WHAT HAPPENED TO THE GROUP HEALTH MARKET FOR SMALL BUSINESSES?

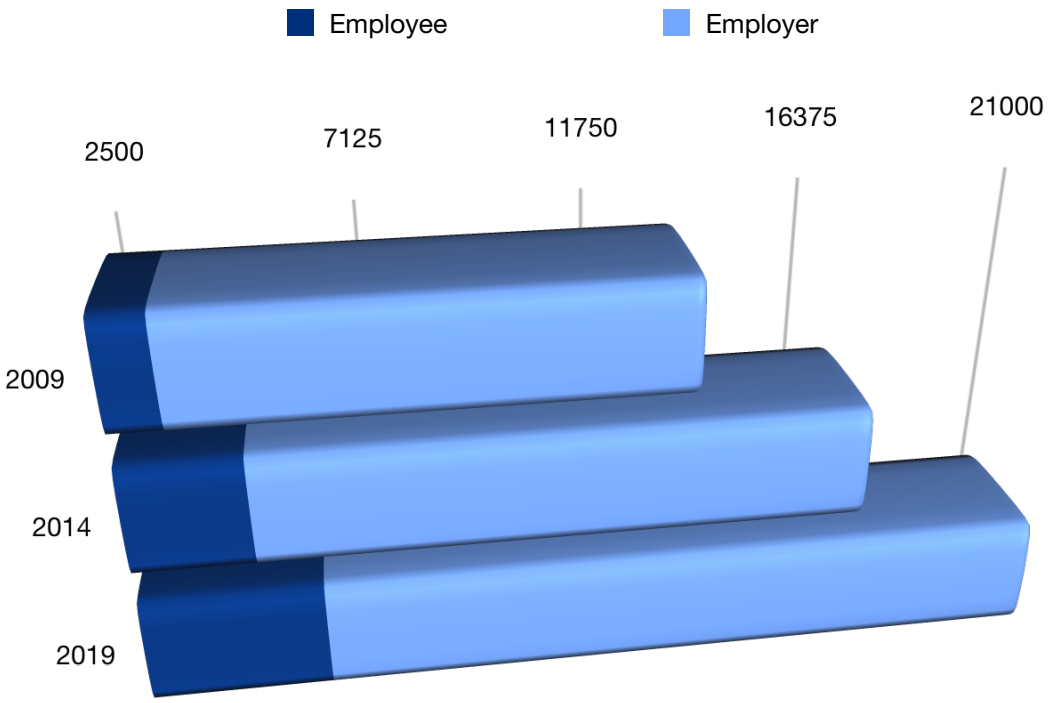
Ask any Small Business owner about Health Insurance and you're bound to get a response. Unfortunately, that response is overwhelmingly negative and for a litany of reasons. The last ten years has seen an acceleration of issues that has wrecked the current group health market for Small Businesses to the point of unsustainability. What are the problems that Small Businesses are encountering with Traditional Plans? How did we get here? And, most importantly, is there anything Small Businesses can do about it?

Finally making it to a point of offering Health Insurance benefits is a momentous occasion for a Small Business. It means that the business has achieved many important benchmarks and has graduated from the initial start up period that washes out the vast majority of new businesses (20% of new businesses fail in the first year, 50% fail by the fifth). Being able to consider offering coverage means the company is likely well established, has consistent revenues and a valuable and talented group of employees. Once the search for coverage begins, however, a whole new reality starts to settle in.

