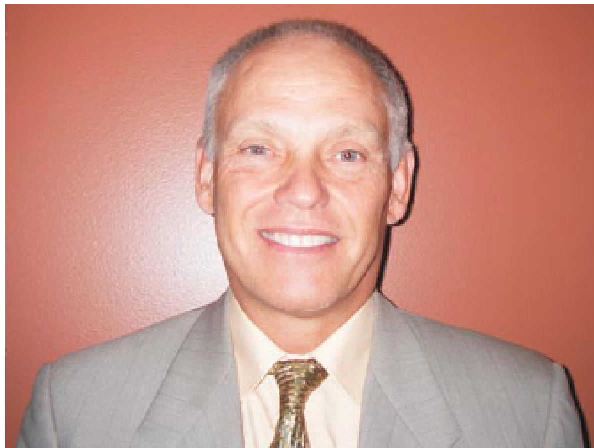
Group Benefits management: Frustration and Passion

By Richard Sirois

When I accepted to write a monthly paper for HRWorld, I was driven by the objectives of the editor to educate and assist HR manager better understand the Group Insurance and Employee Benefits pains but mostly to help them find solutions.
Every month I will share my frustration with the current industry business model as well as my passion in trying to make it better. My frustrations with the management inefficiency comes from 10 years of being an insurance broker (1970-80) and the following 28 as a head of a software firm dedicated exclusively to changing the way we look and work within this industry. My passion, and we need lots of that to enjoy working within this industry for 38 years, is based on the fact that over the years we were able to make some slow but decisive paradigm shift. My current drive is based on my feeling that in the next 5 to 10 years we will see a total reinvention of the way we manage benefits.
The IBM Institute for Business Value Study wrote a report titled « Insurance 2020: Innovating beyond old models », dated May 23rd 2006, presenting the ideal model for managing insurance benefits.



This report defines very clearly a new COLLABORATIVE, OPEN, CLIENT CENTRIC, WEB model that will allow major simplification of processes and cost reduction. They foresee that by year 2020 the industry will have moved into this new model. We fully endorse their conclusions and vision as we came to the same back in 2000. We will discuss this report further next month as well as explore HOW YOU can benefit and gain from this implementation.
The Group Benefit current management model is very complex. (Too complex!)
It started as a simple plan to share the cost of health services for a group of individual around a common sponsor. These sponsors where first major employers who wanted to minimize the financial strain of health services provided to their employees. The program was simple and straight forward: nothing gain nothing lost. The costs of benefits were shared amongst the employees and the employers.
Then it started to take a life of its own. Insurance companies (Carriers) saw an opportunity to extend these services to a larger audience. Independent advisor and/or actuary where called in to assist the sponsor in selecting the right product making certain that the pricing was fair. To do so, the advisor requested proposal to various carriers, compiled the complex data of the offering and then made suggestions to sponsors.
Quickly the tax men came into the picture and defined new laws making certain employers benefits contributions taxable to the employee while providing deductibility to employees for some of their expenses. Sponsor needed to define then collect the employee contributions and provide the government with the detailed contribution to ease the tax management. These calculations are very complex and subject to E&O. Some of these activities and information were shared with the payroll or HR system.
The industry grew to incorporate new organizations, more complex products and facilitators that provided specialised services such as Electronic Drug and Dental adjudication, Employee Assistance Program and more. Health services and product providers as well as some claimants needed to be controlled as this huge industry provided great fraud opportunities.
When we put all of these into perspective we realize that we have a complex web of participants trying to interact together. Roughly we could estimate some 20-50 carriers, 5,000 advisors/actuaries, 125,000 enterprises, hundreds of payroll or HR system, hundred of thousand of health service providers and some 15,000,000 insured.
The problem compounds because each of these participants operates in silos and most of them reinvent their own electronic processes. Most manages independent data bases and use different formats and methods to share information. To make things even worst some are based on OLD legacy technologies that are stretch to the limit and cannot adapt to the new realities.
When we understand that most participants will be managing the same basic information, it is easy to see direct impacts of this inefficient model:

- same data manipulated many time in the various data base,
- useless human intervention create risk of E&O,
- complexity in sharing information,
- difficulty in accessing the right information,
- repetitive technology cost

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to reinvent the same non distinctive tools,

- etc.

If we want to tag a managing cost for this current model we can estimate it to be between 18 and 40% of premiums. Using a median 25% of annual Canadian premium of $25 Billions this mean over 6B$ are spent every year for management only. This represents some $200 to $500 per insured every year.

Should you need further explanation of the useless pain of this model, please go to the following URL web link: **http://www.c-surance.ca/C-SURANCE/newsletter_nov04_en/index.asp?c=1**

You will enjoy the analogy of TODAYS Group benefit management model to the fictional break up of financial card standard. The November 2004 news letter Special issue titled:

WHAT BANKS DON'T WANT TO TELL YOU!.

