful plan,” she shot back. “I’m glad I don’t have something like that.”

Due to a recent COBRA notice to a co-worker, we knew the total premium for her plan to cover her family was $1900 per month. I told her if you were covered by my plan, your premium would be $500 per month. She said, “I wouldn’t want your plan, it’s terrible.”

I asked, “if you were self-employed, you would buy your current plan?”

“Yes,” she said confidently.

I explained, “My plan would cost you $6000 per year in premium and the out of pocket max is $5000 for up to two people. The

most you could pay in a year with my plan in a worst case and unlikely scenario would be $16,000. If your family stayed relatively healthy for the year you would pay in the $6000 to $7000 range counting the premium and a few small bills here and there."

I continued, "With your plan, you are guaranteed to spend a minimum of $22,800 per year before you make your first copay or meet your out of pocket maximum. Would you still really buy your plan? It seems the only thing that makes your plan great, is someone else is paying most of the premium."

"Your plan still stinks," was all she could come up with.

The Bottom Line: most employers don't buy the most efficient plan for their employees.

Chapter 2

Action 2 - To Lower Your Group Health Insurance Premiums Next Month

Your Primary Plan Should be a Health Savings Account Qualified Plan (HSA)

HSA qualified plans are, simply put, the most efficient plan available when you take into account the total premium paid and potential claims at the end of the year. Employers that say the HSA will not "fit" for their business are either making a dismissive statement or have simply never been adequately educated on how an HSA Vs. other traditional plans compare.

The Basics

The Health Insurance

The health insurance plan that is HSA qualified is typically a high deductible plan that has no copays prior to the deductible (except for preventive care which is covered at 100%). The insurance can stand on its own. You are not required to have a separate HSA. When you present your card in the doctor's office, they will not necessarily know that you have an HSA nor will they care. Typically the deductible for an HSA plan will be about $3000, although there are many popular plans that have $5700 deductibles and out of pocket maximums of up to $6500.

The Health Savings Account

The HSA is just a separate bank account in the employee's name. The main difference from other accounts is money that is deposited is pre-tax. So when you go to the doctor's office as described above with a $3000 deductible and the cost for the visit is $100, you could simply reach in your pocket, pull out your

current debit card and pay the $100. If you have an HSA, you reach in your pocket and pay with the HSA debit card. The only difference here is that you have now used pre-tax money to pay your medical bill. It's that simple.

The HSA, as far as I'm aware, is the only account in the US Tax Code, where money can be deposited pre-tax, grow tax deferred and then withdrawn and spent tax free.

HSA Highlights, (from the employee's perspective)

- HSA account deposits become a tax deduction when deposited to the HSA account.
- All money withdrawn and used to pay for qualified medical expenses is also pre-tax.
- If you have EE only coverage, up to $3500 per year can be deposited to your HSA in 2019.
- If you have EE + 1 or more, $7000 per year can be deposited to your HSA in 2019.
- If you are 55 or older, you can contribute an additional $1000 per year.
- You can contribute in any amounts you choose, up to April 15 for the previous tax year.
- Whatever you don't spend in a given tax year, rolls over to the next year.
- If you spend HSA money on non-qualified health expenses, a 20% penalty plus income tax will be due.
- At age 65, HSA account money can be withdrawn for personal use and regular income tax applies.
- If you leave your employer, HSA funds remain available for your use as the account is legally in your name.

What Makes HSA plans So Great?

They are simply the most efficient plan on the market. When you calculate the lower premium associated with these plans and the

savings of paying your deductible with pre-tax dollars, the difference, especially over time, is huuuuuuuuuuuge.

They require very little, if any, regular maintenance by your employees.

The only thing an employee really needs to be aware of during the year is how much is in the account. Because if he wants to pay a medical bill, there needs to be enough money to cover the charge. At the end of the year, the bank administering the account will send a statement telling them how much they can deduct on their income taxes. That's it. No ongoing paperwork.

You should open the accounts for your employees.

In my experience, when an employer offers an HSA qualified plan and then tells their employees that they can open their own HSA, most of the time, the employee never opens the account. You can do it for them, without putting money in. This will help the employee to get started and also help ensure the future success of the plan and satisfaction of your employee.

An HSA can effectively lower a deductible.

If a deductible is say, $5000, and it's paid with pre-tax dollars, the payment is now a deduction and can lower your tax bill. If an employee's total marginal tax rate is 25%, a $5000 deductible becomes an after tax deductible of $3750. The higher your tax rate, the bigger the tax deduction.