Where do most Small Businesses start when it comes to looking for coverage? A Google search, naturally. Also, they often search out referrals from other people in their network. Either approach typically leads to the same spot- a Health Insurance broker that will research Traditional HMO or PPO plans. These are the "one-size fits all" plans that have served as the standard for the last several decades. Broadly speaking, the choices will boil down to whether you want a PPO or HMO and how high you'd like the deductible to be. That's not to say that there aren't other variables within the different policies but, outside of paying more for a better network and/or lower deductible, there's isn't much customization allowed. For instance, what if no one in your group would ever need pregnancy coverage? These plans include it anyway. What if you have one specific employee that has significant health needs and three others that never go to the doctor? What if you have a young workforce that won't need Preventative

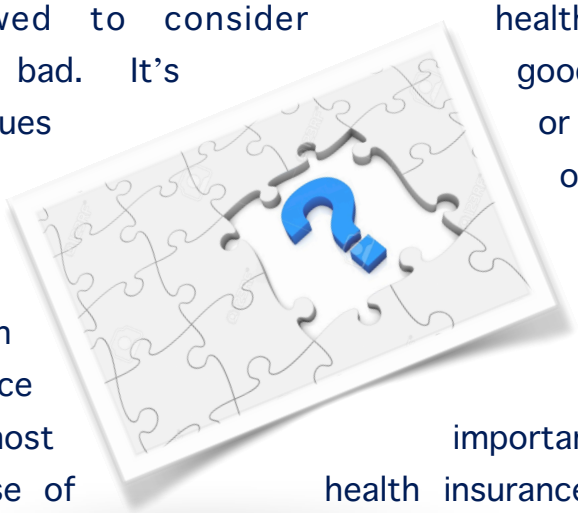
benefits for 50+ year olds? What if the business takes a big financial hit in the middle of the year and wants to adjust their coverage without having to set up a whole new Group Plan? These Traditional plans have certain rigid standards that don't allow them to be adaptive and, ultimately, handcuff the Small Business in many ways. Once a plan has been selected, there is a pretty standard pattern of what the Small Business can expect to see over the course of the next year and up to their first renewal.

In 2019, the respected Kaiser Family Fund did a survey reviewing Employer Health Benefits. Since this article is speaking about the Small Business experience, those are the stats we will consider. In the Summary of Findings, they pointed to several troubling trends. The first trends we'll look at focus on out of pocket exposure. In respect to Health Insurance, out of pocket exposure comes in multiple forms. First is the deductible. This is the amount the insured must pay out of pocket before their insurance begins to pay. Second, is premiums. Some employers will pay 100% of premiums. Some pay a lower percentage. From the employee perspective, they pay premiums on what the employer doesn't cover and for spouses and dependents. The Kaiser report discovered that between 2010 - 2019, overall premiums increased by just under 54%. Breaking that down further, Employer contributions have increased by 71% and Employee contributions have increased by 48%. When it comes to family coverage, the average employer is currently contributing $1,253 a month for a PPO family plan. And remember, that number is rising every year.



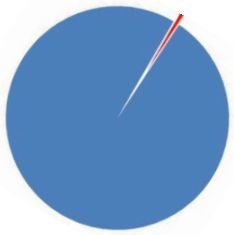
Average Annual Premium Contribution for Family Coverage

One of the reasons that premiums are rising so much every year has to do with underwriting. The Traditional HMO and PPO plans we've been discussing are not allowed to consider health history when issuing coverage. That is good and bad. It's good for those people that have pre-existing health issues or significant ongoing needs that would not otherwise be able to get good coverage. It's bad for the rest of the "pool" or group that is healthy and/or never uses their insurance. When it comes to determining premiums, insurance companies use several data inputs with one of the most important being the risk factors of the pool. In the case of health insurance, when an insurance company is not able to review the pool they are forced to price everyone as if they're sick simply because they don't know who is or isn't. So, although there is a small minority that is actually sick and likely to use their coverage (for these purposes sick meaning pre-existing issues and/or significant ongoing health needs), the policies are priced as if everyone is. Think of this in terms of other types of insurance, for instance automobile. What if an auto insurer was not able to consider someone's driving history or type of vehicle? If you have a clean driving history and drive a low-cost practical car are you as much as a risk as the person your same age with multiple tickets, a couple accidents and that drives a pricey exotic sports car? Would it be fair for both of you to pay the same for your insurance? Or think in terms of homeowner's insurance. Would it be fair to charge the same for a 100 year old home in a flood plain as for a brand new home built in an area with a history of no claims?**