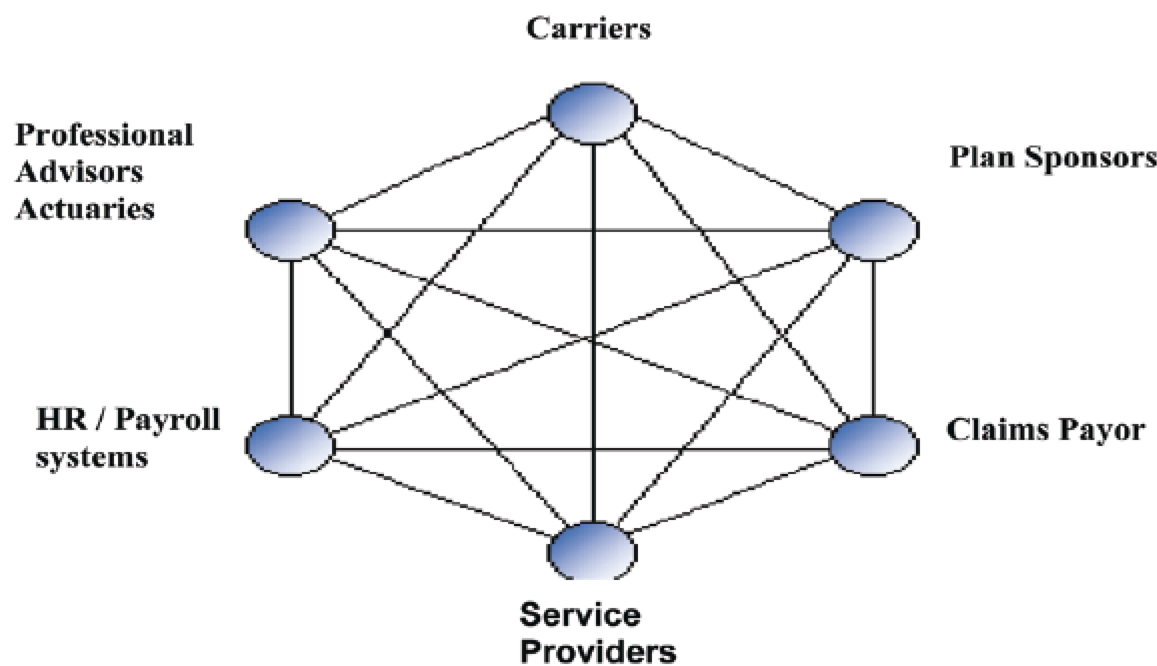
Provide 4 graphics articles that are meant to be shocking only to insure grasping the reality of the model:

2010 will mark the end of Financial Cards

CitiGroup & HSBC's offers will even have James Bond running scare

"Canadian Banks choose their weapons."

Insurance: Save $200 annually in managing cost for each employee



It is easy to see why this model is totally inefficient and must be replaced. It is clear to me that a new COLLABORATIVE CLIENT CENTRIC WEB model could allow to recuperate some 50% of these expenses.

Next month we will be exploring the IBM new COLLABORATIVE, OPEN, CLIENT CENTRIC, WEB model that will allow major simplification of processes and cost reduction. The solution is evident and obvious. Unless you enjoy footing the bill of this inefficiency YOU, the HR professional, will certainly want to get involved,.

In the following issues we will get into more specific subjects such as:

- Sponsors' daily pains in managing employee benefits. The risk of E&O associated with management. We will explore the employer/employee contributions and synchronization with carriers and payroll HR system. Do you have the right tools?
- Selecting an advisor/actuary. Is you professional looking after you and providing you the right services?
- What to look for when going to market. Getting the best values, renewal conditions and market trends,
- Self administration, ASO and self funding using a carrier, a TPA or access WEB management tools.

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Specialist in process optimisation, C-surance.ca provides WEB tools to simplify process and reduce cost of managing Group Insurance and Employee Benefits.
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Survey: HR Pros support Proposed FMLA Changes

Human resource professionals support recently proposed regulations covering the Family and Medical Leave Act (FMLA), according to a survey by WorldatWork.

In February, the Department of Labor published a proposal with new FMLA regulations addressing notice requirements for employers and employees, medical certification, the definition of serious health condition, nonconsecutive periods of service, joint-employer coverage, and other topics.

The survey found that HR professionals generally welcome proposed changes that could ease some of the administrative burden that FMLA creates within their companies. The proposed change that ranked highest among respondents was the requirement to give advance notice for non-emergency, foreseeable leaves. Ninety-five percent of respondents supported the proposed change, with 72 percent of all respondents saying they "strongly agree" that the change should be made.

In the proposal, the department said that absent emergency situations, where an employee becomes aware

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Survey: HR Pros support... *Contd. from page 6*

of a need for FMLA leave less than 30 days in advance, the department expects that it will be practicable for the employee to provide notice of the need for leave either the same day (if the employee becomes aware of the need for leave during work hours) or the next business day (if the employee becomes aware of the need for leave after work hours).

The WorldatWork survey found that 49 percent of intermittent FMLA absences are scheduled, but most intermittent leave users (81 percent) are providing no more than a 24-hour notice, and over half give notice the day of the absence or even later. Survey respondents said that suspected employee abuse is their number one concern about intermittent FMLA leave.

The department's FMLA proposal also covers the procedures employees use to request leave.

The department is proposing that "absent unusual circumstances, employees may be required to follow established call-in procedures (except one that imposes a more stringent timing requirement than the regulations provide), and failure to properly notify employers of absences may cause a delay or denial of FMLA protections. Unusual circumstances would include situations such as when an employee is hospitalized and his/her spouse calls the supervisor to report the absence, unaware that the attendance policy requires that the human resources department be called instead of the supervisor."

In the WorldatWork survey, the second through fifth most popular proposed changes were:

Allow employers to require a fitness-for-duty certificate after return from intermittent leave to jobs that could endanger themselves or others or that they may be unable to perform.

Employers could require annual medical certification when condition lasts more than one year.

Allow employers request for recertification of an ongoing condition every six months, with an absence.

Lengthen eligibility and designation notice requirements to five business days.