You never lose the money you deposit if you don't spend it this year.

Whatever amount of money that is deposited and not spent, rolls over to the next year. You never lose the money even if you quit, are fired or retire.

You should contribute to your employees' HSA.

If you, as an employer, contribute something to the HSA, you will

jumpstart your employees on their way to using and understanding the benefits of the tax free account. This could play a meaningful part in the long term success of the plan. There are several ways to structure an employer contribution that have been very popular over the years with many employers.

The bottom line is that the base plan that you offer your employees should be an HSA plan. This will be your most efficient option and the plan a person educated about their options would purchase if they were picking out a plan on their own. Even if there is some resistance initially to the HSA concept, I've found that over time, once employees get used to how their HSA works, they never go back to a copay plan even if offered.

Chapter 3

Action 3 - To Lower Your Group Health Insurance Premiums Next Month

Let employees waste their money
(We won't present it that way though)

Are there any circumstances were an HSA is not the best option?

In my experience, since HSA accounts were introduced in 2006, I have very rarely seen any situation where the HSA is not the most efficient option. I have seen many cases though, were the perception by the employee is that the HSA will cost them much more in out of pocket expenses. If the employer is paying the full premium for all plan options, this would not be a perception but reality for the employee. But we now know how much money we would waste over multiple employees if we have rich, low deductible plans, so as the employer, we're not going to be the one to overpay. We'll let the employee do it, if they so choose. So how do we do that and keep the employee satisfied that they are getting a good deal on their health insurance? We offer at least two plans and let the employee buy up to the richer plans. It works like this:

Plan 1, HSA plan. Employer pays 80% of this plan for the employee only (you could also pay 50% or any amount up to 100%)

Plan 2, PPO Low Deductible Plan. Employee pays the difference in premium between plan 1 and plan 2. Why would someone do this? If an employee has high prescription expenses that they will incur on the first day of the plan year, with an HSA plan, they would be paying out of pocket for those costs. With the PPO plan

they will only pay their copay. This is very attractive for obvious reasons. Now if during the year, that employee meets their deductible under the PPO plan, they would have been better off being covered by the HSA plan, but if having the first dollar covered on day one is what they want, then let's give it to them.

What we're trying to do with our benefits package is offer the most efficient plan, but keep our employees happy, right? When I do employee meetings with two plans offered such as this, there will usually be a couple of employees that opt for the richer plan even if it means paying more out of pocket in the way of premiums. We can lay out the numbers for them, but in the end it's their decision. If they're happy, I'm happy. But the person with the biggest obligation in group health is the business owner. Multiply his contributions over multiple employees and it becomes imperative that he pays for the most efficient plan.

HSA over time

The concept of an HSA is that over time, with systematic contributions, the employee can get to the point where their deductible is fully funded. If they go a couple of years without any major claim, with consistent payroll HSA deductions, their deductible could become fully funded and they won't have to worry about that major out of pocket expense. As the HSA balance grows, one could even opt for plans with a higher deductible and lower premium, allowing even more contributions to the HSA account, or they could take the difference and maybe just spend it on themselves.

I have a client who has been faithfully adding money to his HSA for the last 13 years. His employer matches his contribution as well. He's had a couple of years where he met the deductible as he's in his early 60's, but he's now accumulated over $50,000 in his HSA account. Think about that. Would you rather send money to the insurance company to buy additional benefits,

money that you will never see again, or put that money aside in your own account? When he turns 65, HSA money is treated like an IRA in retirement, in that you can withdraw whatever you want, whenever you want, and you will only have to pay income taxes on the withdrawal. After 65, withdrawals used for qualified medical expenses are still tax free. And, there is no Required Minimum Distribution associated with the HSA.

The $3000 per Month Family Health Insurance Premium

A new phenomenon has reared its ugly head with some small group health insurance renewals in TN. I'm talking about a nearly $3000 per month premium for family coverage. I have run into several people who are actually paying $2700 or more for their family health insurance. About 10 years ago, when family premiums were routinely showing up in the $1200 range, I used to tell folks that this was more like a mortgage payment than an insurance premium. Now, in the $3000 range, I feel like you are paying for a second beach house, but you never actually get the house.

Consider what a $3000 a month premium means:

$36,000 per year in payments (plus your deductible) before the insurance company pays for any type of major medical coverage. How many families have medical cost that exceed $10,000 each year, much less $36,000 on a regular basis.

