

Employees' Guide To The Open Enrollment Process

Note: JoAnn Laing is President and CEO of Information Strategies, Inc., whose company communicates with four-plus million employees and managers each month. The company surveys and talks with these managers on a regular basis and it is from their feedback that this primer is based.

Each year at this time, most employees are faced with an important decision that materially affects themselves and their families for the following 12 months. During the "open enrollment period" millions of Americans are faced with making choices about their healthcare coverage. For many employees in recent years, each open enrollment period seems to bring more choices. At the same time, employers are asking staff to take up more of the responsibility, including cost, while asking them to choose a new or modified healthcare plan for the coming 12 months. Among the plethora of choices are:

- What deductible to choose?
- How much they will contribute?
- Should their families be covered and to what extent?
- What provisions to accept and which to decline?
- Can participation in wellness programs help?
- Does it pay employees to take more and more of the responsibility for choosing how they utilize their insurance coverage?

Healthcare costs are amongst the single highest cost for all Americans. Since the millennium, healthcare costs rose at a pace five times the inflation rate and four times the average rate of wage increases, according to Dr. Henry E. Simmons, National Coalition on Health Care article, April 19, 2006. This means that most employees are devoting a higher percentage of their salary to healthcare today than in 2000.

As the process by which companies strive to balance employee needs with rising healthcare costs becomes more complex, the options open to staff often become more varied. At the same time, insurance providers are creating many new options as well. Unfortunately, most of these changes work are at best a neutral gain for employees. What is a positive and gaining considerable traction is the growing usage of wellness and health improvement programs.

For many companies, the burden of choice is shifting more and more to employees along with the requirement that they shoulder additional costs. With steady, sizable annual premium increases companies are looking for ways to lower their cost, from using higher deductibles and less coverage options to shifting the burden of rising health-care costs to employees. Over the next few years, enrollment options and choices are expected to become even more complex along with a shift in who is paying for healthcare.

This primer is designed to help employees sort through the options to figure out what is best for themselves (and their family). To start, the process begins with workers being given detailed handouts and asked to choose among medical plans with varying deductibles and coverage options, allocate pretax dollars to medical savings/spending accounts, and perhaps participate in wellness programs to save money.

Among the first questions any employee should ask are:

- What are my current and expected healthcare issues?
- Do I (or a member of my family) have a recurring illness that requires ongoing care?
- Do I expect or want a specific procedure performed in the coming year?
- Are there any safeguards in place should I have a catastrophic illness or accident?
- Are there vision or dental problems that are or will need to be addressed?
- How much can I put aside to cover anticipated and unanticipated healthcare costs?

Current Options:

Most American workers covered by company supplied healthcare insurance have one of three types of programs, Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) or Point-of-Service (POSs). A rising number participate in Health Reimbursement Accounts (HRAs), Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs). These latter options have some tax benefits as well.

Most HMO, PPO, and POS accounts have a minimum deductible with a co-pay provision for doctor, hospital and other services. In these programs, there are no incentives for the worker to minimize or husband healthcare resources.

For staffs with HRAs, FSAs and HSAs there are usually higher deductibles but some rewards for better managing usage of healthcare resources. (A comparison of these three options is attached as Appendix A.) These offerings come under the common title of consumer directed healthcare or CDH.

Rather than use the traditional managed care programs (HMOs, PPOs and POSs), many companies are looking at consumer directed care programs (HSAs, FSAs and HRAs). The theory under the latter is that workers will accept a higher deductible for a lower overall premium, and use money set aside to help pay out-of-pocket expenses.

That approach is designed to make them more frugal health-care users. Information Strategies, Inc.'s studies show that this is the case; consumers with CDH plans use the emergency room less often, while on the other hand utilize more preventive care programs and switch to generic drugs. Because people are so much more exposed to the costs of health care, spending wisely and staying well is much more important. At the same time, doing so can put money in their pocket.

However, most American workers are unsure about these options and often decide to stay with their current enrollment rather than explore how these offerings may reduce their tax bill. While often the premiums for these CDH programs are lower for both employer and employee, companies are reluctant to make the wholesale substitution and often offer them as an option.

Given that there are now at least six choices, experts say some workers also are becoming confused by all the choices they face. In 2005, only about 30 percent of employees eligible for benefits bothered to change their options, down from 2003, when 36 percent of eligible employees actively chose their coverage, according to a study for Lincolnshire, Ill.-based Hewitt Associates. Employees who fail to choose are defaulted into something or lose their coverage.

The best thing to do, like it or not, is for employees to embrace the process and evaluate their choices.

