Get Covered: Understanding your employer-sponsored health plan

Health insurance offered through your or your spouse's employer—called "group" plans—offers advantages over individual plans, not least of which is a lower cost because the employer pays all or part of your premiums. While your employer will narrow down your health insurance options, you'll still be faced with a crucial decision: Which plan is best for you and your family? Choosing the wrong plan can result in inadequate coverage and much higher out-of-pocket costs.

This publication will explain how employer-sponsored health insurance works, how to approach the selection process, and what to know about enrolling and maintaining coverage.

How employer-sponsored plans work

Many employers offer health insurance as a benefit to their workers. Typically, the employer splits the cost of coverage with employees—what portion of the premium the employer pays varies from company to company. The portion of the premium that employees pay is deducted from their wages before taxes are taken out. Using pre-tax dollars to pay your share of the premiums is an added financial break (you do not have to pay taxes on this money).

Employees are usually offered a handful of plans and coverage levels to choose from. Benefits are usually available to the employee's dependents, at a cost.

Under the Affordable Care Act (Obamacare), employers with 50 or more full-time employees must offer affordable health insurance to their employees who work at least 30 hours a week.

Types of insurance plans

It's important to understand the different categories of health care plans so that you can choose the plan type that best meets your needs.

- **HMO:** A health maintenance organization is an association of medical professionals and facilities that provide all needed services to insured individuals. Some HMOs, such as Kaiser, own the medical facilities and employ the health care professionals directly; others are networks of contracted health care providers and hospitals. An HMO requires that you choose a primary care physician, and that doctor makes referrals to in-network specialists if specialized care is needed. Out-of-pocket costs (copays, coinsurance and annual deductible) are usually lower and easier to anticipate than for other types of plans, and there's no need for claim forms. Out-of-network services are not covered except in an emergency.
- **PPO:** A preferred provider organization offers greater flexibility than an HMO: You don't need to choose a primary care physician, you can see an in-network specialist without a referral, and you can get care from providers outside the network if you choose (though you'll have to file a claim form and the rates might not be as advantageous as they are through network providers). However, premiums for a PPO are higher than for comparable coverage from an HMO, and your out-of-pocket cost for non-network services will be higher than if you stayed in-network.

■ **EPO:** An exclusive provider organization plan can be similar to a PPO in that you may not need a referral to see a specialist. However, an EPO requires that you use only providers in the plan's network (though these networks generally are larger than HMO networks). You can't get care outside the network unless it's an emergency. Premiums tend to be lower than for a PPO.

■ **POS:** Point-of-service plans combine elements of both HMOs (the requirement to choose a primary care physician and obtain a referral to see a specialist) and PPOs (the flexibility to go outside the network for care). The premiums tend to be slightly higher than for an HMO, but lower than for a PPO. A drawback of POS plans is that you must pay any out-of-network provider's fees upfront and then file a claim for reimbursement.

High-deductible health plan

Many employers offer a high-deductible health plan (HDHP) as an option. An HDHP can be an HMO, PPO, EPO or POS—the key difference is the size of the premium (much lower) and the deductible (much higher, though some preventive services may be free, even if your deductible hasn't been met yet). Once the deductible is met, you pay only a portion (coinsurance) of the cost for health services. The 2020 minimum annual deductible (a factor qualifying a plan as "high-deductible") is $1,400 for self-only HDHP coverage and $2,800 for family HDHP coverage.

Out-of-pocket maximums for HDHPs (including deductibles, copayments and coinsurance, but not premiums) in 2020 cannot be higher than $6,900 for HDHP individual coverage or $13,800 for family HDHP coverage.

HDHP plans typically are coupled with a Health Savings Account (HSA), which allows you to save pre-tax (or tax-deductible) dollars and earn tax-free interest on your savings. Some employers even contribute to their employees' HSAs. You can withdraw funds to pay for qualifying medical expenses, including annual HDHP deductibles.

