

Are You Maximizing Your Employee Benefits?

Presented by Dick Bell to the National MS Society "Relationships Matter" Audioconference on April 24, 2008

Good evening and thanks for joining this call. I'm a financial planner by background and education but most of my income is made in the employee benefits arena ... working with companies and their employees in the areas of group insurance, retirement planning and executive benefits. I'm hired by employers to help them maximize their employee benefit dollars. And the cost of employee benefits is a significant dollar amount for employers. When you take into account the costs of workers compensation insurance, Social Security and Medicare matching contributions and contributions to group insurance benefits and retirement plans, it is not unusual for a company to be paying over 40% of payroll in employee benefits. In other words, for every dollar you get in salary your employer may well be paying another 40 cents or more in benefits costs. In fact, the cost of group health insurance alone is often the second largest expense item for a corporation, only exceeded by payroll costs. It's usually more expensive than office rent, for example.

Employees recognize that benefits are a significant factor in their overall compensation package. And, as benefits get more expensive, more of the costs or risks are getting transferred to employees today. So it's even more important for you to understand how your benefits work and what your rights are.

One challenge today is that everything is getting more complex. So tonight I'm going to go through some areas that are of particular concern for those who have ongoing health problems, such as MS. And I'm will try to anticipate some of your questions in advance, but please have a pen and paper handy to take notes and write down any questions. At the end of this session, we will invite you to call in with your questions or comments. One caveat, however. When it comes to health insurance, many states have different mandated benefits so I'm going to keep my comments as generic as possible.

Here are some things that I hear from time to time.

I can't get health insurance because I have MS. OR

I don't dare leave my job because any new employer's health insurance plan will have pre-existing conditions limitations that won't cover my medications. OR

My company group disability plan won't cover me for MS.

And I hear people make those statements with absolute certainty. Which reminds me of Will Rogers comment that went: "It isn't what we don't know that gives us trouble ... it's what we know that ain't so!" So tonight I hope to clear up some misconceptions and perhaps give you some direction on how to utilize your employee benefits more effectively.

So here goes. The most visible and most highly valued benefit, particularly for somebody with an ongoing medical condition, is HEALTH INSURANCE. Health care in this country now consumes 16% of our gross domestic product. That's an economic term but suffice it to say that the magnitude of the cost is alarming. So let's talk about how to maximize your benefits here.

Step #1 ... learn how your group insurance plan works

The language of health insurance, or any insurance for that matter, can be bewildering. It's an alphabet soup of HMOs, PPOs, HSAs, FSAs, POS plans, etc. You may have some choices available to you.

The more you understand what the words mean, the more you will be likely to make smart decisions and the less likely you will be to make an error. Errors inevitably cost you money.

HMO: A Health Maintenance Organization (HMO) is a prepaid health plan. It's a throwback to the Chinese medical system of 4000 years ago where you paid your doctor when you were healthy and you did not pay when you were sick. Therefore, the doctor had every incentive to keep you healthy. An HMO provider gets paid every month, whether or not you show up for services. And when you do show up, you will normally have a very modest payment at the time of service ... perhaps a \$10 copayment for an office visit. The objective of an HMO is to encourage you to come in to get things taken care of when they are small ... before they become large. That's good medicine. So you will normally not have a "disincentive" like a \$250 deductible before you can get HMO services.

The biggest detriment to an HMO plan is that you give up your freedom of choice to seek services wherever you want, whenever you want. All your services must go through your HMO gatekeeper. You can't just go to any specialist you want to without the preapproval of the HMO. And you'll have a much more limited number of specialists available. That's not a knock on HMOs. It's just a statement of fact. HMOs are known as gatekeeper plans. You sign up to go to a certain doctor or medical group. Your doctor is known as your "primary care physician" or PCP. Let's assume it's Dr. Jones at the Jones Brown Medical Group. Now, every month, part of your insurance premium is paid to Dr. Jones or his medical group ... whether you show up or not. HMOs love to have 18 year old single males as members because they NEVER show up unless they bang themselves up playing softball or something like that.