You are diverting massive amounts of money over time that could/should be going to retirement savings. A $1500 per month savings in premium invested at 5% interest will grow to $237,000 over 10 years, $624,000 over 20 years.

How to lower the Family Premium

You guessed it! High deductible HSA plans rarely come with a

family premium in the $2500 plus range.

If a family is relatively healthy and the spouse does not have access to a subsidized group health plan, then we can look at putting them on an individual plan. Usually this would be a one year short term plan that coincides with the group's renewal date.

Don't Subsidize Employee's Families

Last winter, as I was preparing to meet with a group for their renewal, one thing about their plan left me a bit perplexed. They had about 6 employees, but their monthly premium total was over $7000. They even had a couple months out of the year when they were late on their payment and were in jeopardy of having their coverage terminated. When I looked at their billing statement, it was clear what the issue was. Almost everyone on the plan had family coverage. When I met with them, I asked, "You know you have a really high premium for a group your size and it's because most of your employees are covering their family. How much do you pay for employees' dependents?"

She responded, "We pay 100% if they want to add their family to our plan."

My reaction, "That is a wonderful thing for you to do in the way of an employee benefit, but it's resulted in almost all of your married employees taking advantage of your kindness and it's increased your health insurance bill by about $30,000 per year."

What was happening was even some of their employee' spouses that had employer coverage elsewhere, were joining my clients plan to save a few dollars a month. I explained that it's ok to pay some of the spouse and kid's portion, but typically small employers let the employee pay the dependent premium. At the most, I think it's ok to offset dependents to a small degree, and

years ago, there were some employers who felt covering employee's dependents was an obligation. But these days, with family premiums routinely exceeding $1000 per month and in some cases closing in on $3000, it's simply cost prohibitive for employers to fully subsidize their employee's families.

And by the way, when that employer reconfigured their contributions after renewal, their total monthly premium went from just over $7000 to $4500.

Chapter 4

Action 4 - To Lower Your Group Health Insurance Premiums Next Month

See if you can Qualify for a Level-Funded Plan

Level Funded Health Plans for Small Businesses
Over the last 23 years, I've seen health insurance carriers steadily raise premiums on the small businesses I represent. I'm the one who delivers the bad news and tries to find ways to offset the premium increases with ideas on making plan designs more efficient. I've heard employers often say, "My small group had basically no claims, so not only do they keep all the money I paid, they're increasing my premium as well."

In 2017, I was able to bring a fresh idea to my clients, basically a new concept for small businesses. It's built around the self-funded platform which was previously utilized only by large companies. Now for the first time, I could offer a "Level Funded Plan" to companies with as few as 5 employees, and it goes something like this:

- We introduce the new plan benefits which can mirror what you have now, to your employees.
- During the year, employees use the insurance just as they always have.
- All year long, the insurance company keeps a running tab of total claims by your employees.
- If the claims your small group has over the plan year are less than the target amount set by the insurance company, the employer will be entitled to a refund of the excess premiums.
- The refund is equal to 50% of the target amount less claims.

So rather than of all the hard earned money that you send to the insurance company each month going to insurance company profit, some of those dollars can be returned back to you and potentially increase your bottom line instead.

If claims by your employees exceed the target amount, you simply don't get a refund. The insurance company pays all claims as there is no liability beyond the monthly premium for the business owner.

The best news, if your group can qualify for this type of plan, premiums can be up to 20% lower than you are paying now, and that's before a potential refund at the end of the year.

In the beginning of 2019, I received the following email from a small group owner:

> *Hi, Rick. We received a letter from Aetna to let us know that our account created a surplus of around $12,000 for the last plan year. We will receive half of the amount. We are pleased with this result and want to thank you for setting us up in this type of plan*.

A Real Opportunity to Lower Your Premium

There is no gimmick here. This is quality health insurance similar to what you have now. If we do not mention to your employees that this is a "level funded plan," they wouldn't have any concern that they were covered by a "new" type of plan. They will use the insurance coverage just as they did before. You can have a plan design, deductible, copayments, etc., similar to what you have now. You don't have to sacrifice benefits.

The network of doctor's and hospitals will be comparable to

what you have now. This is not a scaled down network where you will have to change your doctor. Remember the famous quote, “If you like your doctor, you can keep your doctor.” Well in this case it’s true. In all of the group’s I’ve switched over, only one had a doctor that was not in the network. And the insurance company even reached out to the doctor and invited him to join their network.