For 2020, the annual HSA contribution limit is $3,550 for individuals with self-only HDHP coverage, and $7,100 for individuals with family HDHP

Costs

- **Premium:** The cost of insurance, usually expressed as a monthly amount
- **Copayment:** A fixed dollar amount you must pay when you receive a service (for example, a $10 "copay" for a primary care doctor visit, or a $35 copay for a visit to a specialist)
- **Coinsurance:** A fee for service that is calculated as a percentage of the total cost
- **Deductible:** The amount you must pay out-of-pocket for medical services within a year before your plan begins to pay
- **Out-of-pocket maximum:** The most you could have to pay for covered services in a plan year (a combination of deductibles, copayments and coinsurance, but not premiums), after which your health plan pays 100% of the cost of covered benefits

Note: Not all plans use all three out-of-pocket expense types (copayments, coinsurance and deductibles), but all use one or more.

coverage. If you're 55 or older, you can contribute an additional $1,000 for the year.

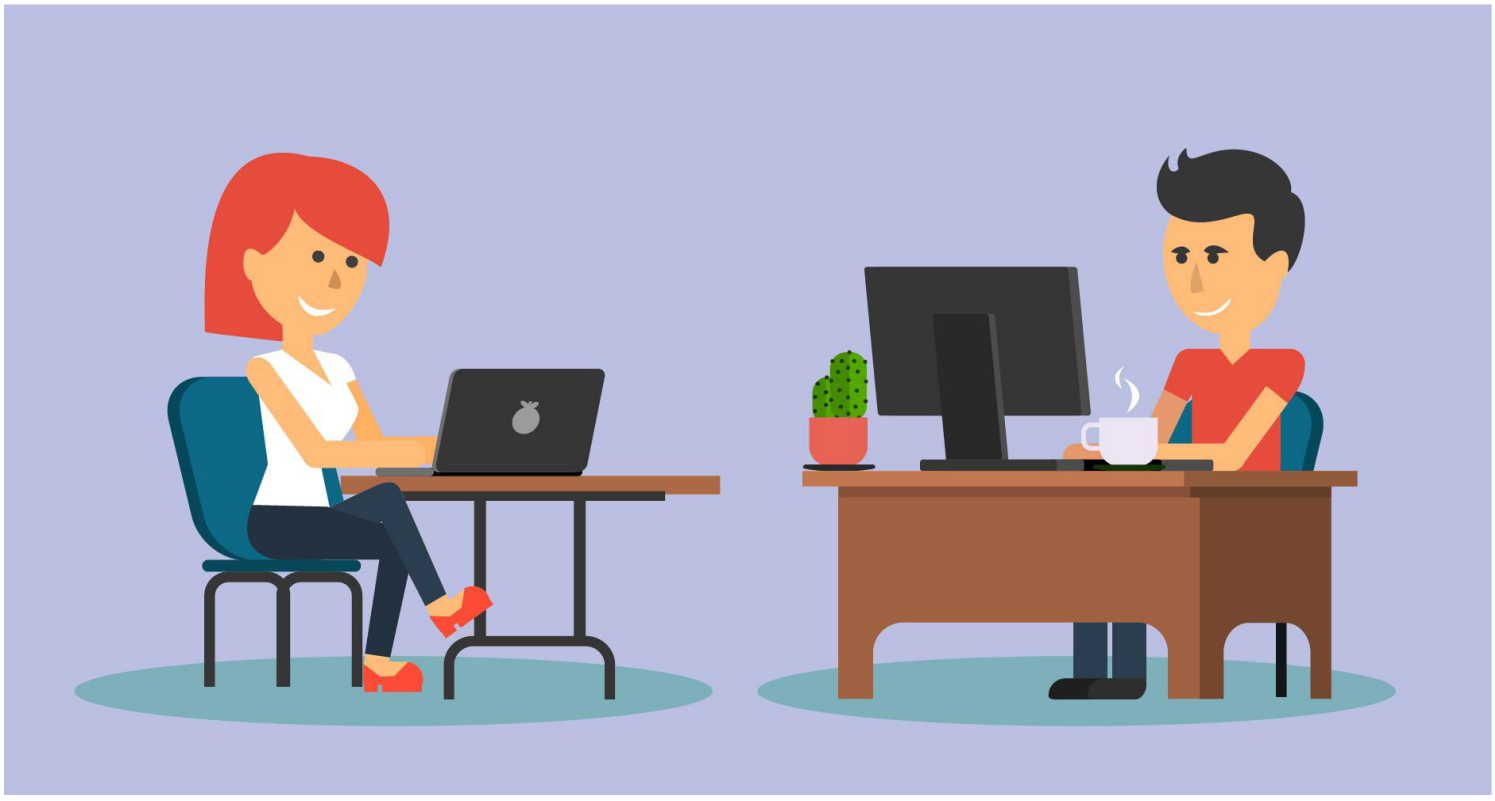
HSA contributions are made pre-tax (or, if made with after-tax dollars, are deductible on your tax return), which lowers your tax bill for the year. HSA savings can be invested, and your earnings accrue tax-free. Your withdrawals are tax-free as long as the money is used for qualified medical expenses (see IRS Publication 502 for a list of eligible expenses [*https://www.irs.gov/pub/irs-pdf/p502.pdf*] or get a list from your health plan).

