



Navigating Health Care For Employers

Health care is expensive and confusing. Many employers and employees alike consider it a burden and a hassle – myself included.

Whether we're choosing or using our health coverage, we want to make our decisions quickly and get back to our real work. So, we end up paying a lot of money without ever taking the time and trouble to really understand our coverage or how to maximize it.

There's an opportunity for consumers of health care to be more engaged and more empowered. While we are all frustrated, we can do more to ensure the system works better for us.

At the Denver Metro Chamber of Commerce, we're working to make changes. To reduce costs and improve quality in health care. To fight for more transparency and accountability. To create a more rational, functional, lower-cost system through legislative advocacy and partnerships with organizations like the Colorado Business Group on Health and the Center for Improving Value in Health Care. Change is necessary – and we have had some early success in Colorado. But it is also slow-going and can feel far removed from the day-to-day experiences of businesses and consumers.

Luckily for us, we also have an opportunity – and a responsibility – to support employers and employees to be more savvy and effective consumers of health care insurance and services.

This toolkit is a first step in our effort to engage and empower Chamber members and businesses across Colorado. Inside you'll find tools and resources that are a starting point for thinking about why we need health insurance, how we use our coverage and how to maximize its value.

This high-level resource is intended to be relevant to a broad cross-section of companies. It is designed to complement, not replace, other tools available from brokers or insurance companies. Recognizing that every company is different and that the health care landscape varies significantly from Denver to Durango, we're not endorsing any specific approach or recommending any products. Rather, we're offering key questions for you and your organization to consider, providing clear definitions to confusing terms and connecting you to other resources that we've found helpful for employees and employers of all sizes.

We put this together with the help and input of dozens of Chamber members – inside and outside the health sector – and health care stakeholders who aren't our members. We're grateful to them for sharing their time and expertise! We offer this with the hope of helping empower employers and employees to be part of the health care solutions we so desperately need.

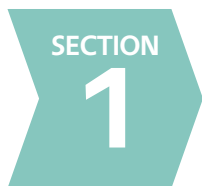
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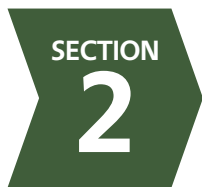
Kelly G. Brough

Kelly Brough, President and CEO
Denver Metro Chamber of Commerce

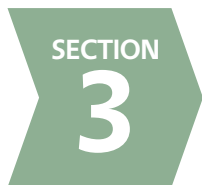
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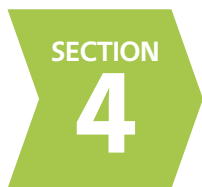
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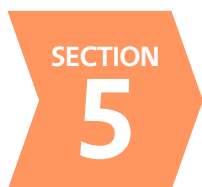
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Why Health Insurance?

A values approach.

At its most basic, employer-sponsored health insurance is an agreement between you and your employees to provide them with access to health care for an agreed-upon price, so long as they follow the limits of your plan. If you choose to offer a commercial insurance product, your insurance carrier is also a party to this agreement.

The health insurance benefit that you choose to offer your employees can provide:

- ▶ **Compensation** in the form of a non-cash benefit that is highly desirable for many employees, particularly if you cover a significant part of the premium.

- ▶ A **competitive advantage** for you as an employer, especially if you choose to offer benefits and/or fund premiums at a level that is higher than your typical competitors.

- ▶ **Access** to health care for your employees and their family members, helping to maintain the productivity of your workforce and their health, as well as that of their dependents.

In addition, many employers are required by law to provide insurance for their full-time employees, and there are tax benefits for doing so. Employer-sponsored health care in the U.S. is an exceptionally complex system to navigate – for employers and for their employees. As you make decisions about what health plan(s) to offer

and how to structure cost-sharing with your employees, consider which of those qualities are most critical to you as an employer and how the structure of your plan might best align to your goals. Also consider what your employees need from their health insurance, but recognize that their needs may not always match your goals.