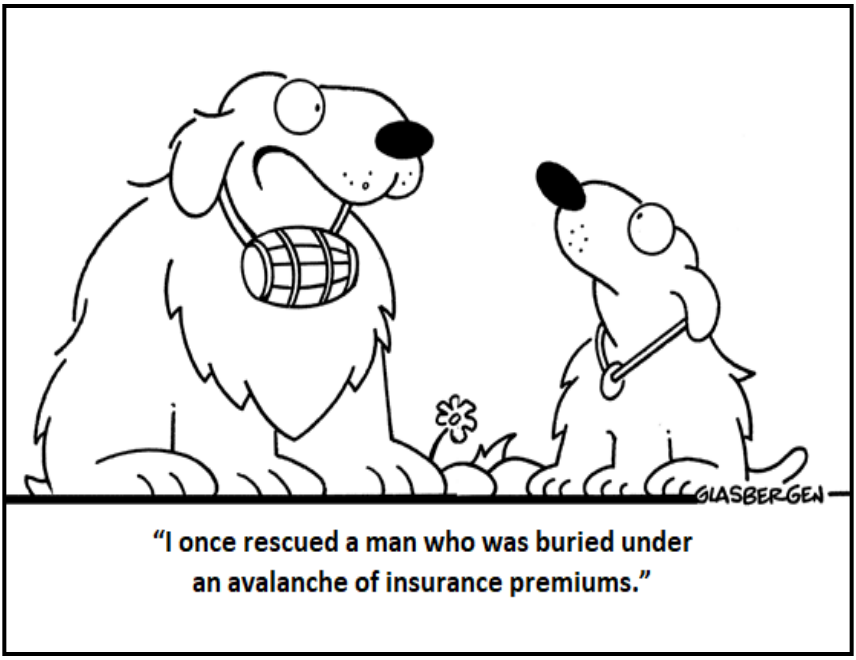
One of my loyal groups that I have worked with for 20 years, was looking at a significant rate increase when the grandfathered plans were being eliminated in 2017. Their renewal premium for a group of 20 employees was increasing to $8900 per month. They applied for and were accepted by the level funded plan. The new plan would still be an HSA, just as they previously had. It would have the same out of pocket maximum for each employee and their network of doctors was virtually the same. Their new premium - $3300 less per month. A savings of $40,000 per year. These are real numbers from an actual group. Then at the end of the year, if their claims came in less than expected, they would be entitled to a refund of excess premiums. FYI, about 60% of my groups received refunds last year.

The Catch: You Have to Qualify

How can this insurance company offer similar plans, similar network and quality coverage for less? Simple, they underwrite your group. Your employees will be required to fill out brief health questionnaires. The company will either accept your group or they won’t, so there is no risk in applying.

If you Haven’t Checked These Plans Out, Why Not?

This is a no brainer. If you haven’t looked at level funded plans yet, you should. Unless of course you are ok with donating possibly $40,000 per year to an insurance company’s profits to help them pay for granite counter tops in their lobby.



"I once rescued a man who was buried under an avalanche of insurance premiums."

Chapter 5

What The Affordable Care Act Attempted to Do

In reality, I believe that there are only two types of people that profess their enduring approval of Obamacare - those that are covered by Obamacare and are receiving generous subsidies and cost sharing, and those that are not covered by Obamacare at all but side with the underlying politics that ushered in this law. The rest of us, who are forced to sign up, pay full price or be fined (fines were eliminated in tax year 2019), have seen skyrocketing premiums and out of pocket limits that might be triple what our previous coverage offered. I've heard a lot of political bantering in the repeal and replace debate about those that will lose their healthcare if the plug is pulled on Obamacare. When Obamacare was first passed, I lost my healthcare. Twice! I didn't lose *access* to healthcare though. When/if Obamacare is repealed there will be those that lose their healthcare, but they should not lose access to a new plan.

I will offer a fair observation of my opinions of Obamacare and what the law was intended to do. Healthcare was definitely in need of a fix and overhaul, but I just don't think this law was the right direction. It may have been well intentioned, and I accept that those for its passage had their hearts in the right place, I just don't believe the design of this law was what we needed. I think these were the four major objectives of the Affordable Care Act:

1. Make coverage affordable for everyone
There were many predictions during the attempt to pass Obamacare about the effect the law would have on lowering the price we pay for healthcare. The popular line was that American's on average would save $2500 per year on their healthcare. But from day one, the cost of insurance coverage doubled in my state. My personal coverage for my family went

from $250 per month to $550. Curiously though, there were others that I had previously sold insurance to that had their premium *drop* from say $250 per month to as low as $50 per month or even $0 in some cases. How was this possible? Did their premium actually go down? Not at all. Their premium did the same thing as mine, it doubled. The secret sauce behind the reduction in premiums for health insurance under Obamacare was not actual decreases, but government subsidies. Income brackets were created and depending on your annual salary, the government would pay your premium, in part or in full. The lower your income, the more the government would subsidize your premium. In some cases, the government would even pay your deductible. The Affordable Care Act was never designed to actually result in the cost of insurance decreasing, it was however, supposed to result in lower premiums to the end user if you were lucky enough to be in the right income bracket.

