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A Top 10 List for Selling Group Health Insurance

BY HANA RUBIN

Health insurance is on the forefront of everyone's mind today: where to get it, how to get it cheaper, which networks work best for whom, etc. There are so many questions and just as many answers. And, as always, agents have a wealth of opportunities to sell this product. There's more to health insurance than individual policies, however — group health insurance is also a hot product, with plenty of prospects operating, owning, and opening businesses every day. Following are the top 10 steps you should take with a group health prospect.

1. Brush up on the terminology

You need to know what you're talking about before selling any type of insurance. Proper training and experience can get you a good foundation in health insurance; here are a few key concepts to start you out.

- HMO (health maintenance organization) — This type of plan provides coverage for network benefits only. A network provider must be used. A primary care physician must be selected, and referrals are required to see specialists. Visits to providers usually require copayments, typically a flat dollar amount, but sometimes a percentage of the provider's reimbursement (co-insurance). Options for these plans generally relate to the amount of the copayments.
- POS (point of service) — This type of plan can be best thought of as an HMO plan with out-of-network benefits. In-network benefits are virtually identical to an HMO plan's, in that a primary care physician must be selected and referrals are required to see a specialist. Out-of-network benefits are available subject to an annual deductible and co-insurance and out-of-pocket maximums. Because of the availability of out-of-network benefits, there are many more available design options than for an HMO plan.
- PPO (preferred provider organization) — This type of plan provides both in and out-of-network benefits similar to the POS plan; however, primary care physicians do not have to be selected and referrals to specialists are not required. This type of plan is also referred to as "open access." This is the most liberal and easy-to-use plan — and generally the most expensive. As with the point-of-service plan, there are many available plan options.
- HSA (health savings accounts) — An HSA actually refers to a combination of a qualified high-deductible health plan (HDHP) provided by a group medical insurance carrier and a personal health savings account. The HDHP reduces the premium costs, and the HSA may be funded on a pre-tax basis up to $2,850/single and $5,650/family per calendar year. The money in these accounts can be used for approved medical expenses on a tax-free basis and is owned by the employee.

2. Make sure there is a valid group

Group health insurance is offered only to groups where an employer/employee relationship exists. The relationship generally needs to be substantiated with payroll records or other tax forms.

3. Ask what type of coverage is currently being provided

The best place to start is with a review of the current benefit plan. You should ask what the employer likes about it and what they find lacking. Find out what their trigger points are — price, coverage, specific benefits, etc. Ask some questions, such as, do their employees contribute to the premium? Or do they offer coverage to the families of the employees?

4. Ask to see the most recent premium notice

This shows you the cost of their present plan and provides a starting point for comparison. It also shows how many people are on the plan and what type of coverage they have (single or family, etc.).

5. Find out the policy renewal date

Many employers start shopping around once they receive their renewal notices. Renewal notices are generally sent 60 days prior to the renewal date.

6. Ask to see the renewal letter

The renewal letter provides plan design and options and the premium rates for the new policy year. Often, the renewal letter will provide options to reduce the amount of the required rate increase.

7. Obtain the required census information

The information you need to obtain will be determined by the rules of the state in which your prospect is located. In New York, for example, because of its community rating law, the only data you need for a group with 50 lives or fewer is family status and location of the group. Carriers in most other states will require the traditional census data showing sex, date of birth, family status, and resident ZIP code. ZIP codes are important for those companies with employees in multiple locations and those that need national networks. Keep in mind that some carriers might have additional requirements.

8. Start shopping the marketplace

When shopping, you can contact each carrier

directly, use an online quoting service, or enlist the services of a general agent. After you have been selling health insurance for a little while, you will learn which carriers have the "hot products" of the moment. Keep in mind, however, that carriers are "hot" cyclically, most often because of their rates, which can fluctuate.

9. Complete paperwork and submit to carrier

This must be done in a timely manner to ensure the insurance begins on the effective date requested by the client.

10. Finish the sale

Advise your client of the carrier's acceptance and provide the policy number. Congratulate yourself on a job well done.

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