For example, as health care costs continue to rise, one option that may control costs is selecting a narrow network of providers for your employees. Another option would be requiring pre-approval from a primary care provider prior to getting a referral to a specialist. These trade-offs could also impact how competitive your employees consider your plan to be, even if the premiums are lower.

Considering all aspects of your employees' total compensation may help you identify both your organization's core values and how health insurance benefits compliment or contrast with the other aspects of compensation. This in turn may provide guidance as you select the best health plan for your business and for your employees' health.

Continuum of Coverage

There are many different types of health plans. Generally, they vary based on flexibility - or amount of choice in how, when and from whom you get health care services - and cost. Often, consumers are asked to trade flexibility for cost savings. This chart shows four common types of health plans with typical features or elements of each.

Typically less flexible and less expensive



Typically more flexible and more expensive

HMO

HMO plans are often the most restrictive type of plan but with lowest monthly premiums. Typically, HMO plans:



Don't cover out-of-network care



Require referrals from primary care providers, especially specialty care



Limit care from specialty providers



Have narrow limits on in-network providers

EPO

EPO plans are often less restrictive than HMO plans but with lower monthly premiums than PPOs. Typically, EPO plans:

Don't cover out-of-network care, except emergencies

Allow some visits to specialists without a referral

Limit in-network providers, but provide more choice than HMOs

PPO

PPO plans often have higher monthly premiums, but with more flexibility to choose providers. Typically, PPO plans:

Provide some coverage for out-of-network care

Don't require referrals for specialty care

Offer broader provider networks

FFS

Typically, fee-for-service, or FFS, plans will only pay a % of reasonable and customary charges, leaving clients responsible for the remainder. Typically, FFS plans:

Don't limit care to a network

Don't put restrictions on benefits

Don't negotiate lower rates with providers for cost of care

Note that different health insurance policies vary in both costs and benefits, regardless of plan type. Ask your HR team, insurance broker or carrier to learn any plan's specifics.



**Develop a health plan
that best aligns with your
organization's values.**



Considerations For Selecting a Health Plan

The basics for navigating a complex system.

After considering how health insurance aligns with your organization's values and total compensation structure, the logical next step is to develop a health plan or plans that best align with those values. But health insurance plans are complex, even for experts.

You'll need to consider the **plan design** that best meets your needs, the **financing** mechanism that aligns with your business and the **costs** to your employees and the **care** they can access.

► What is covered?

Under the Affordable Care Act, most employer plans are required to provide certain benefits,

such as preventive services like vaccinations and some screening tests. However, there are still many differences in the level of services a plan may provide and in how much choice employees have over their provider and their care. In addition, you may choose to provide additional health and wellness benefits such as dental care, prescription pharmaceutical coverage, vision care, substance use treatment, employee assistance plans and more.

Is it reasonable to expect your employees to put aside savings on a regular basis to pay for upfront costs if you offer a high deductible health plan?

You may also want to consider how your employees' health needs or demographic makeup will change over time. Is your

employee base stable or do you see significant turnover? Do you anticipate the median age of your workers to increase over time or do you regularly bring in younger workers as your current workers age? As you consider the design, structure and financing of your health insurance benefit, recognize that these and other outside factors may change over time.

► **What is the best plan design?**

Plans are structured differently both in how costs are shared and how care is accessed. Co-pays may be required of employees at every provider visit, or they may pay nothing at all until receiving a bill. HMOs may require referrals to specialists from in-network primary care providers, while PPOs may allow your employees to select any provider or pay higher co-insurance to see an out-of-network provider.

High deductible health plans place the responsibility on the employee to pay 100 percent of most health care (some preventive services may be an exception) up until reaching their full deductible (either individual or family, depending on the plan). Health savings accounts and health reimbursement arrangements, which may or may not be provided in conjunction with your insurance plan, may be helpful ways for employees to save to cover these up-front costs. It is worth considering your employees' overall compensation and their ability to save when deciding if this is the right option for them and your organization's needs.