If you earned too much to qualify for a subsidy, you were stuck with the entire bill or pay a fine for not having insurance. I was quoting monthly insurance premiums of $1700 per month for some of my clients that had to transition to Obamacare with no subsidy. That kind of premium is outrageous and unfair. Why was it so high? Because insurance companies were no longer permitted to underwrite an applicant.

2. **Make coverage available to everyone**

When I started in the health insurance business there were a vast array of insurance companies in the individual and group markets. Some were terrible actually, and they were weeded out in time. But consumers had a choice among viable competing plans. As government mandates kept adding restrictions and requirements on the coverage offered, making it harder for a profit to be made in the selling of health insurance, companies would routinely bow out of the market. After three years of Obamacare, even Blue Cross Blue Shield of TN left the major individual markets in TN. Today, in the small group market there

are about four major players left and they all charge about the same for their plans. No real competition. In the individual market, there are 3 companies in my area for sale on healthcare.gov. And by the way, the cheapest plan for me right now, a 55 year old male that does not qualify for a subsidy is $700 per month with a $6750 deductible.

So sure, coverage is *available* to everyone, thanks to Obamacare. On open enrollment, you are permitted to sign up with no questions asked as far as eligibility is concerned. But a Corvette is available to everyone too, right. There's nothing stopping anyone from walking into a car dealership and driving off in that brand new Corvette you've been dreaming of all your life. Except the price.

Health insurance in the individual market is affordable to those in the right income bracket and cost prohibitive to most everyone else, just like that brand new Corvette.

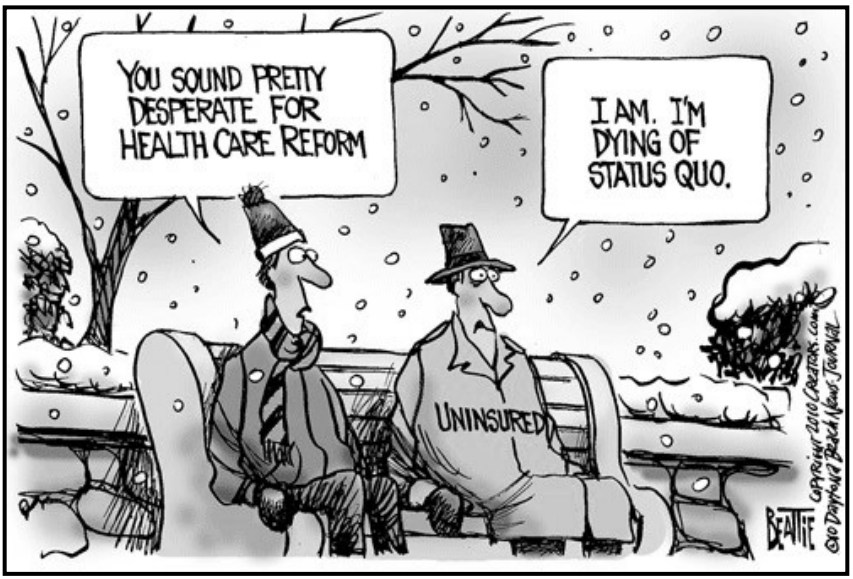
3. Eliminate underwriting and pre-existing condition exclusions

Obamacare was touted and sold under the noble principal that insurance companies could not reject anyone with a pre-existing condition, and your plan would have to cover that pre-existing condition from day one. That sounds like the right thing to do from a standpoint of compassion, but as a business model for insurance companies, it's unsustainable. I address the issue of pre-existing conditions in the next chapter.