Compare Your Old Plan With The New Offering.

Surveys have found that over the past three years, no matter what policy is offered, most company sponsored plans have at least one major change each year. Usually the change is in one of three areas -- deductible, drug payments or services covered.

A specific method of evaluating plan changes for an employee and choosing the right plan is to identify what healthcare services he or she (and the family) used during the current year. This will give the employee an excellent "handle" on what is important to them. Except in states which mandate coverage, one of the biggest changes over the past few years is maternity and psychological services benefits. Another growing area of change is usage of hospital emergency rooms. Many policies now cover the so-called "Mini-clinics" or "walk-in providers" while raising the co-pay costs to employees.

Choosing what's best for you.

Review your healthcare needs over the past few years, and consider if this usage will change over the next year or two. What are your costs (total premium, out-of-pocket expenses)? There is a handy, short form entitled "Yearly Healthcare Cost Analysis" attached to this document as Appendix B.

Consider using tools like health-risk questionnaire. According to a recent Hewitt study of more than 18,000 U.S. employees, three-fourths of the employees who completed questionnaires said they found them valuable, and more than 40 percent said they learned something new about their health.

Other studies have shown that most Americans (73%) do not spend \$500 on out-of-pocket medical expenses. This fact alone should make any employee think seriously about the connection between health and wealth, money not spent on premiums or medical costs can be saved. The average company sponsored premium is more than \$9,000 of which, on average the employee is paying about a third. This means that an employee in a PPO, POS, or HMO is spending \$3,000 that he or she would not see again. If he or she spends only \$500 during the year that means that \$2,500 is not recovered at the end of the year.

The CDH plans offer some forms of tax relief and in the case of HSAs, a vehicle to build a reserve for future medical events as well as for retirement. (See Appendix A)

Look at who owns and controls any monies not spent.

For those enrolled in more traditional plans (HMOs, PPOs, POSs) there is no direct savings programs attached to them. For those in CDH plans, there are certain provisions that provide some monies for use in later years. (See Appendix A).

Even though more and more employees are paying a higher proportion of the healthcare premium, the insurance policy is chosen and managed by the company and if the staff member leaves, the monies spent on this policy is lost. The COBRA insurance available for a limited time usually requires a hefty increase in monthly payments.

The employer is not your friend but in business to make a profit.

Too often, employees rely on the employer to assure them that the healthcare plan(s) being offered provide the best possible coverage. Employees need to remember that many Chief Financial Officers, and in some cases the Chief Human resource Officer, chooses what plans to offer employees. Both are charged with maximizing the financial resources of the company. Employees need to figure out what offering is best for him or her (and the family). In addition, the insurance provider is there to make a profit from providing coverage that best fits their financial model, not the employee's need. That is why it is crucial that an employee review the plans in light of their needs. Often the best plan is not the preferred offering by the employer but rather the one that offers the best return for their dollars spent.

Specific situations require answers in writing.

If the employee has a specific situation and contacts the human resource department, his or her supervisor, or the insurance company, the response should be in writing. More importantly, that answer should be kept so that if questions arise in the future, it can be produced. The courts and arbiters only recognized written documentation.

Key considerations for choosing any health plan:

No matter what policy an employee currently has or is planning to opt for, there are several key parameters to consider. They include:

Identify what is the total cost of premium and deductible. An employee should know how much he or she is paying for all aspects of the healthcare program, including co-pays, deductible and maximum out-of-pocket.

Is the insurance provider reliable and able to handle extraordinary claims or draw downs. For more traditional plans, the average usage is about 100% of premiums. If a company has a bad year, they may not be able to pay all claims quickly and reliably. Employees should ask their company representatives if the insurance provider has been vetted in these areas and is indeed registered to sell insurance in the state in which they are domiciled.

Carefully review what the plan covers and compare it to the current plan to insure that the employee is covered to the same extent. Ask for specific comparison of the new plan against the older offering. In particular, ask which medical procedures, services and expenses are included and what are the common exclusions

Until a major incident happens, few employees realize how important is the **Care management policies** (pre-authorization permission) is to his or her (and the family) well being. Care management programs are also helpful when a new illness or accident happens and having a good advisor becomes a critical element in getting the best care.

Coverage outside the state (for traveling) is often overlooked in the process of choosing a provider and many company based policies have severe restrictions in this area. Know what is covered and what is not covered when the employee (and the family) is away from home.

Of late, many companies are seeking a **guarantee of renewal** and rate protection for next few years. Employees with ongoing conditions are particularly vulnerable when coverage shifts from one insurance provider to another.

