

BENEFITS REPORT



Because You're Different

OPEN ENROLLMENT

HOW TO HELP YOUR STAFF MAKE BETTER PLAN DECISIONS

A **SUCCESSFUL** open enrollment requires giving every employee a meaningful opportunity to understand their options and select coverage that fits their health care and financial needs.

However, a survey by human resources firm WorldatWork found that roughly 50% of employees spend less than an hour choosing their health plan despite the financial and health consequences that decision can carry throughout the year.

Employers and HR teams preparing for open enrollment should prioritize clear communication, decision-support tools and access to human resources staff that can help employees make the right choices for themselves.



Helping your employees

One of the biggest risks is that employees focus on the most visible costs like their premium contribution while overlooking out-of-pocket costs that could have a greater effect on their finances.

Consider an employee choosing between two plans. One has a lower deductible, making it appear to be the better deal. But it may also require higher coinsurance for a medication the employee takes regularly. Depending on the drug and its tier, those costs could outweigh any savings from the lower deductible.

Many health plan details are easy to overlook but can have significant financial consequences later. Encourage employees to choose a plan using the following checklist:

Checklist for your staff

- Consider all costs. That includes your share of premiums, deductibles, copays, coinsurance, out-of-pocket maximums for medical services and prescription drugs.
- If you take medications, check the plan's formulary before enrolling to ensure yours are covered and how much you would be expected to pay for it in copays or coinsurance. Mind the deductible as well.
- Look for prior authorization or other requirements that may affect access.
- Confirm that your physicians, specialists and preferred facilities are in the network of the plan you are considering. If you want to stick with your current plan, check to see that your preferred providers are still in network.

Provide different ways to get help

Finally, tailor your open enrollment communications to staff with different needs. They may benefit from a combination of benefits guides, webinars, question-and-answer sessions, benefits fairs and online decision-support tools. Use as many as you can.

Technology can help your staff compare plans based on their family circumstances, prescriptions, expected medical needs and preferred providers. However, some may prefer printed materials.

Additionally, set aside time for staff who may need one-on-one guidance so they can ask questions and understand their choices. Consider providing access to knowledgeable people who can answer questions when an employee's situation is too complicated for an online tool.

PRIOR AUTHORIZATION

ENCOURAGE YOUR STAFF TO APPEAL DENIALS; THEY MAY WIN

ONE OF THE biggest frustrations health plan enrollees can face is learning that care recommended by their doctor has been denied by their insurer.

Many health insurers use prior authorization, which requires approval before the plan covers certain medical services, procedures or treatments. But employees who receive a denial may not realize that they have the right to appeal the decision — and that an initial denial is not necessarily the final word.

Recent research by *Bloomberg News* and KFF found that a significant share of appealed prior authorization denials is overturned. While the research examined Medicare Advantage, Medicaid-managed care and Affordable Care Act Marketplace plans rather than employer-sponsored group health plans, the findings highlight the potential value of challenging a denial.

Employers can help by educating workers about their appeal rights and directing them to their health plan's procedures when care is denied.



A growing source of frustration

Prior authorization has become a hot-button issue as patients and doctors complain that the requirements can delay medically recommended care and create administrative headaches.

Health insurers say prior authorization helps prevent unnecessary or overly expensive care and control health care costs. However, criticism from patients, providers and policymakers has prompted the insurance industry to take steps to streamline the process.

Insurers participating in an industry initiative have pledged to reduce the number of services subject to prior authorization and standardize the way requests are submitted and reviewed.

Still, denials remain common enough that employers may want to make sure workers know what to do when they receive one.

Appeals can succeed

The *Bloomberg News* analysis found that about half of prior authorization denials were reversed when appealed, with reversal rates reaching roughly nine in 10 for some plans.

KFF's analysis of insurer data for 2025 found similarly significant reversal rates. Among appealed standard prior authorization denials, 43% were overturned in plans sold through the federally facilitated ACA Marketplace.

At the same time, appeals are relatively rare. That suggests some patients may be abandoning recommended care after receiving

an initial denial even though an appeal could have resulted in approval. Provide your staff with guidance from the box below.

What your employees can do

- **Read the denial notice.** Determine exactly why the request was denied and note all appeal deadlines and instructions.
- **Contact their doctor.** The provider may be able to supply additional medical records, correct missing information, resubmit the request or request a peer-to-peer review.
- **Contact the health plan.** Ask what documentation and coverage criteria were used to make the decision and what is required for an appeal.
- **File an internal appeal.** Follow the procedures and deadlines listed in the denial notice and plan documents.
- **Request expedited consideration when appropriate.** Urgent situations in which a delay could jeopardize a patient's health may qualify for faster review.
- **Explore external review rights.** If the insurer upholds its denial, the employee may have the right to have the case reviewed by an independent outside organization.
- **Keep records.** Employees should retain denial letters, medical records, appeal documents and notes from conversations with the insurer and providers.

ANCILLARY COVERAGE

HOW TO HELP YOUR STAFF COVER RISING OUT-OF-POCKET COSTS

AS MORE workers struggle with rising medical and pharmaceutical costs, one emergency room visit or hospital stay can leave them paying large amounts out of pocket for deductibles, coinsurance and copayments even when they have employer-sponsored health insurance.