4. Create a voting bloc

Finally, the last objective of Obamacare was to create a bloc of voters that could be counted on to support candidates that championed the continuation and expansion of Obamacare. An everlasting legacy, just like Social Security or Medicare. Think about it. If 80% of those on healthcare.gov receive a subsidy and pay little to nothing for their coverage, and if many of those also

receive cost sharing that pays the cost of their deductible so that their out of pocket for their health expenses is literally $0, doesn't it make sense that that 80% would fight any perceived threat to take away their "healthcare?" Why was the law designed to subsidize only those in the lower income brackets? And why was it passed with not even one Republican vote? I think both the Democrats and Republicans care more about their political survival than they believe their own rhetoric. Obamacare, no matter how well intentioned the goals, was sold on premises that it would clearly not deliver on, resulting in one side of the aisle arguing for its sustainability and the other side arguing for its repeal. This is just politics 101 in Washington, D.C. And how committed were the Republicans to the repeal of Obamacare? According to the Washington Post, the Republican controlled house voted more than 50 times to repeal Obamacare up to 2016. They knew that everyone of those votes would be vetoed by President Obama. When Donald Trump became president, he asked the house to repeal as he would sign the bill. Not one time would they vote to repeal when a president would sign.



Chapter 6

How to Fix Healthcare - 5 Things

In this short book, I have laid out strategies to help you make the best of a flawed system. But can the healthcare delivery system in our country be "fixed" or improved? I think so, but there is truly no way to "fix" healthcare to satisfy everyone. The issue invariably becomes a political football and common sense gets lost as politicians spend most of their efforts preaching to their voting base rather than offering the necessary hard fixes.

If I was to go so far out on the fringe that I would be called crazy, but would actually be right, I think that employer sponsored health care should be eliminated. There's really no link between your employment and your health insurance. Health insurance should be like car or life insurance - everybody buys their own. When was the last time you saw a television commercial that said 15 minutes could save you 15% on health insurance? Never, right? But if everyone negotiated and bought their own health insurance, prices would come down. But enough about this pipedream as it's never going to happen.

Some will argue that universal health care, single payer system or Medicare for all is the answer. That would not be a "fix" but a complete replacement of health care delivery in the US. I think our country is too large, diverse and innovative to prosper with a government takeover, as enticing as the idea of free healthcare for all might sound when promised in a general sense by our politicians.

If we could take politics out of the discussion to "fix" healthcare, we might be able to make some progress, but healthcare and politics are inextricably linked. Politicians on both sides of the aisle who enjoy their own personal healthcare coverage which is

highly subsidized by the federal government and use healthcare as a wedge issue, are not going to come together any time soon. Heck, President Trump couldn't get a repeal of Obamacare passed when Republicans controlled the House and Senate. Why? Because no Democrats would vote for any proposal he offered, and then add in the fact that he couldn't even get some of the feckless Republicans united on the issue, and it's no wonder we are stuck with a law that needs to be addressed but is for now, untouchable. But I'll jump in, politics aside, and offer my top 5 things that need to happen:

1. **Price Transparency**

The cost of insurance does not drive the cost of healthcare, it's the other way around. Politicians are consumed with the concept of making insurance affordable. But insurance would be more affordable if the cost of healthcare was lower. I believe the consumer of healthcare must make decisions based on real competition among providers (doctors, hospitals, pharmacies, etc.). What other product do we purchase where we do not know and can't really even ask the price before we buy it? When was the last time you picked out a new car, drove it home and then waited for the bill to come in the mail to see how much you spent? Never, right? No one would do that with any purchase. But that's what we do with healthcare when there is a third party payer.

Ask someone whose been taking a prescription on a monthly basis for years, "By the way, how much is the total cost of your medication?"

"I don't know," will be the usual response, "My copay is $10, I don't know how much the insurance company pays."

How Much is this Going to Cost?

About a year ago, my wife decided due to family history of colon cancer, that she should get a colonoscopy. She was 46 at the time, and our health insurance would only pay for a colonoscopy as preventive care after the age of 50. Due to this, the procedure would be subject to our deductible which was $5000. I had a colonoscopy myself about a year before, and insurance paid for mine as I was over 50. The total charge for my procedure was about $1200. Of course, I learned about the cost after the procedure was complete and I received the Explanation of Benefits from the insurance company. I knew it would be covered at 100%, so why haggle over the price.

My wife was referred to a different Gastroenterologist than I was, and this doctor recommended a different facility also. I was reasonably expecting the cost to be about the same as mine, so $1200 was what we budgeted. As a precaution, we called the facility and the doctor, to inquire as to how much the total charge would be. They responded that they couldn't tell us exactly because it is dependent on how much the insurance company allows. "Since you do these procedures every day," we asked, "you must know how much this insurance company allows, right?" We received no definitive answer. Just a deferral to the insurance company as the final say.