Dr. Jones is going to direct all your medical treatments. And, in most cases, you cannot see a specialist without a referral from Dr. Jones. You see, when Dr. Jones refers you to an orthopedic specialist for your knee injury, for example, Dr. Jones must reach into his own pocket to pay the specialist. That's why HMO's will not always give you quick referrals to specialists. Ralph is a friend of mine I play tennis with. Several years ago he injured his shoulder playing tennis and went to his HMO doctor, asking for an MRI of his shoulder. The doctor refused, telling him to put some Ben Gay on his shoulder every day and come back to see him in two weeks. Ralph did so and the pain persisted. He saw the doctor again, asking for an MRI on the shoulder. Again, the doctor told him to rub Ben Gay on his shoulder and see him again in two weeks. In two weeks, the shoulder was healed. That's good medicine and the cost of an MRI was saved.

So, a few tips about how to use HMOs effectively. First, get to know the office staff who will be responsible for arranging your appointments. You have to be courteous to them. But you also must be persistent. If you feel you truly need to see a specialist, keep asking until you get the referral.

Speaking of specialists, let's assume you have an ongoing condition for which you are being treated and you are changing employers and getting a new health insurance plan. And your new plan is an HMO. Check to see if your current specialist is a provider under that HMO. Let's assume he is. Now, you probably will not be able to sign up with that doctor as your Primary Care Physician. But what I would do is find out which HMO PCPs are able to refer to that specialist. And then sign up to go to one of those Primary Care Physician. Each medical group may only have a few orthopedic specialists they refer to, for example. So you work backwards from your specialist to find the HMO medical groups who refer to him. You may also ask the staff at your specialist's office to suggest HMO providers who are able to refer to them.

PPO ... Preferred Provider Organization ... if you don't have an HMO, you probably have a PPO. A PPO plan works this way. The insurance company or the plan administrator will approach doctors and hospitals to be in their PPO directory. The providing doctors agree to provide services for a reduced fee. And doctors are willing to take that discount because they expect they will increase their patient traffic. It's not like an HMO where you have a gatekeeper who directs all your services. You can go to any PPO doctor at any time.

PPO plans are designed to provide better benefits for those who use the PPO doctors. You may have 80% coverage, for example, whereas you may only have 60% coverage using a non-PPO provider. And remember, with the PPO doctor you are paying 20% of the discounted price ... with a non-PPO doctor you are paying 40% of the full retail price. It's a huge difference. Go out of your way to use PPO doctors whenever possible.

My wife has an OBGYN who is not on our PPO listing. She is very comfortable with that doctor. And the costs involved are not large so we have agreed as a couple that we are willing to pay more out of pocket for her to continue seeing that doctor.

By the way, PPO doctors do not have huge discounts for office visits, for example. Let's assume the doctor normally charges \$80 for an office visit. Under a PPO plan, the doctor is probably getting \$68 or so. With a PPO plan, you aren't treated like a second class citizen and, like it or not, that can happen with an HMO. The BIG discounts are on hospital bills. A few years ago I saw a \$123,000 maternity bill for the hospital and the PPO discounted to under \$13,000.

One of the challenges we all face in life is CHANGE ... something is no longer the way we remembered it to be ... or thought it was. I heard a speaker talking about change a few years ago and he said that the change that bothered us the most and gave us the most stress was any change that affected us directly ... and we didn't see it coming.

When you mess us with your health insurance plan and do something that you should not have done, perhaps because you did not know any better, it is likely to cost you money. You get a surprise bill that you thought would be covered by insurance.

So here's a tip on how to use your PPO plan most effectively. You already understand that you save money when you use preferred providers. A few years ago you used to get a PPO directory ... a hard copy list of all the providers. But doctors are going on and off PPOs all the time. Your best bet is to go on-line to find a provider or confirm the doctor you want to see is a preferred provider. That's your homework. That's your responsibility. But you have one more step and that is to confirm with the doctor's office that he or she still has a PPO contract.