► **What are the financing options?**

Many employers are comparing pros and cons of self-funding their health insurance plans compared to choosing commercially available insurance products. Key considerations may include your number of employees, their demographic makeup and current and future health care expenditures (e.g., if you anticipate their health needs to increase as the workforce ages). Past health care utilization data may help in making this determination. Your organization's ability to manage an unexpectedly large claim is another factor, though there are also options for insurance to protect against this type of large loss.

► **What are the costs?**

Costs incurred by both you as an employer and your employees are important to consider, including how those costs are shared. Will you cover the majority of the premium for your employees? What about their dependents? (Note that under the Affordable Care Act, there are specific requirements around affordability for employer-provided coverage. Learn more at <https://bit.ly/28MZtKE>.)

Co-pays, deductibles, coinsurance and out-of-pocket maximums all impact the price of care for your employees. And if employees choose to receive care outside of your plan's network, those costs may be higher still.



How To Maximize The Value Of Your Health Plan

Helping employees understand that in health care, cost may not correlate to quality.

One of the most confusing aspects of navigating health insurance is understanding how to evaluate the quality of care. Typically, in health care, more is not actually better, and, often, the highest quality care is not the highest price. And it's often hard to know what health care really costs. Sometimes, it's only after the fact that the true price – the cost to the health plan, the employer and the employee – becomes clear.

But there are steps to controlling prices while providing access to the highest quality care available. Encouraging your employees to be

thoughtful about where they go for care (provider's office, urgent care or the emergency room for true emergencies), considering technology alternatives like telemedicine and promoting a healthy workplace culture can all impact your bottom line and your employees' well-being.

Organizations that purchase commercially available insurance for their employees can work with your brokers to see if there is health care utilization and cost data that can provide further insights into where your employees' costs are higher than typical patterns and where there might be opportunities for better care at a better value.

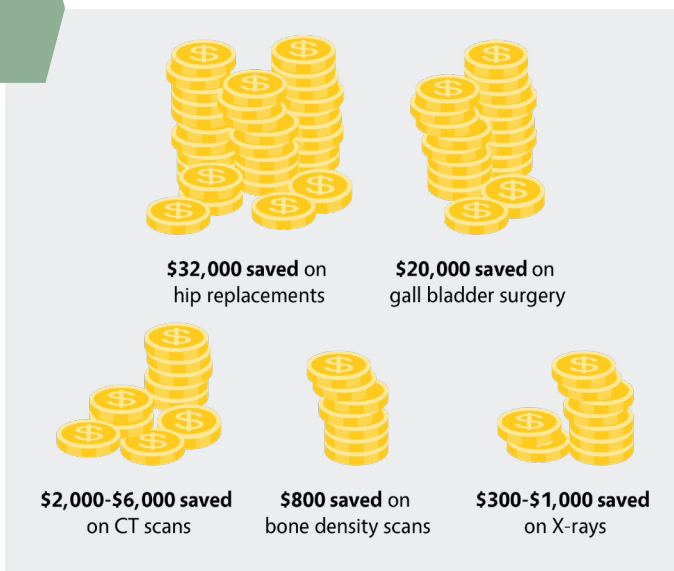
Self-insured employers should strongly consider

participating in the All Payer Claims Database (APCD) through the Center for Improving Value in Health, or CIVHC (www.civhc.org), Colorado's comprehensive source of health care cost information. By sharing your health insurance claims data with CIVHC, your information will help inform a better understanding of Colorado's health care landscape and where there is room for improvement – both in terms of cost and quality. Employers that submit data can also access reports comparing your employees' aggregated costs and usage to other employers and health plans. This, in turn, can lead to specific ways to save money on premiums and improve your employees' health.