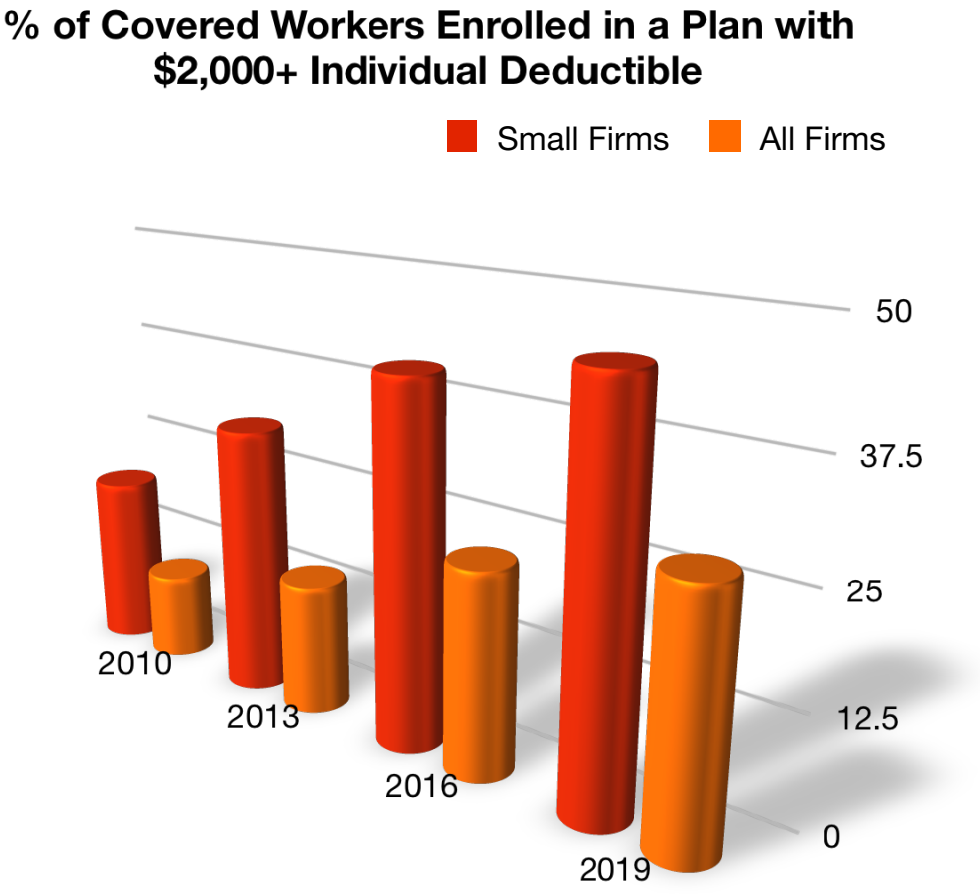


Although underwriting is not considered initially on these Traditional Plans, it is considered when it comes time for annual renewal. This is an aspect that disproportionately affects Small Businesses. When it comes time for renewal, the insurance provider is now going to look at the claims and usage for that Group Plan over the past year and use that information (as they would in a normal market as referenced above) to determine what the premiums should be. Since the Group is considered as a whole, what happens when a small business of 5 employees has just one person that had medical needs over the past year? Just that single person represents 20% of the pool, forcing the insurer to increase premiums to counter the risk.

Compare this to the dynamic with a larger company that has 50,000 employees. Even if they had hundreds of employees with high insurance usage, that would only represent a fraction of 1%. Here's a fair question to ask now that we know these plans are already priced in advance as if everyone's sick: does the insurance company lower the premium at renewal because no one used their coverage? What do you suppose the answer is? This leads to one of the primary aggravations Small Businesses have when it comes to Group Health coverage- the need to change plans every year because of huge renewal increases. It's a pervasive enough issue that it's nearly impossible to find a small business that's been on the same Group Plan for more than one year.