Unlike deposits to Flexible Spending Accounts (see below), the money you contribute to an HSA doesn't expire, which means that unused funds can roll over indefinitely, and can follow you from job to job.

Compare your options

Employers typically offer a variety of plans to meet the different needs of their employees. Here are some things to consider when narrowing your options:

- **Plan types:** If the plans offered are a mix of different types (see list above), determine which plan type will work best for you. For example, if you want to be able to see specialists without a referral from a primary care physician, then a PPO (and certain EPOs) would be your best option. If low cost is your main priority, then an HMO would be your best bet. If seeing out-of-network providers is crucial, then your choices are limited to PPO and POS plans.
- **Network providers:** If you already have health care providers you want to keep seeing, check the plan's provider directory to see if they are in the plan network. And, because directories are sometimes outdated, you should ask your doctors/providers directly if they accept insurance under that plan. If that's not an issue, check that there are sufficient local in-network providers and facilities available to you—these will be less expensive than having to see an out-of-network provider (if allowed). If you regularly travel to certain places, make sure you have access to in-network providers in those areas.
- **Cost:** Your cost will be your share of the premiums (deducted from your paycheck) plus your out-of-pocket costs (copays, coinsurance and the deductible). Each plan will also have a



cap on your annual out-of-pocket costs. Generally speaking, the higher your premiums, the lower your out-of-pocket costs, and vice versa. Typically, choosing a plan with lower premiums can make financial sense for employees who are healthy and rarely need anything but preventive care. Employees (or dependents on the plan) who frequently see doctors or need urgent care, have a chronic medical condition, will be having a baby, foresee needing surgery, or have any other frequent or major medical needs are more likely to benefit from a plan that pays more of these costs in exchange for a higher premium. As a last step in the process, gauge your potential out-of-pocket "risk" for each plan by adding your premium share (if any) for the year to the annual out-of-pocket maximum—that's how much you could possibly have to pay.

In addition to comparing the options offered by your own employer, compare your options to those offered by your spouse's employer if you're married and he or she has a workplace health insurance plan. It's possible that the best choice is for each of you to have coverage through your own employer's plan, particularly if one of you is healthy and the other isn't (resulting in different coverage needs). But there can be advantages to having the whole household on a single policy. These might include lower premiums or more attractive plans offered by one of the employers, as well as being able to avoid being subjected to two separate out-of-pocket maximums. If a multi-member household divides coverage among two plans, the out-of-pocket limits (in 2020, $8,200 for individual coverage and $16,400 for family coverage per policy for in-network care for all ACA-compliant plans) apply to each policy.

Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA; often called a Health Reimbursement "Account") allows an employer to provide a tax-free monthly allowance for employees to use for eli-

gible medical expenses. In the past, HRAs were only offered alongside a health insurance plan, to reimburse employees for out-of-pocket health care expenses. However, a recent change will allow employers, beginning in 2020, to provide an "individual coverage HRA" *instead* of health insurance, for employees to use to purchase their own individual coverage (in the Health Insurance Marketplace or outside of it) and to pay for qualified medical expenses. The change will also allow employers who do offer group coverage to provide an "excepted benefit HRA," which workers can use—even if they decline employer-sponsored group coverage—for short-term health insurance, vision and dental coverage, and qualified medical expenses (but not comprehensive health insurance).