CIVHC has also created an interactive map that illustrates regional variation for 11 common services such as C-section, hip replacement and tonsillectomy. Prices for common health care services vary significantly in different parts of the state, and frequently, the regions with the highest and lowest prices are not consistent when comparing different services. This information can help demonstrate how health care prices vary across communities and by service type – and can help employers better understand what is driving premiums and look for solutions to lower costs.

CIVHC's Shop for Care tool allows employers and consumers to compare prices and patient experiences at Colorado health care facilities for nearly 40 imaging and high cost procedures.

Shop for Care could help identify thousands of dollars in savings on imaging services and procedures.





What Resources Are Available?

Information and assistance for employers

Businesses that are navigating the complexities of designing or selecting, and then managing, a health insurance plan may want to work with a **benefit advisory consultant or broker**. Their entire focus is thinking about health insurance strategies from a business perspective, giving them expertise in an area that is probably not your only, or even primary, responsibility. But, it's important that this relationship be both transparent and beneficial – your organization needs to understand how these advisors determine the best plan for your needs and how they are compensated.

Be prepared to work with a health plan advisor by knowing the types of questions you can ask and the information they can provide. You know your organization best: what both you and your employees value.

Questions to consider might include:

- How is the advisor paid?
- How will the advisor analyze the health care needs of your employees to provide the best options for plan design? What data can you provide to make this analysis as effective as possible?
- How can the advisor help you identify and implement cost containment strategies, both immediate and long-term? How can your

employees be supported to manage their out-of-pocket costs?

- What technology can you access to better understand your organization's needs and the design of your health plan options? What kinds of support and resources will be available on an ongoing basis – for you and for your employees?
- How can the advisor help you consider benefit options beyond health insurance, such as employee wellness?

You should also be aware that there may be types of government-sponsored health insurance

options that could benefit some of your employees.

- Employees who are age 65 or over and continuing employment can learn more about Medicare.
- Low-to-moderate-income employees may benefit from Health First Colorado, Colorado's Medicaid program, and, if they have children age 18 and under, CHIP.

Medicare Interactive



A two-minute video (<https://bit.ly/2Ma7T5P>), *Medicare or Medicaid – Which Program Covers Who?* explains the difference between these two public coverage programs. With more and more people in the workforce eligible for public coverage, it is important for employers and employees to understand what public benefits are available.



Open Enrollment

Employee Enrollment Form

To speed the enrollment process

In Be

Navigating Health Care – Words to Know

CHIP: Children’s Health Insurance Program

Enacted in 1997, CHIP is a federal program that provides health coverage for low-to-moderate income children and pregnant women who earn too much to qualify for Medicaid. States design and help fund their own CHIP programs within broad federal guidelines, so CHIP programs vary from state to state. Colorado’s CHIP program is called Children’s Health Plan Plus, or CHP+, and there are more than 80,000 women and children enrolled. It is possible that low-to-moderate income working Coloradans have dependents who are eligible for or enrolled in CHP+.

COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of

1985 ensures that employees can continue to pay for and access their employer-sponsored health coverage for 18 to 36 months after they leave a job or reduce their hours. It is important to know that COBRA is a law protecting employee rights, not a type of health plan.

Co-insurance

The amount the employee is required to pay toward covered health care services once the deductible is met. Typically, co-insurance is set as a percentage of the cost of the service, not a fixed amount. Not all plans are structured to include co-insurance.

Co-pay

A fixed dollar amount that the employee is required to pay for certain health care services. Co-

pays are typically a modest amount (e.g., \$20 for a doctor's office visit or \$10 to fill a prescription) paid at the time of routine medical service and are often printed on the insurance card, so a client can easily reference them before seeking care.

Deductible

The amount that the employee must pay each year for certain covered health care services before an insurance plan will begin to pay. For example, if the deductible is \$2,000, the plan won't pay anything until an employee has paid \$2,000 for covered health care services. Often, preventive health care services – such as annual physical exams – are not subject to deductibles, so are paid for by the health plan immediately.

