OPEN ENROLLMENT

Selecting Benefits for Your Employees to Protect Their Health

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NORM National Organization of Rheumatology Management

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As an HR professional, you may play an active role in selecting health benefits and assisting employees with health plan enrollment.[1] In light of rising health care costs in the U.S. and the ever competitive job market, it is important to choose benefits that are both fiscally responsible and responsive to the needs of your employees. This guide is intended to assist you during the open enrollment process so that both your company and your employees get the most value out of the benefits package.

Needs Assessment

Before selecting health benefits, it is helpful to begin with a needs assessment.[2] This process will help you determine what your employees prioritize most and how much value they are getting out of existing health benefits, which can assist in selecting future benefits. A needs assessment can be conducted through a survey, focus groups, one-on-one meetings with your company's staff,[3] or through benefits-use data on how your employees are utilizing their benefits.[4]

To help you understand how your employees are specifically utilizing their health benefits and aid you in selecting plans best-suited to your company's needs, consider asking your employees direct questions on the following topics:

- The frequency of their utilization of in-network vs. out-of-network care;
- The frequency of their utilization of primary care vs. specialty care;
- Their satisfaction with currently available plans;
- The level of cost-sharing with which they are comfortable;
- The relative importance of the aspects of health benefits plans (e.g., high deductibles, copay amounts, and size of network);
- Difficulty accessing prescribed treatments or care;
- Rates of denials for prescribed treatments or medical services and ease of navigating the appeals process; and
- Aggregate and voluntary information about anticipated benefit needs while respecting employee privacy and applicable employment laws.

You can also assess the open enrollment process in its entirety to understand where you can improve.[5] Consider incorporating questions such as:

- Did employees receive enough notice about open enrollment to make an informed benefit selection?
- Were there any lapses in communication that created conflict?
- Did all HR professionals receive the right information to assist employees in making their benefit selections?
- Were changes in benefits communicated effectively to employees?
- Did you reach your goals for open enrollment?

Plan Design

In selecting health benefits, it is important to choose plans that offer employees access to quality care and flexibility while also managing costs. Various plan designs are available to meet your employees' needs, each with its own benefits and disadvantages. Given that each employee's needs may differ, it is often beneficial to offer more than one option.

Common health plan designs include:

Health Maintenance Organization (HMO): A plan that provides all health services through a network of health care providers (e.g., physicians, nurses, therapists) and facilities (e.g., hospitals, medical offices, clinics).[8]

- **Pros**: Premiums and copays are relatively low in comparison to other plans. There is also typically less paperwork as compared with other plans. This type of health plan is best for employees who have low health care utilization and only require basic services.
- **Cons**: The plan will limit employees' abilities to obtain services outside of the plan's network. Employees may not be able to choose their health care provider. Employees will need a referral from their primary care provider (PCP) before they can see a specialist. Employees can incur high costs for complex care.

Preferred Provider Organization (PPO): A plan that includes a network of doctors, hospitals, and other providers and institutions that have agreed to charge less for plan members.[9]

- **Pros**: Employees do not need a referral from their PCP to see a specialist. Employees can also see out-of-network providers.
- **Cons**: Employees will have to pay more if they go outside of the plan's network. Employees may have to meet the plan's deductible before it will cover the cost of out-of-network services. Employees may have higher premiums than with an HMO.

Point-of-Service Plan (POS): A plan that is a hybrid between an HMO and a PPO. Employees can select their PCP and they are also able to see out-of-network providers. If an employee visits an out-of-network provider, they will be responsible for greater out-of-pocket costs unless they first receive a referral from their PCP.[10]

- **Pros**: Employees will be able to see a broad selection of providers, both in-network and out-of-network. Many POS plans may offer lower cost-sharing for in-network services than some PPO plans.
- **Cons**: Employees who don't need to see specialists will not get as much value out of this type of plan. The requirement to obtain a referral before going out-of-network and the amount of paperwork involved could be too inconvenient or time-consuming for some employees.