Let's assume you have Aetna as your insurance carrier. Here's the wrong way to set an appointment. Call the office and ask: "Does your office accept Aetna?" The office staff will probably say something like: "We accept all insurance companies." What's wrong with that? They didn't say that they were Aetna PPO providers. And if they were not, your plan might still pay the doctor but at a lower percentage of full retail rates. And you would be responsible for a large balance ... and you didn't see it coming. That's a big screw-up.

OK, you say, how do I do it right? Call the doctor's office and say: "Is Dr. Jones still a preferred provide with Aetna and will my \$15 copayment be acceptable for the visit?" If they say "yes", you're good to go. But, again, it's your responsibility to ask the question the right way.

Here's another problem. You set an appointment with Dr. Jones and when you get there you find that Dr. Jones has been called out of the office on an emergency and you are going to see Dr. Smith instead. Do not assume that Dr. Smith has a PPO contract with Aetna. It is not

unusual for a medical group to have some doctors who have PPO contracts and some doctors to not have PPO contracts.

OK, what do you do when you see Dr. Smith instead of Dr. Jones, assuming logically that Dr. Smith is also a PPO provider, and then you get your Explanation of Benefits (EOB) from your medical insurance plan and you find that Dr. Smith is being paid as a non-PPO provider? This means that you have to pay a higher percentage of the bill. What can you do?

1. You can just suck it up and pay the bill.
2. You can complain to the doctor's billing office.

In all fairness, you want to be paying Dr. Smith the same amount you expected to pay Dr. Jones ... right? It may be as simple a solution as having the doctor's office rebill the insurance company using the tax ID number of Dr. Jones instead of Dr. Smith. Another solution is for the billing office to simply write off the balance of the bill but that may not happen. In fact, you don't even know what the PPO discount would have been and how much you should have paid. Here's the best solution. Involve the group medical insurance broker. I know this works because I am a broker. And I have a financial interest in getting problems solved for my clients because if I don't the employer will simply find another broker.

My daughter called me a few months ago. Her husband is diabetic and broke his insulin pump. And they were being billed \$2,000 for the replacement because the insurance company refused to honor a PPO contract. The employer was headquartered in Ohio and the provider, a company named Minimed, said that they did not have to honor a PPO contract with Blue Cross/Blue Shield for services in California. I got in the middle of this because I know what all the words mean. Blue Cross/Blue Shield agreed that Minimed should be accepting the PPO discount. They got in touch with Minimed and made the argument but got rejected. Lots of phone calls, some angry, back and forth between the insurance company and the provider. Finally, I suggested to my daughter that she bring in the big guns ... the insurance agent who wrote the policy and was receiving commissions. And that was what finally worked. All along, I advised my daughter to remember the golden rule ... the guy with the gold makes the rules. DO NOT PAY any bill you don't think is right.

Unless you are a veteran of dealing with insurance companies and/or doctors' offices, I recommend that your first line of defense should be the health insurance agent who wrote the company policy. That person is your employer's hired gun.

We do a lot of problem solving like this in my office, so here's what you need to know when you call the insurance agent. You need to have a copy of your Explanation of Benefits. NEVER throw these out. They have virtually all the information on them that an agent might need to

either solve your problem or explain to you what happened. It would be a nice touch if you had the name, address and phone number of the doctor, as well.

Sometimes a doctor's office will make a mistake and not recognize a PPO discount. So they send you a bill for the balance, which is called "balance billing". Here you'll need the EOB to solve the problem. Call the doctor's office and tell them that they did not recognize the PPO discount. Do not be shocked if they do not have a copy of the EOB. They won't keep it in most cases. I would ask the billing office if you could fax them a copy of the EOB so they would give you the proper credit. That's why you keep the EOB's, folks.

Here's the most important rule, though. If something does not look right to you, do not delay in asking about it. I'll get calls in my office that go like this: "I have a medical bill that hasn't been paid and now they are going to collection with it and it will ruin my credit." I'll ask: "How long have you known about this?" and they'll invariably say: "Oh about 7 or 8 months. I just figured they would straighten it out so I ignored it." Folks, errors do not correct themselves. Get your hired gun involved as soon as possible. It's a lot easier to solve a problem before it goes to collection. So, if there is a problem with a bill, call the insurance agent as quickly as possible.