Learn more about the new HRA rules at Investopedia.com (*https://www.investopedia.com/articles/personal-finance/112015/how-hras-work.asp*). If your employer offers an HRA, review your HRA plan documents for details.

Flexible Spending Account (FSA)

A Flexible Spending Account (FSA) for health care is a special account that allows employees with employer-sponsored health insurance to set aside money to be used to pay for out-of-pocket health care costs. During Open Enrollment, you choose the amount to be deducted from your paychecks throughout the year. The money goes into your account before taxes are taken out—how much you save on taxes depends on your tax bracket. You can use your FSA dollars to pay for copayments, deductibles, prescriptions and other eligible expenses.

Employee FSA contributions are capped by the IRS at $2,750 for 2020. However, your plan may have a lower annual limit. Employers can make contributions to your FSA, but they aren't required to, and many don't.

Your entire health FSA "election" (the total amount you "elect" to contribute for the year) is available on the first day of the plan year to cover any expenses up to that level (even if you haven't accumulated the full election amount through paycheck deductions yet), and your available funds decrease as you use them. Some FSAs provide a credit card to use to pay expenses. Other times, you will have to submit receipts for reimbursement.

It's very important to estimate your expenses as accurately as possible when making your FSA election (amount to be taken from your paychecks) because of the IRS's "use-it-or-lose-it" rule. In many, if not most, plans, FSA dollars that are not used between the first and last day of the "plan year" are forfeited. (Employers may, if they choose, allow employees to either carry over up to $500 for use in the next plan year or

to incur eligible expenses during a grace period of an extra two months and 15 days after the plan year ends.)

Your election can't be changed during the plan year unless you have a qualifying event (such as a change in employment or marital status) and your employer's plan allows it.

Enrollment

In most cases, you can enroll in your employer's health insurance plan when you start your job or after completing any probationary period. Once enrolled, you can make changes (switch plans, add or drop options, add or remove dependents, etc.) only during the employer's Open Enrollment Period (usually a few weeks in the fall), unless you have a "qualifying status change."

Certain life events make you eligible to change your benefit elections outside of Open Enrollment. These include: birth or adoption; change of your or your spouse's employment/benefits; death of a dependent or spouse; and marriage, divorce or separation. You usually must notify the employer within 30 days of the event.