High-Deductible Health Plan (HDHP): A plan that includes a network of providers that have agreed to accept payment from the health plan. These types of health plans offer lower monthly premiums than other types of plans but have higher deductibles. These plans can be accompanied by a health savings account (HSA) or health reimbursement arrangement (HRA), which can help employees offset their out-of-pocket costs.[11]

- **Pros**: Employees with low health care utilization may benefit from lower premiums and the ability to contribute to an HSA.
- **Cons**: Employees with high health care utilization or who have chronic health conditions will have to satisfy the plan's deductible before the plan will start sharing the costs. For some employees, this type of coverage will be inadequate for their needs. The high deductible may discourage them from seeking necessary care.

Exclusive Provider Organization (EPO): A plan that includes a network of providers that employees can see. Employees will be unable to see out-of-network providers, except in an emergency.[12]

- **Pros**: These plans will have much lower costs than other types, which could be attractive to some employees.
- **Cons**: Because employees will be unable to see out-of-network providers, the plan may prevent them from accessing the care that they need.

Indemnity Plan: A fee-for-service (FFS) plan that offers coverage to employees without limiting their choice of providers to a network or requiring referrals. These plans include an annual deductible that must be met before the plan begins sharing the costs.[13] Once the deductible is met, the plan will typically pay a percentage of the "usual, customary, and reasonable (UCR) rate" for services.[14]

- **Pros**: Employees will have access to any provider they wish to see without needing to select a PCP or obtaining a referral beforehand.
- **Cons**: Costs to employers may be higher because the plan does not negotiate discounted rates with a network of providers. The plan may not fully cover health care costs, so employees could have higher out-of-pocket costs as well. Employees will also need to file claims for all covered services.

Formulary Design

While selecting a type of health plan to offer your organization's employees is a complicated task by itself, there are additional factors to consider when reviewing the terms of these health insurance policies. Most health plans will contain a "formulary" which lists the medications that will be covered and the cost-sharing requirements associated with them. However, a medication being listed on a formulary does not guarantee that employees will be able to access that medication when they need it. Below is a list of common formulary policies and how they can influence employees' access to care:

Copay Accumulator: A policy that prohibits the value of financial assistance[15] paid by third parties from counting toward the health plan's deductible or maximum out-of-pocket limit.[16]

- **2023 District Court Decision:** The United States District Court for the District of Columbia ruled that private health plans cannot use copay accumulators for brand name medications that do not have medically appropriate generic alternative available. You can learn more about this court case here.
- **Recommendations**: If you choose to implement a copay accumulator policy, that policy should only apply to medications for which generic alternatives are available. You should also provide clear and explicit notice that the plan has adopted the copay accumulator policy and the impact of that policy during the open enrollment period. You should offer at least one health plan option that does not include a copay accumulator so that employees have choices.

Alternative Funding Programs (AFPs): These programs are marketed to reduce employer health plan costs by sourcing high-cost drugs through international pharmacies, manufacturer assistance programs, or charitable foundations. While promoted as innovative cost-saving strategies, they often shift financial and legal risks onto employers and employees.

- **Pros**: AFPs may appear to lower pharmacy costs in the short term by avoiding traditional insurance channels, but the savings are often uncertain, difficult to verify, and dependent on employees' enrollment in outside assistance programs.

- **Cons**: Employees are often unfamiliar with the AFP and can feel uncomfortable completing paperwork for PAPs that are intended for individuals without insurance. These programs can also disrupt access to necessary treatments if sourcing is delayed or denied. Additionally, some programs require consumers to import drugs from outside the U.S., potentially violating FDA regulations and exposing consumers to legal and safety risks.

- **Recommendations:** Conduct thorough due diligence and legal reviews on any vendor offering these programs. Prioritize employee access and continuity of care. Weigh long-term risks against short-term savings, and consider alternative plan design strategies that offer more reliable and compliant cost control.