OK, what if the bill is so old that it has gone to collection. And you know the bill is legitimate. In many cases you really owed the bill because it was applied to your deductible, etc. Or you had gone to a non-PPO provider and you owed a balance. When a bill goes to collection, the collection agency will get roughly 50% of whatever they collect. Let's assume I have a collection agency after me for \$1,000. I may offer to pay \$600 of that bill to make it go away. But if I make an offer like that, I have to have the \$600 available to pay the bill RIGHT NOW because the collection agency will want to be paid within 24 hours. I've seen some parents negotiate unpaid bills for their children on this basis. But I recommend that you never let it get that far.

Let's assume you are changing jobs but you will have health insurance at your new employer. The first thing you need to know is: "When will my coverage start?" In most cases, your coverage will start on the first of a month ... often after a waiting period such as a month or three months.

It's important that you maintain health insurance elsewhere, assuming you have it now, up until you are eligible for coverage at your new job. Why? So that you can avoid having any pre-existing conditions limitations in the policy.

The description of what constitutes a pre-existing condition will vary a little bit from insurance plan to insurance plan, but normally anything you have been treated for in the past six months is considered a pre-existing condition. By the way, treatment includes taking any prescription drugs so if you have MS you have a pre-existing condition. Will you get insured for your pre-

existing condition? The answer is “yes” as long as you have had previous coverage. This is all part of the Health Insurance Portability and Accountability Act of a few years ago. You’ll hear that act referred to as HIPAA ... but it’s spelled HIPAA and not HIPPA. HIPAA says that your pre-existing conditions will be covered as long as you have not had a break of more than 63 days without coverage. That’s why it’s so important to keep your insurance up to date.

If you are leaving a job, you will be offered COBRA coverage, as long as the employer has at least 20 employees on a typical business day. COBRA is Federal law. Many states have a COBRA law that extends to employers with fewer than 20 employees. In California, for example, a small employer must offer CAL-COBRA coverage. Under COBRA, you get to retain the exact benefits you had when you were working but you have to pay 100% of the cost yourself. And you may be charged an extra 2% by the employer ... legally. As a rule of thumb, you can retain COBRA coverage for up to 18 months, or up to 36 months in the case of a spouse in a divorce situation. If your state mandates coverage that is superior to Federal COBRA laws, your state laws prevail.

When you change jobs and your old group insurance ends, you’ll want to prove to the new insurance company that you have had coverage all along so that your pre-existing conditions limitations will be waived. You must provide what is called a “certificate of creditable coverage” and your former employer will get one for you.

OK, what if you did not have prior coverage, for whatever reason. How will the pre-existing conditions limitations affect you? Normally, you will not be covered for that pre-existing condition until you have been under the plan a certain length of time, such as six months. This will vary from state to state. After that time period, you’ll be insured for MS or any other ongoing condition.

Here’s a tip about prescription drugs and pre-existing conditions. Most group medical plans will provide some sort of prescription drug card where you have a certain co-payments, such as you pay \$10 for a 30 day supply of a generic drug or a \$40 copayment for a 30 day supply of a brand name drug. Drug cards are blind to pre-existing conditions. So even if you have a pre-existing condition limitation in your policy, you will probably be able to get your prescriptions filled using the drug card.

A few other tips on prescriptions. Always ask your physician or your pharmacist if there is a generic drug that you can substitute for a brand name drug. You’ll save money.

Another tip. Use mail order drugs wherever possible. My wife takes a prescription drug where we have a \$40 copayment for each 30 day supply. If she orders the drugs through a mail order service attached to the medical insurance plan, she pays only two copayments for three months

of drugs. Instead of paying \$120 for three months of drugs, she pays only \$80. If you are on any maintenance drug, you'll probably save money using mail order.