EPO: Exclusive Provider Organizations

A type of health insurance plan. Typically, EPO plans:

- have limited networks;
- do not cover care provided by out-of-network providers, except in some cases of emergency; and
- allow visits to specialists without a referral.

Most EPO plans are thought to be more flexible than HMO plans.

HMO: Health Maintenance Organization

A type of health insurance plan. Typically, HMO plans:

- have limited networks;

- do not cover care provided by out-of-network providers, except in some cases of emergency; and
- have other benefit restrictions in place, such as requiring a referral for specialty care or limiting the number of eligible visits for services such as physical therapy.

In return for a more limited choice of provider and tighter caps on benefits than with a PPO plan, HMO plans are often less expensive, meaning they have lower premiums and low or no out-of-pocket expenses such as deductibles or co-insurance.

HSA: Health Savings Account

A tax-exempt savings account that can be used to pay for certain medical expenses. Employers may make HSAs available to their employees. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan (HDHP). Note that there are many different types of tax-exempt accounts that can be used for health and dependent care costs, including Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA). Each type of account comes with different rules for allowable contribution amounts, portability and acceptable expenses.

Indemnity or Fee-For-Service (FFS) Health Plan

A type of health insurance plan. Typically, Indemnity or Fee-for-Service plans:

- have no networks;

- put no restrictions on benefits; and
- will only pay a set percentage of reasonable and customary charges (the average price charged for services from a specific type of provider within a set geography) and the client is responsible for any/all charges above that amount.

While clients get maximum choice and flexibility, they do not get the benefit of negotiated rates as provided for in HMO and PPO network plans and they are responsible for paying all fees above the percentage of reasonable and customary charges paid by the insurer.

Medicaid

Enacted in 1965 under the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term-care coverage to certain low-income Americans, including children, pregnant women, adults and people with disabilities. States design and help fund their own Medicaid programs within broad federal guidelines, so Medicaid programs vary from state to state. Colorado's Medicaid program is called Health First Colorado and there are more than 1.2 million Coloradans enrolled, most of whom work.

Medicare

Enacted in 1965 under the Social Security Act, Medicare is a federal entitlement program that

provides health insurance coverage to people age 65 and older, and younger people with permanent disabilities, end-stage renal disease and Lou Gehrig's disease. Unlike Medicaid and CHIP, Medicare is a fully-federal program, consistent from state to state and people are eligible for it regardless of income. It is common for Medicare beneficiaries to also have private insurance.

Network

The health care professionals, facilities and suppliers – e.g. doctors, hospitals and companies – that an insurance company has contracted with to provide health care services to its clients. The health insurer has negotiated discounted rates for services with providers in their network, so clients will pay less – often substantially less – when they access care through in-network providers.

Some insurance plans offer “narrow” networks, which limit the client's choice of provider in return for lower premiums and out-of-pocket costs. And some plans have “tiered” networks, meaning the client pays differentiated rates depending on the provider. Some plans will cover a limited portion of costs for services provided by out-of-network providers and some plans will not cover any part of the cost of services provided by out-of-network providers. An insurer will tell clients which providers are in their network.

Out-of-pocket maximum

The most an employee will pay during a policy period – typically a year – before health insurance begins to pay 100 percent of covered services. The health insurance premium does not count toward the out-of-pocket maximum, nor do any health care services that are not covered by the plan. Health plans vary as to whether health care expenses, such as deductibles, co-pays and co-insurance, count toward your out-of-pocket maximum.

PPO: Preferred Provider Organization

A type of health insurance plan. Typically, PPO plans:

- have networks, but the networks are usually broader than the network offered in an HMO or EPO plan;
- will provide some coverage for care provided by out-of-network providers; and
- do not require referrals for specialty care or put other benefit restrictions in place.

While clients may get more choice and flexibility than with an HMO plan, PPO plans are typically more expensive, meaning they are likely to have higher premiums and more out-of-pocket expenses, including higher deductibles and co-insurance.



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