Formulary Exclusion Lists: A formulary exclusion list is a list of medications that are not covered by the health plan. An employee that fills a prescription for an excluded medication will be responsible for the full cost of the medication.[17]

- **Pros**: Formulary exclusions can improve the ability of a health plan to negotiate for lower medication prices for the treatments that are included on the formulary.

- **Cons**: When a medication is excluded from the formulary, it may be unaffordable for employees. If a treatment is medically necessary for the treatment of their condition, employees may incur significant out-of-pocket costs to stay on their
- **Recommendations**: Whenever possible, delay changes until open enrollment. If a midyear change is unavoidable, provide clear advance notice so impacted enrollees can pursue an exception or appeal before the change takes effect.

Mid-year Formulary Changes: A policy change that occurs when the formulary is adjusted in the middle of the plan year by the health plan. This can include elevating a medication to a higher cost-sharing tier, imposing additional formulary restrictions on a medication, or removing a medication from the formulary altogether.[18]

- **Pros**: Making formulary changes midyear allows health plans to react to sudden drug price increases or new evidence about a medication's safety or effectiveness.

- **Cons**: Removing a drug or raising its cost-sharing midyear can disrupt continuity of care for employees who are stable on that treatment. Because they are locked into the plan until open enrollment, they may have no other way to access it. If no equivalent alternative exists, forced switches can lead to adverse health outcomes and higher downstream costs.

- **Recommendations**: Whenever possible, delay changes until open enrollment. If a midyear change is unavoidable, provide clear advance notice so impacted enrollees can pursue an exception or appeal before the change takes effect.

Prior Authorization: A policy that requires an employee to obtain approval from the health plan before it will authorize coverage of a health care product or service.[19]

- **Pros**: Requiring prior authorization before allowing coverage of a treatment or service can help ensure that the requested services are medically necessary. Preventing the utilization of unnecessary services can save the health plan money.

- **Cons**: When prior authorization is required, it creates an additional hurdle that employees must overcome before they are able to access the services recommended to them by their provider. This can create care delays that can result in greater health care costs and disease progression. A health plan's medical necessity standard may not be consistent with clinical standards of care, the required forms may be confusing and time-consuming, and the process for filing may require outdated modes of communication such as fax.

- **Recommendations**: If prior authorization is required, it should be consistent with clinical standards of care. The health plan should use standardized paperwork for prior authorization requests and should accept prior authorization requests electronically. The health plan should ensure that a response to a prior authorization request is rendered quickly and that the request is reviewed by qualified health care practitioners.

Quantity Limits: A policy that limits the amount of medication that can be covered over a set period.[20]

- **Pros**: Limiting the quantity of a medication that can be dispensed can save the health plan money by preventing employees from filling a prescription for excessive quantities of the medication, which they might not even use.

- **Cons**: Limiting the quantity of a medication that can be dispensed can sometimes result in employees not being able to obtain the quantity of the medication that was prescribed to them by their doctor. In some instances, the prescribed quantity is medically necessary, even though it is outside the bounds of ordinary prescribing habits or treatment guidelines.

- **Recommendations**: Allow greater quantities to be dispensed if a prescriber notates that the medication should be dispensed as written.

Step Therapy: A policy that requires an employee to try and fail on alternative treatments before the health plan will cover the prescribed treatment.[21]

- **Pros**: Requiring step therapy can save the health plan money by forcing patients to try medications for which the health plan has negotiated a better deal before filling a prescription for a more expensive option. If a patient tries an alternative medication and finds that it works for them, the health plan will save money on the more expensive prescription that was avoided.

- **Cons**: Requiring step therapy can cause unnecessary care delays while employees try and fail on alternative medications. In some instances, an employee may already know that a treatment will not work for them, but they could be forced to try it regardless. These care delays can result in greater health care costs and disease progression.

- **Recommendations**: Make sure step therapy protocols are consistent with clinical standards of care. Do not require patients to try and fail on the same medication more than once. Allow a health care practitioner to request an exception if he or she finds that a medication is medically necessary for the patient.