The **quality of customer service** is an important element for any employee. If he or she (or the family) have had poor experiences with the current carrier, it is important that this be communicated to the company. If a new carrier is being offered, it is critical that the terms and conditions of customer services are clearly explained and detailed. Some carriers now offer nurse practitioners who help employees with medical problems find the best care.

A list of **approved healthcare providers** need to be examined to make sure current doctors and hospitals are still covered. The single biggest complaint heard from employees when a plan changes is that the new plan does not include their current physician.

Reimbursement policies need to be clearly spelled out so that if an employee pays monies to a healthcare provider, the carrier or company needs to be promptly repaid.

Individual requirements are often on a one-off basis and the employee must articulate them to the employer during the enrollment period. If a family has a child with a particular health issue, it is important to ask the employer or the insurance representative what are the specific policies as regards to this issue. The time to ask is during the enrollment period, not when the first bill comes in.

Pre-existing conditions are an increasingly difficult area for employees. Insurance companies differ in how they recognize already existing situations. In addition, there are also state-by-state regulations which must be addressed during the enrollment period.

What the employer will do is another question that should be asked during the enrollment period. Many employers have stand-by or loan programs to help employees cope with medical situations. Most will not address these in open sessions but if there is a concern, than a private meeting with human resource staff or supervisors is appropriate.

Finally, stay aware of the closing date for enrollment. Many employees fail to properly fill out or even file an enrollment decision. It is important that this be done in a timely manner and a record kept of when it was provided to the appropriate company representative. The courts are rife with cases involving misfiled, miswritten or unsigned documentation that can come back to haunt both employee and employer.

Appendix A

Making sense of Consumer Directed Health Plans

HSA (Health Savings Account): Employee owned- and controlled-plan that pays for medical expenses and accumulates tax-free, and is an inheritable asset. It must be used with a high-deductible health plan that meets IRS requirements. Many refer to this plan as a “medical IRA” as it pays for medical cost tax-free when needed and builds tax-free to supplement retirement.

HRA (Health Reimbursement Account): Employer-controlled program that reimburses for benefits not covered or otherwise paid for under a company health plan. Some refer to it as the “bent knee” or “lack of privacy” plan, because of HR’s involvement in approving expenditures.

FSA (Flexible Spending Account): Employee-funded savings plan that pays for health-care costs not covered under an employer-based health insurance group plan. Many know it as the “use it or lose it” plan, because funds used by the cut-off date are no longer available.

CDH Plan Comparison

	<u>HSA</u>	<u>HRA</u>	<u>FSA</u>
Ownership	Employee	Employer	Employer
Portability	Yes	No	No
HDHP Required	Yes	No	No
Funding	Anyone	Employer Employer	Employee,
Cashing Out	Taxed + 10% Penalty	No	Section 125 Rules
Roll-over	Yes	Employer Decides	No

➤ A more detailed comparison can be found on www.HSAfinder.com

Traditional Managed Care Programs

PPO (Preferred Provider Organization): A plan that takes its name from the organization (network) of hospitals, doctors and service companies that agree to treat policyholders for a set fee or discounted fees. Policy holders typically pay no fees or reduced fees as long as they only use providers “in the network.”

HMO (Health Maintenance Organization): A “prepaid” insurance policy plan that requires policyholders to pay more than \$1,000 in medical fees, to the limit of the deductible, before the insurer will pay for subsequent care expenses.

POS (Point-of-Service): Any health insurance plan that permits a policyholder to chose either in-network or out-of-network providers.

Appendix B
Yearly Healthcare Cost Analysis

	2005	2006	2007
Yearly cost of healthcare premium (12 times monthly premium)	_____	_____	_____
Deductible (How much you pay of costs)	_____	_____	_____
Total co-pays (estimate if not known) (Use chart below to estimate)	_____	_____	_____
Other payments made (includes non-covered medical services, co-pay of ER visits, other procedures)	_____	_____	_____
Total out-of-pocket expenditures	_____	_____	_____
Comparing Costs:			
Deductible amount	_____	_____	_____
Rate of co-pay for doctor visit	_____	_____	_____
Co-pay for ER visits	_____	_____	_____
Co-pay for brand drugs	_____	_____	_____
Co-pay for generic drugs	_____	_____	_____
Co-pay for non-formulary drugs	_____	_____	_____
Co-pay for drugs	_____	_____	_____
Co-pay for other services	_____	_____	_____
Dental included?	Yes / No	Yes / No	Yes / No
Vision plans	Yes / No	Yes / No	Yes / No