Reluctantly we went forward, buttressed by the comfort that I had just had the same experience a year earlier and still had my EOB's that showed the cost.

When the procedure was done, our total bill was $2400. This was due to the fact that the facility that

this new doctor preferred, charged us $1800. Mine charged $800. The rest of the bill was seemingly split between doctors and the anesthesiologist.

Had I been able to get an honest disclosure that the cost would be double if we used this doctor and location, we would not have scheduled. I would have looked into her using my doctor and facility.

After the procedure is complete, you have very little leverage to negotiate. So, we paid the bill.

There really is nothing we buy and consume with as much secrecy on price as healthcare. And further, for those that have already met their deductible, there is very little attention or even motivation to be concerned as to what the price actually is. Why should we worry about what the hated insurance company that charges us so much in premium is paying anyway?

I propose that every provider of healthcare including pharmacies should be required to present a menu of all services with exact prices, presented in a clear and concise manner, readily viewable by the general public. Full and binding quotes prior to a procedure would also be required. These would be prices that are not controlled by insurance company networks. With this level of transparency, you would be able to make true consumer based decisions on where to receive your care.

If you are in the emergency room and they offer an additional scan for precaution, you ask, "How much will that cost?"

"That will be $800."

"No, I'll pass on that, thank you."

That type of discussion is impossible today.

Price transparency was actually mandated by the Trump administration last year. The healthcare industry's response? An online listing of endless prices and billing codes that offered nothing useful to the consumer. In today's heated partisan environment, the effort has since stalled.

In addition, a complete review should be conducted of what drugs are not sold over the counter. Should we really need a prescription for antibiotics? If more prescriptions were sold on supermarket shelves, the prices would plummet.

2. Insurance Companies should be able to design any type of plan and underwrite the applications

Do you think you should be able to wreck your car, call a car insurance company, buy insurance, and then say, "By the way, I need immediate repairs on my car?" Most people would think that's ridiculous. But how is that different from allowing someone who has pre-existing conditions to purchase health insurance, with the requirement that the insurance company cover those pre-existing conditions immediately? (we deal with pre-existing conditions in #3) Other than the fact that we're talking about one's life instead of a replaceable object like an automobile, there's really not much difference from a business perspective. In 2010, before Obamacare, in my state of Tennessee, a 40 year old husband and wife with two kids could buy a major medical plan with a $5000 deductible for $262 per month. Today in 2019, a plan with a $6500 deductible for that family is $1094 per month. That's a difference of $9984 per year in premium and $1500 in out of pocket costs. You hear that 80% of those that apply on the exchange qualify for a subsidy which would lower the $1094 premium (but 100% of those that apply off the exchange do not qualify for a subsidy). Those are the people I deal with most. Subsidy or not, the underlying cost

continues to rise. Someone is paying it.

You hear a lot of talk about insurance across state lines. I'm not opposed to it, but this alone will do nothing to lower costs. If Blue Cross Blue Shield loses $300 million in TN in 2016, how are companies from other states going to sell in Tennessee with the same government designed policies for less, at a profit? They will not.

We must allow insurance companies to design the health insurance plans they offer for sale, let the consumer choose if they want to buy them and permit the insurance companies to underwrite the application. Only then could we have true competition between companies. The only government requirement I would impose is the policies must be guaranteed renewable, and one's renewal rate could not be singled out and increased based on claims. Renewal rates must be by block of business.

3. Healthcare.gov could survive with a Government Option for those with a Pre-Existing Condition.

Most people get their health insurance from an employer group plan and pre-existing conditions are covered with continuous coverage. Those with a significant pre-existing condition, and not working for an employer that offers group coverage, must be afforded access to coverage. However, their risk pool must not be combined with those that purchase underwritten policies. A separate risk pool with some government backing would be needed. Could we get rid of Medicaid as an insurance plan for the lowest of income levels, and have a government option with private supplement plans on the exchange? Something similar to Medicare? Why not, but it must not be free. Everyone should have some skin in the game. The government option could be Medicare like, but it should have premiums that reflect the fact that this is a high risk pool. Probably two or three times as much

as an underwritten plan. We could also require states to set up separate high risk pools, as many did pre-Obamacare, but from a practical sense, leaving pre-existing conditions up to each individual state, would never fly in today's highly partisan atmosphere.

I have a daughter who was born with Cerebral Palsy. Her entire life, she has not been eligible for any individual plan in Tennessee (pre-Obamacare) due to her pre-existing condition. Since she was born to today, at age 20, there has not been one day that has passed where she was without coverage. She always had *access* to coverage and we never let it lapse.