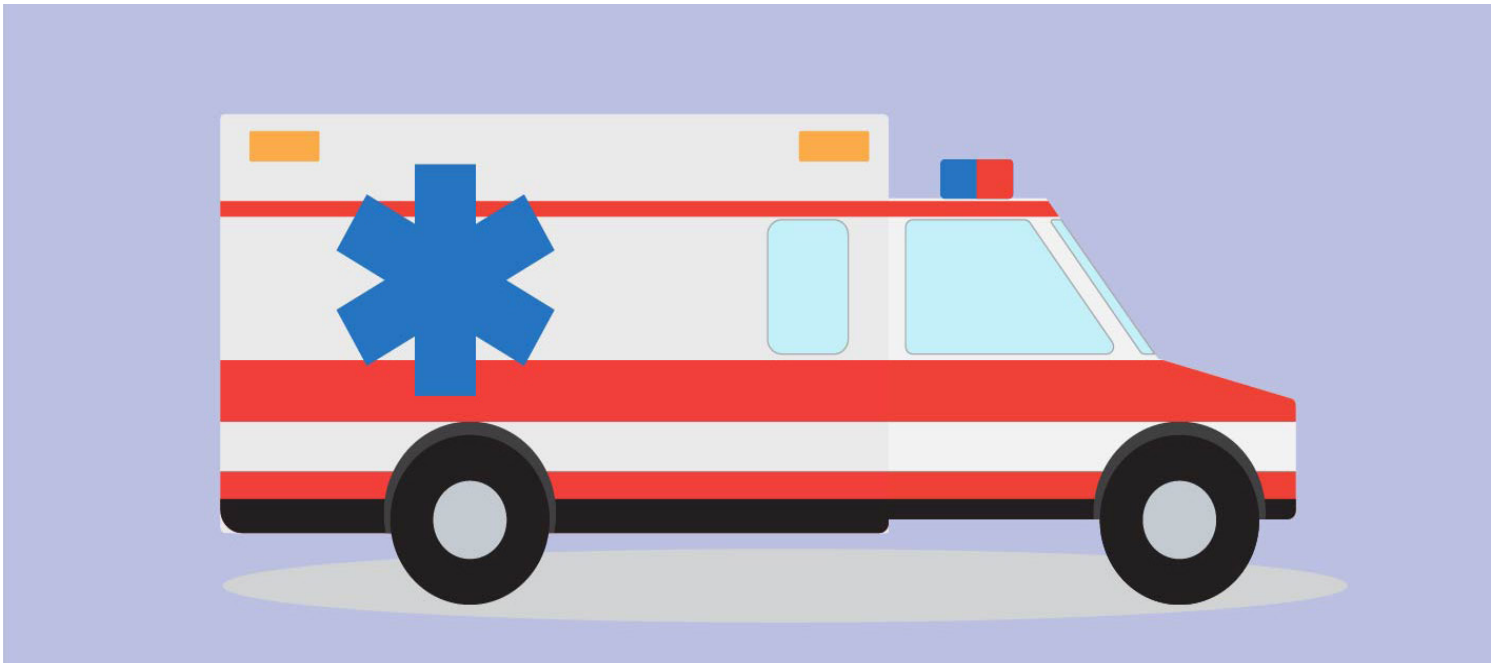
If you lose coverage

If you lose your job or your hours drop below a minimum threshold for coverage, the Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to continue your health insurance coverage under your employer-sponsored plan if you pay the full premium on your own. COBRA coverage typically lasts for up to 18 months, though you can qualify for up to 36 months under some limited circumstances.

While your cost will be (often significantly) higher than it was when your employer was paying part of the premiums, it might still be lower than an individual plan. However, you should consider your other options.

If you're married and your spouse has employer-sponsored health insurance, you should find out if being added onto his or her plan is an option—it might be less expensive than COBRA.

Another option is to shop for coverage through the Health Insurance Marketplace. As long you have job-based insurance available to you that is considered affordable and meets minimum coverage standards (most do), there are no real



benefits to purchasing coverage through the Marketplace. But once your employer-sponsored coverage ends, you could qualify for premium tax credits or subsidies when purchasing coverage through the Marketplace.

There is usually a window (typically 30 or 60 days) following the qualifying event during which you can enroll in a plan outside of Open Enrollment. If you miss that window, you'll have to wait until the next Open Enrollment Period.

Complaints

If you have a complaint about your employer-sponsored health insurance, submit the complaint, in writing, to the health insurer's customer service department. You can also submit it to the agency that regulates health insurance in your state. This may be the Department of Insurance (find yours here: *https://www.naic.org/documents/members_membershiplist.pdf*), the Department of Managed Health Care (if your state has one of these) or something similar.

If you think your employer should be aware of the complaint, share it with your HR/Benefits representative.

Resources

- **HealthCare.gov** is the federal Health Insurance Marketplace (*https://www.healthcare.gov/*). In addition to being a source of health insurance plans, the site offers a glossary and information about health insurance in general.
- **The U.S. Department of Labor's Health Plans & Benefits webpage** (*https://www.dol.gov/general/topic/health-plans*) provides links to resources related to employee benefits, including health insurance.
- **Nolo's Understanding Your Health Insurance Coverage webpage** (*https://www.nolo.com/legal-encyclopedia/understanding-health-insurance-coverage-32245.html*) educates readers on how to avoid unpleasant surprises when using their health insurance and how to handle a dispute.

■ **What Does That Mean? Understanding Health Insurance Coverage** (*https://www.thebalance.com/understanding-health-insurance-policy-2645652*), from The Balance, explains key terms that will help you better understand and compare your health plan options.

■ **Consumer Action's Health Insurance module** (*https://www.consumer-action.org/modules/module_health_insurance*) offers free fact sheets like this one on the topics of individual health insurance and Medicare, as well as a Q&A providing additional details on health insurance-related topics.

About Consumer Action

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About this guide

Consumer Action's Insurance Education Project created this guide.