Let's talk about some income tax planning issues related to health insurance. We all just completed our income taxes. If you're like me and you filed a Schedule A where you itemize your property taxes, mortgage interest, charitable deductions and out-of-pocket medical expenses, then this will relate to you. To get a tax deduction for your out-of-pocket medical expenses, your bills need to exceed 7.5% of your adjusted gross income. In people talk, if your adjusted gross income is \$50,000, you can't get a tax deduction until your unreimbursed medical bills exceed \$3,750. That's like have a big deductible before you can get a tax break.

Ah, but there is relief. Your employer may offer a cafeteria plan, also known as a Section 125 plan. Let's assume your share of the monthly medical insurance premium for you or your family is \$300. Under a cafeteria plan, you can pay your share of the premium with before-tax dollars. It works like this. Assume you make \$5,000 a month. You say to your employer: "Reduce my pay by \$300 and pay my share of the monthly premium." It's a win-win deal. Instead of paying income taxes based on making \$5,000 a month, you'll pay based on making \$4,700 a month. Plus, you'll only pay Social Security and Medicare taxes on \$4,700 a month. By the way, the employer also saves money because he or she is matching your Social Security and Medicare contributions. If your employer offers a cafeteria plan, make certain you take advantage of it ... at least for your share of any premium payments.

But a cafeteria plan has a few other features and hopefully your employer offers these, as well. One of them is called a Flexible Spending Account, or FSA. I participate in an FSA and it works this way. Each year my wife and I have some out-of-pocket medical bills. Oh, they may be for office visit or prescription copayments, policy deductibles, 20% co-insurance for various things, etc. Or they might include my 50% of a crown that my dentist says I need. Under an FSA, I ask my employer to withhold an extra \$150 a month ... on a pre-tax basis ... and make that money available for me to pay my medical bills that are not reimbursed by insurance. So, if I am making \$5,000 a month, I'm only going to pay income taxes on \$4,850. The only loser here is Uncle Sam, who won't get as much revenue. One heads up for you ... this is a "use it or lose it" account. Don't set aside more money than you expect to actually spend in a given year. I know that every year we underestimate it.

So far we have seen two of the cafeteria plan "buckets" ... the one that pays your share of the insurance premium and a second bucket that pays for bills that are not reimbursed by insurance. There is a third bucket called a "dependent care assistance account". Let's assume you are married, you both work, but you have a child in child care during the day. In that case, you can set aside up to \$5,000 as a couple on a PRE-TAX basis to pay for dependent care. You know, the same rule applies if you have an elderly parent living with you and, because you both

work, you take your parent to an adult day care center during the day. You can be paying with pre-tax dollars.

One thing I cannot stress enough. You are responsible for understanding how your health insurance plan works. If in doubt, call the insurance broker's office to discuss your questions. You need to know when your coverage starts and when it ends. Here's a for-instance for you. Assume you have a 20 year old child in college. Read your plan booklet to determine what constitutes an eligible dependent. In many case, it says that coverage stops at age 19 for a dependent child unless that child is single and in school on a full-time basis ... with coverage usually going to age 23 or 25. Problem! Your child drops a course or two and no longer has full-time student status in the eyes of the college ... or your insurance plan. Under those circumstances, your child should be offered COBRA coverage ... but it's not up to your employer to find out about it ... it's up to you to tell your employer.

I'm going to switch subjects over to dental insurance. If you're fortunate enough to have this coverage, you need to know your benefits. And it's nowhere near as difficult to understand as medical insurance. With dental insurance ... you have three different types of services and they will be reimbursed differently, depending on the plan. The first will be preventive services ... these are the cleanings and annual bite-wing Xrays. Many plans will pay 100% of the cleanings ... but no more frequently than every six months. And folks, they mean 6 months to the day. If you have ever had a teeth cleaning on January 15th and another one on July 14th, you'll know what I mean. The insurance companies will not pay for the second cleaning. Granted, you were only one day early. Tough. It's up to you to make certain your appointments are at least six months apart. Dental offices are often very good at tracking this timing, but what if you are changing dentists. The new dentist does not know the last time you had a cleaning ... but your insurance company does.