When it comes to deductibles, according to Kaiser, 82% of workers have a deductible in their plan. That is a 30% increase from a decade ago (2010). Combining the increase of large deductible plans with the increase in Employee premium contributions, there's been a "162% increase in the burden of deductibles across all covered workers over that same decade". For reference, wages have increased 26% over that time. Although the average deductible is still relatively low at $1,655, it's not uncommon to see plans with deductibles as high as $5,000 - $7,000. Since the deductible is the up front part Employees have to pay out of pocket when it comes to using their insurance, how realistic is it to think the average employee has $5,000+ to come up with when they have a big medical event? This question forces the Employer into the constant struggle between quality of



benefits and affordability. What's a Small Business to do? They want to offer compelling benefits to their employees so they can stay competitive but, it's getting harder to sustain this as each year passes.

Earlier, it was mentioned that there are many forms of out pocket exposure. There are actually more areas of exposure to the Employee and those come in the form of: co-pays for doctor visits, lab work and prescriptions along with "balanced billing" for out of network charges. Let's begin with the co-pays for doctor visits. Most Traditional plans will provide for 2-4 visits per year to a primary care doctor with a low co-pay (usually about $20; a Specialist will typically have a co-pay closer to $50). Whenever it comes to labs, however, it's not uncommon for those to be counted against the deductible meaning the Employee has to cover the first few thousands out of their own pocket. Prescription drugs are another area with lots of out of pocket exposure. Most Traditional plans cover prescriptions on a tiered scale. As a drug becomes more designer or moves up a Tier, the amount the insurer will cover decreases. For example, you could see a plan that pays 100% of Tier 1, 75% of Tier 2, 50% of Tier 3 and 25% for Tier 4. Tier 1 would include generics and low cost drugs (which represent over 90% of overall prescriptions in the US). The higher Tiers would be drugs that are non-generic or don't have generic alternatives. So, someone might receive 25% coverage for their Tier 4 drug but, how much does that really help if the drug is $10,000 a month? That question aside, as you can see, having to figure out different co-pays and percentages can get very confusing very quickly.

On a more current (2020) note, we now have to consider the implications of living in a world where we can risk exposure to a highly contagious virus. How comfortable will people be in scheduling elective surgeries at medical facilities that may house others with the virus? How will doctor's offices adapt their waiting areas to keep people socially distanced? How will companies keep up with the latest news, research updates and safety measures surrounding the virus? These questions only represent the tip of the iceberg but, it's safe to say there's little doubt that health care and health insurance need to change in order to adapt to the "New Normal". Telemedicine and Direct Primary Care Physicians are going to become much more important. Facilities that only perform lab work will become more popular as people try to avoid doctor's offices and medical facilities.

The final question comes down to what, if anything, can Small Businesses do about this? Surprising as it may seem, there are solutions in the market that address many of the legacy issues presented by Traditional HMO and PPO plans. One of the powerful forces in our american economy is the adaptation of the market when exposed to new forces. Rather than selecting a one-size fits all plan that has a several thousand dollar deductible and will see a 20%+ increase at annual renewal, Small Businesses need to select coverage that is customizable. Customizable Small Business Group Health plans are perfectly suited to the needs of Small Businesses and are designed to eliminate many of the legacy issues. Comprehensive packages can be created that have $0 deductible or co-pay, stable renewal premiums and nationwide PPO coverage for significantly less than the Traditional PPO plans that are much more suited for Large Businesses. In fact, because these plans are customizable (isn't everything else customizable these days??) they can serve as a permanent solution going forward, eliminating that huge annual headache of having to change plans.

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***You can access the 2019 Kaiser Health Benefits Survey at**
https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/

****To be very clear, the discussion of covering pre-existing conditions and significant ongoing health needs has many facets to it. This article is not intending to provide any social or political commentary on this issue. The intention is simply to break down the implications that this has on the health insurance market and how it affects coverage and costs.**