Those expenses can be particularly difficult for workers with limited savings or interrupted income. Employers can help by offering insurance that pays predetermined cash benefits for covered events or services, such as hospitalization or an emergency room visit.

Employees can use these benefits to cover medical expenses and everyday bills. As medical costs grow, insurers are introducing more of these plans.

Types of plans

- **Hospital indemnity plans:** These pay set cash benefits for a covered hospital admission, each eligible day hospitalized or both. Some include additional benefits for intensive care.
- **Emergency services indemnity plans:** These pay fixed benefits for covered emergency room visits, ambulance transportation or other specified emergency services.
- **Hospital and doctor fixed benefit plans:** These combine scheduled benefits for a range of covered services, which may include physician visits, urgent care, emergency treatment, hospitalization, surgery, diagnostic testing and prescription medications.
- **Accident indemnity plans:** These pay a set cash benefit for covered accidental injuries and related care, such as treatment for fractures, emergency visits, surgery or hospitalization.
- **Critical illness plans:** These typically pay a lump sum following the diagnosis of a covered condition, such as cancer, a heart attack or a stroke.

How the coverage works

Fixed indemnity insurance pays a scheduled amount when an insured person experiences a covered event. The payment generally does not depend on the actual medical bill or how much the employee's primary health insurance pays.

For example, a policy might pay \$1,000 for a covered hospital admission and \$200 for each covered day of hospitalization. An employee admitted for three eligible days would receive \$1,600, subject to the policy's terms.

Benefits are typically paid directly to the insured, although some policies allow payment to a provider.

These policies provide supplemental protection. They do not replace comprehensive health insurance and may pay only a portion of the expenses arising from a serious illness or injury.

Combining coverage

Employees may be able to combine policies to address different expenses. Someone with emergency treatment coverage and hospital indemnity insurance could receive an emergency room benefit followed by admission and daily confinement benefits if the event qualifies under each policy.

Each insurer determines coverage under its policy. Buying multiple plans does not guarantee that every service will trigger multiple payments.

Before offering coverage, employers should review benefit amounts, covered events, waiting periods, pre-existing condition restrictions and limits on payments or covered days.

Enrollment materials should explain these details with examples employees can understand. Employers can offer coverage as an employee-paid voluntary benefit or contribute toward premiums.

Who may benefit most

These plans may be especially useful for employees who:

- Have substantial deductibles or coinsurance under their existing health plan.
- Have limited emergency savings to absorb an unexpected medical expense.
- Would struggle to pay household bills after an unexpected event or medical service.

Employees should weigh premiums against the available benefits. Someone expecting regular care should also check whether waiting periods, exclusions or benefit limits would restrict payments.



Contact us to learn more about these increasingly important plans.
Call us today! (707) 789-3048

ADDRESSING COST DRIVERS

HOW POINTS-BASED WELLNESS PLANS CAN REDUCE COSTS



EMPLOYEES WHO put off recommended screenings or struggle to manage chronic conditions can develop complications that require expensive treatment, which can filter into what you pay for group coverage.

Encouraging workers to stay on top of preventive care and seek appropriate care earlier offers a way to reduce the need for expensive treatment that can drive up group coverage costs. One way employers can do that is through a points-based wellness program, which rewards employees with lower payroll deductions for health insurance when they attend health screenings, keep up with vaccinations and take steps to improve their health.

How the programs work

With these programs, employers work with a wellness plan administrator to establish a menu of eligible activities, assign point values and set a threshold employees must reach to earn a reward. A benefits platform or program administrator tracks participation and verifies completed activities.

Employees might earn points for:

- Attending an annual physical or dental checkup.
- Receiving recommended cancer screenings or vaccinations.
- Participating in diabetes education or health coaching.
- Completing nutrition, exercise or stress-management activities.
- Attending financial wellness sessions.

Employees who reach the required point total receive a discount on their health insurance contribution, often for the following plan year. Offering several ways to earn points helps workers choose activities relevant to their needs.

Where potential savings come from

The employee's discount does not automatically reduce the health plan's total premium or claims expenses. When an employer lowers the worker's contribution without a corresponding reduction in plan costs, it generally assumes more of that expense. Administration and incentives also carry costs.

The potential financial benefit comes later, if participation helps employees avoid complications or manage existing conditions more effectively. Connecting someone with diabetes to ongoing treatment, for example, may help prevent an expensive hospitalization.

Self-funded employers pay claims directly, so lower claims can reduce their costs. For fully insured employers, improved claims experience may lead to more favorable renewal pricing, although medical inflation, the insurer's rating practices and other factors also influence premiums.

Savings are not assured. A randomized study published in Health Affairs found that a workplace wellness program improved some reported health behaviors but did not significantly reduce spending after three years. Employers should evaluate results rather than assume participation alone produces savings.

What employers can do

- Work with us or administrator to prioritize appropriate preventive care and chronic-condition support.
- Explain how to earn points, meet deadlines and qualify for the premium discount to employees.
- Offer accessible activities for employees with different abilities and schedules.
- Have advisers review incentive rules, privacy protections and applicable wellness requirements.
- Track participation, claims trends and total program costs to determine ROI.

The strongest approach connects rewards with useful care and follow-up support, giving employees an immediate financial benefit while pursuing better long-term health outcomes.

If you have questions about your coverage or our products, please reach out to me:

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