After the cleanings, your plan may require you to pay a deductible, such as \$50 or \$100 before other services are covered. And you have two types of service ... I'll just call them "little items" like fillings and "big items" like crowns. You may find that your plan will cover 80% of the small items but only 50% of the large items.

And you can bet that your plan will have an annual maximum benefit such as \$1,000 or \$1,500. If you have orthodontia coverage, it's normally a separate 50% benefit with a lifetime maximum of \$1,500.

Here's a tip for you. Any time you are going to have some major dental work done, where the bill will exceed \$250, ask your dentist to submit a claim for a pre-treatment estimate. He or she sends the information to the insurance company and they will get back to you with a statement of how much they will pay. Why is that important? Because dentists in offices right next door

to each other could charge dramatically different rates for a crown, for instance. One may charge \$750 and the other dentist will charge \$900. You, not knowing any better, think that you will be reimbursed at 50% ... regardless. The reimbursement is driven by the insurance company's "reasonable and customary" fee schedule in that zip code. And the insurance company may determine that anything in excess of \$750 is unreasonable. So they will pay 50% of \$750 or \$375. But what if you go to the dentist who is charging \$900? Does this mean that you will owe the entire \$525 balance ... that's \$150 more than you expected to pay? That's why you want to get the pre-treatment estimate ... so you can ask your dentist why his \$900 fee is out of line. In many cases the dentist will reduce his fee to the reasonable and customary level ... but that's not as likely after the crown is already in your mouth. Do your homework and negotiating in advance ... there are lots of capable dentists out there.

Switching subjects again, let's talk about group long term disability insurance. This is a surprisingly inexpensive benefit for an employer to offer.

Long term disability insurance normally provides a percentage replacement of your income (60% is typical) if you are disabled and cannot fulfill the duties of your occupation. Now that 60% is usually reduced by whatever you get from Social Security disability or from a state disability program, which only 5 states have. And benefits are normally payable to your age 65 or, on more recent or updated contracts, to your Social Security normal retirement age ... which is age 66 for anybody born between 1943 and 1960.

If you join a company that offers group long term disability insurance, by all means sign up for it, even if you have to pay for it yourself. Why? If you have MS, you will not be able to get an individual policy. A group insurance policy is your only choice. The insurance company will probably not ask you medical questions if you apply for coverage as soon as you are eligible. But they can ask you medical questions and reject you for coverage if you are to apply at a later date.

But how do they treat your pre-existing condition? Many group policies will provide coverage for your pre-existing condition after you have been insured under the plan for one full year.

Like your health and dental insurance, you are entitled to an employee benefit booklet that describes the coverage. This is referred to as a Summary Plan Description or SPD. In many cases it will be available to you on-line. Here are the things you want to know about any disability insurance contract:

1. What is the definition of disability?
2. How much do I get a month?

3. When do benefits start ... 30 days, 60 days, 180 days, etc.?
4. How long are benefits payable?
5. What are the exclusions or policy limitations?
6. Does the plan provide for a partial disability benefit? In other words, if you can only work three days a week, will the plan still pay something because you have a loss of income?

If you are currently employed and your employer does not offer long term disability coverage, ask your Human Resources Department if they will look into it as an employee benefit.

I'm going to wrap this up and ask for questions from the audience now, but here are some take-aways from this evening:

1. It is your responsibility to understand your benefits. Get copies of the Summary Plan Description and go over it in detail. Know what to expect.
2. When you have a problem, go to the insurance broker who sold the group policy. That person wants to keep the business and look good in the eyes of the employer. And if you do not get action from that person, complain in writing to your boss or the Human Resources Department.
3. Also keep your Explanations of Benefits for medical and dental claims.
4. If you have a cafeteria plan available to you, take advantage of it because you will reduce your income taxes.
5. Finally, if your employer does not offer coverage that would be of value to you, ask them to look into it ... even if the employees have to pay for the benefit themselves. This is particularly critical with long term disability insurance.

With that, I'd like to ask the operator to open up the phone lines for any questions.