When reviewing the terms of the health plans that will be offered to employees, look for these limitations to understand the trade-offs you will be making with coverage. While some of these limitations may appear attractive for their ability to save the organization money on benefits, restricting access to health care services can often create additional medical costs in the future by delaying care and increasing the risks of disease progression and hospitalization. If you have employees who rely on prescription drugs to manage their health conditions, pay close attention to these formulary limitations to ensure that your organization's employees can stay healthy and productive.

Appeals Process

It is important to have a clear and easy-to-navigate appeals process to ensure that your employees can promptly access medically necessary treatments or services. For example, the process should include standardized and simple paperwork for all requests, an electronic submission portal that allows for online tracking, and prompt response deadlines (typically within 24 hours in emergency situations or 48-72 hours in non-emergency situations). If a benefit is denied, you can provide your employees with simple instructions on how to file an appeal and resources, including a patient navigator, to assist with the process.

Communicating Benefits

In addition to selecting the benefits that will be offered to your organization's employees, HR professionals are responsible for communicating with employees about the benefits package that was selected, communicating any changes that were made to the benefits package, and assisting employees with enrolling in the benefits that are being offered.[22] Effectively communicating with employees about their health benefits is important because if an employee fails to enroll in a health plan during open enrollment, he or she will be unable to obtain health coverage until the following year's open enrollment period.[23] Implementing a communications plan for open enrollment is critical for ensuring that your employees understand the enrollment process. Depending on the size of your organization, you may need to tailor your communications to different audiences within your organization.

When communicating with your organization's employees about their health benefits, be sure to use clear and concise language when describing the benefits. Use plain language as often as possible to reduce the likelihood of confusion. This is particularly important when describing individual policies within health benefits, such as a copay accumulator policy or step therapy requirements. When communicating with employees about these policies, HR professionals should be able to answer questions about how these policies function and how employees could be impacted by them. It could be helpful to conduct a formal training on these topics to ensure that your entire team is fully prepared to discuss them.

If your organization's employees are not particularly engaged during the open enrollment process, look for new ways to get their attention. You may want to consider hosting "office hours" during the open enrollment period to help engage and allow them to more easily ask questions about their benefits. Alternatively, you can leverage unofficial communication channels, such as social media or text messages, to send reminders to employees about upcoming deadlines and to emphasize the importance of the benefits being offered.[24] Additional incentives, like raffles or lotteries can help induce employees to get more involved in the benefits selection process.

Conclusion

As the cost and significance of health care continue to play a vital role in attracting and retaining talented employees, the importance of HR professionals' selection of fiscally responsible and responsive benefits packages continues to grow. During the open enrollment period, remember to carefully consider the issues discussed throughout this guide in order to get the most value out of the benefits package for your company and employees.

About Aimed Alliance

Aimed Alliance is a 501(c)(3) not-for-profit organization that seeks to protect and enhance the rights of health care consumers and providers. We advance our mission by conducting legal research and analysis, developing economically sound policy recommendations, educating the public, and advocating for the enforcement of laws and professional ethics.

About National Organization of Rheumatology Managers

The National Organization of Rheumatology Managers (NORM) is a forum that promotes education, expertise and advocacy for rheumatology managers and their practices. NORM provides value across the nation by cultivating a thriving community of rheumatology managers and physicians. Together, we are focused on supporting our patients and pursuing excellence in medical practice management.

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3 Note that group settings might put a damper on the feedback you receive as employees may be more hesitant to share personal information related to their health in front of a group.
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15 When patients cannot afford their medications, they may rely on financial assistance from pharmaceutical manufacturers and other third parties to meet their health plan's cost-sharing responsibilities and fill their prescriptions. The value of this financial assistance typically counts toward the health plan's deductible or maximum out-of-pocket limit, unless the health plan has implemented a copay accumulator or copay maximizer program.
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