OPEN ENROLLMENT BEST PRACTICES

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As I write this (around Labor Day) HR officials, brokers, consultants and others are not thinking so much about the end of summer, but rather the approaching open-enrollment season. That special time of the year is upon us once again.

Having been involved with many open enrollments over the years as an insurance company executive, third-party administrator, wholesaler, consultant and retailer/broker, I have accumulated some insight as to what employees/enrollees should be considering during this important time of the year. Call these my "open enrollment best practices," or the things enrollees/employees should consider as they enter open enrollment season.

1. When reviewing health insurance options (and, for that matter, dental, vision, life insurance, etc.), always annualize the premium amounts presented/offered. Most of the time, the employee/enrollee is going to be enrolled for a full, 12-month period, so it just makes sense to look at financial responsibility on an annual basis. Plus, plan-related deductibles and out-of-pocket accumulations generally refresh after a period of 12 months.

2. Consider ALL available health insurance options. It might turn out that coverage offered by a particular employer to a particular employee may not be the best option. There are other options worthy of consideration, such as:

- Spouse's employer plan
- Medicare (with associated supplemental coverage(s)/Medicare Advantage
- Individual coverage purchased on the private market
- Individual coverage purchased on the public exchange/marketplace
- Veteran's Administration
- Tricare

3. Don't just focus on one aspect of the coverage (e.g., copays for office visits, the deductible, the coinsurance percentage, etc.). Rather, tally up the entire out-of-pocket expense of the option(s) and consider the plan(s) that make the most sense for the individual and/or families healthcare needs. If the individual/family uses little to no healthcare services, the plan offering with the lowest premium makes more sense. Alternatively, the individual/family that uses a fair amount of healthcare services should consider the plan with the lowest potential out of pocket limit. Ask if there's a decision-support tool available to help employees make a more informed decision of coverage based on their historical use of healthcare services.

4. Take into account the offering of dollars to be used for healthcare expenses that insurance doesn't cover, or for use meeting deductible/copay/coinsurance obligations. Sometimes, employers offer/fund/provide dollars in multiple spending arrangements. These usually end in the letter A, as in HAS, FSA and HRA.

5. Inquire into stipends and assessments that may apply, based on enrollment decisions. Some employers offer an opt-out or waiver stipend (either post-tax or tax-free through a flex plan) if an employee opts to waive the coverage offered. On the flip side, some employers require an assessment (in addition to the premium cost share) for covering a spouse who has coverage available through their employer. These additional amounts of dollars are significant factors in making open-enrollment decisions.

6. If a wellness incentive is offered, it's very important to understand what the requirements are in addition to the associated rewards/penalties. There are myriad wellness programs being offered, with untold ways of incentivizing (or penalizing!) employees. Some wellness programs require very little, yet yield a high reward (e.g., premium reduction, HSA contribution, cash reward, etc.). Others require much, yet provide a marginally small incentive.

7. Many employers offer their employees the opportunity to pay their portion of the premium for health, dental and vision coverage with pre-tax dollars through a flex plan (or a Section 125 or cafeteria plan). This is a great way for employees to reduce their tax obligation, but enrollees need to know that if they take advantage of this offer, they are committed to remaining enrolled in the plans they are paying for with pre-tax dollars for the entire 12-month period of the flex plan. The only way to dis-enroll earlier is to experience a qualifying event.

8. Speaking of flex plans, HSAs and HRAs, these arrangements/accounts offer enrollees outstanding tax benefits, along with the means to pay for lower cost healthcare. Employees/enrollees should consider the use of tax-preferred dollars available to them in one or more of these, and take full advantage. Many times, I see employees offered both an HSA and a limited purpose FSA, and either or both are completely ignored… *by high utilizers!*

Have a wonderful open-enrollment season! HIU

PPACA'S HEALTH PLAN IDENTIFIER REQUIREMENT

As the old saying goes, "The devil is in the details," and PPACA has its more than its fair share of details. Among the rapidly approaching compliance deadlines for many employers is requesting/obtaining a ten-digit Health Plan Identifier, or HPID. While ALL employers offering health insurance plans must comply with this requirement, the due date for obtaining the ID, along with determining who is responsible for obtaining it, varies based on a couple of factors. Here's an overview of the whole HPID matter.

PPACA includes an important section known as Administrative Simplification. Included in this section is the requirement that virtually all health plans obtain an HPID. At this point, we know HPIDs will be used in making HIPAA-related electronic transactions (e.g., medical/dental claims, premium payments, enrollment, disenrollment, etc.). Further guidance pertaining to the use of the HPID is expected from HHS in the near future. In the mean time, here is the when and who affected by this PPACA compliance requirement:

WHO:

- Employer-sponsored group health plans
- Health insurance issuers and HMOs (NOTE: Employers with fully insured plans are not required to apply/obtain an HPID. Rather, insurers will have and use HPIDs on behalf of their employer group customers.)
- Federal employee health benefits (FEHB) program and governmental health plans
- Controlling Health Plans (CHPs) and Subhealth Plans (SHP)

WHEN:

- Employers with annual receipts of $5 million or more by November 15, 2014
- Employers with annual receipts less than $5 million by November 15, 2015
- Plans generating HIPAA electronic transactions required to use HPID by November 7, 2017

Partially self-funded/self-funded employers are required to obtain their own HPIDs, and TPAs and ASO providers are not allowed to obtain the HPIDs for their customers. To assist affected employers with this application process, CMS has developed a variety of resources:

- www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Downloads/HPOES-TrainingSlides02132013.pdf?elq=8cf0385af6094e55b17daa7b9297c171&elqCampaignId=1491
- www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html
- https://portal.cms.gov/wps/portal/unauthportal/home/

Affected large (i.e., over $5 million in annual receipts), partially self-funded employers are encouraged to apply for their HPID as soon as possible. The application requests an employer's "payer ID number" but CMS has advised employers that do not have such a number to enter "not applicable" in this field, and continue with the process.