There are certainly some in our society that need subsidized care, but I contend the number is significantly smaller than the 80% that receive subsidies on healthcare.gov. For those truly unable to pay for the government option, subsidies should be designed, but they should take no one to zero premium except those that are mentally ill or physically unable to work. Remember, everyone must pay.

Insurance companies that underwrite policies will try and dump anyone with a slight pre-existing condition on the government option. This would need to be addressed.

4. **Americans Need to accept the Fact the Healthcare Costs Money and they have to pay for it**

On occasion, my wife will go to a nail salon and get a full treatment of whatever it is they do there. It makes her happy and she can easily spend over $100 in the process. Now, if she takes our 17 year old son to the doctor because he's not feeling well and they send us a $100 bill, she views this as a nuisance charge that we should not really have to pay. "The insurance company should pay it," is her default position. I think most of us think this way and I believe we have to get in the consumer

mindset when it comes to healthcare. We must accept the fact that medical bills should be no different than food, transportation expenses or new shoes. Most of us don't walk into a supermarket and somehow think the food we need to survive should be paid for by a third party. Is healthcare a right or privilege? My only position is that since it's not free, we all should expect to pay for our care in the form of insurance

premiums and deductibles. If we approach healthcare as a commodity and turn doctors, hospitals and pharmacies into sellers of their services, we will see lower prices.

The idea that anyone can walk into an emergency room, receive care and then claim they cannot pay needs to stop. If treatment

is given, and it should be in an emergency situation, the bill must be due. The IRS never writes off their bills, neither should hospitals that treat those that have no insurance and no intention of ever paying. We all end up with higher costs in the form of rising premiums and medical charges. Now remember, we're talking about a hospital that discloses its prices up front, so we should be able to get away from an emergency visit where the hospital sends outrageous bills with no relation to reality to those without insurance coverage.

5. Everyone must have a deductible and access to a Health Savings Account

Everyone should have the option, regardless of which plan that are covered by, to open a Health Savings Account to pay their healthcare expenses pre-tax. Health Savings Accounts (HSA) are a very powerful tool to put the American consumer in charge of their health care spending. I believe everyone must have a stake in the healthcare dollars they spend. I would propose that no one could have a deductible less than $1000 (not many do any more) and there should be no doctor copays before the deductible. If everyone pays the first $1000, or $5000 if they opt for a higher deductible, and providers are required to disclose price, we would have nothing short of a complete transformation on how healthcare services are priced, delivered and consumed.

Chapter 7

What You Should Do Now To Start Saving Money Next Month

If you read most of this book, you probably have an idea of my philosophy. I think employers should buy the most efficient plan and employees should have skin in the game in the form of a higher premium payment if they want a richer, more efficient plan.

I believe that health insurance is meant to cover the big things. If we knew in advance that for the next 5 years, our total health care expenses would run about $500 per year on average, would we even buy a health insurance policy? I wouldn't. I would pay the $500 cost out of pocket and save the approximate $8400 per year in premium I would have to pay for a policy on healthcare.gov. When you think about it, if your total out of pocket expenses were $500 year and you were also paying for a typical policy, you'd even pay the $500 out of pocket due to your deductible.

But if I knew next year my medical expenses would run $100,000, of course I would buy a policy. But we don't know, so the best we can do is buy the most efficient plan available on a annual basis.

Why not see if you are overpaying for health insurance?

1. Contact me - Phone (615) 376-8899, or Email - rick@DixonAdvisoryGroup.com, so we can discuss your current situation.

2. I will send you a census that you can complete and return to me. You can also download a census on my website: www.GroupHealthTN.com. This will allow me to get to work on your no obligation, no cost consultation.

3. With most small businesses, I usually find ways to make your plans more efficient and save you money while keeping your employees satisfied.

You do not have to wait until your renewal to change plans or carriers if we see an opportunity. Most of the insurance companies I represent will even credit deductible you have met so far this year so you don't have to start over in the middle of a plan year.

I look forward to working with you.

About the Author:

Rick Dixon started his career in the insurance industry in 1996. Since that time, he has conducted over 3000 interviews with clients and potential clients, both individuals and small business owners.

> "I take my job as an advisor seriously and consider it extremely rewarding. Bringing a sense of freedom and security to the lives of my clients truly adds joy to my life."

Outside of his career, Rick and his wife Kianush have been blessed with three happy children.

Spare time hobbies include songwriting, jogging, and woodworking.