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# Health 411: Answers on healthcare and Medicare open enrollment

If you get your health insurance through your job and haven't yet looked at your 2012 benefits package, wake up! You're about to miss your chance to pick insurance coverage for next year.

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Open enrollment periods, which take place in companies across the country, typically close sometime in November. If you haven't missed your window of opportunity, now's the time to get busy reading those health insurance pamphlets because employers are making changes this year that can have a significant effect on your wallet.

Medicare beneficiaries are also in the throes of an annual open enrollment period, which started last month and ends Dec. 7, nearly one month earlier than in years past. Now is the time to make changes to — or sign up for — a Medicare Advantage or Part D prescription drug plan.

To help with what many people find a confusing process, here are answers to your most pressing questions about open enrollment.

## **The cost of my employer's plan went up again this year. Can I find less expensive coverage someplace else?**

Maybe. But experts say that even with rising costs, you're still likely to get the best deal on a health plan through your employer.

If your spouse has the option of getting insurance through work, compare his or her coverage with yours to see if it makes sense to sign on there. If that's not an option, you can look to the private insurance market.

Private plans are becoming more attractive, with richer benefits and prices that are in some cases comparable to plans offered by employers, says Keith Mendoza, a consumer specialist with the online insurance broker eHealthInsurance.com. The healthcare reform law requires all insurers — even those selling individual policies directly to patients — to include benefits such as preventive care with no cost-sharing and to eliminate lifetime maximum spending, Mendoza says. Just remember that, unlike employer health insurance, you can still be denied coverage on the private market due to a preexisting medical condition.

If your employer-sponsored insurance options have gotten more expensive, you're not alone. According to the National Business Group on Health, the country's largest corporations expect to see health insurance costs rise by about 7.2% in 2012. For mid-sized to large companies, costs are projected to rise about 5.9%, according to a survey by Towers Watson, a human resources consulting firm.

"Employees won't necessarily pay more out of their pocket through their payroll deduction, but they will pay more when they go to see the doctor," says Michael Thompson, of PricewaterhouseCoopers' Health and Welfare Practice.

One potential option for saving money is to consider a consumer-directed health plan, which more employers

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are offering. These are high-deductible plans that “usually cost the employee less but they require them to pay more out of pocket,” says Helen Darling, chief executive of the National Business Group on Health, a nonprofit that represents large employers on health policy issues.

**The cost of insurance for my family is extremely expensive, and I’m not sure I can afford it. What do I do about my spouse and my children?**

Not all family members need to be on the same plan. Mendoza suggests that people mix and match coverage. Often you can save by insuring younger, healthier family members with a plan you purchase on the private market. That may be a good option considering that 73% of employers will require employees to pay more for dependent coverage next year, according to the Towers Watson survey.

You can compare plans side-by-side at [eHealthInsurance.com](http://eHealthInsurance.com) or speak with one of their licensed agents by calling (800) 977-8860. You can also find a licensed insurance agent in your area at the National Assn. of Health Underwriters website. Go to <http://www.nahu.org>, click on “Consumer Information” and choose “Find an Agent.”

**If I choose a different health plan for next year, will I still be able to see my doctor?**

Not necessarily. If you switch plans, the provider network may change too, even if you stick with the same insurance company. And visiting a doctor who is out-of-network means greater out-of-pocket costs.

If you decide to hold on to the same plan you had this year, it’s still wise to confirm that your doctor will accept your insurance. You can do that with online tools typically made available on insurers’ websites. But it’s always a good idea to call your doctor directly to ask.

**Will all of my prescriptions still be covered?**

Again, don’t count on it. Formularies — an insurer’s list of covered drugs — can change from year to year. What might have been a preferred brand in the past won’t necessarily be so going forward.

Consumers can expect insurers to promote the use of generic drugs over expensive brand-name ones,

especially since patents are expiring for blockbusters like the statin Lipitor and the blood thinner Plavix, allowing generic alternatives to come on the market, Thompson says. “Many health plans will reach out to you if you’re on one of the medications that are now available in generic and encourage you to change,” he says.

**My employer offers both HSA and FSA accounts. What’s the difference?**

Both flexible spending accounts and health saving accounts allow employees to set aside money, tax free, in order to pay for out-of-pocket medical expenses. In both cases, an employer may choose to contribute money.

**FSAs can be used to pay for dental and vision care, prescription drugs, deductibles and co-pays. But you’ll need to anticipate all of your medical costs for 2012. “An FSA is a use-it-or-lose-it type benefit,” says Martin Rosen, co-founder and executive vice president of Health Advocate, a patient advocacy organization based in Plymouth Meeting, Pa. That means any money that isn’t spent will be lost.**

An HSA is an investment account paired with a qualified health insurance plan that has a deductible of at least \$1,200 for an individual and \$2,400 for a family. You can set money aside to spend on a wide range of medical expenses, including prescription drugs. That money is yours to keep and grow tax-free over the years. In addition, any money you withdraw from the account to spend on qualified health costs is spent tax-free.

There are limits to how much you can contribute to an HSA in a year; in 2012, the cap will be \$3,100 for an individual and \$6,250 for families.

Keep in mind that you can’t use funds in your FSA account to reimburse yourself for expenses that are covered under another health plan, including one tied to an HSA. This is why many employers offer a “special purpose FSA” that only covers dental and vision expenses and has no effect on the limits placed on your HSA, Thompson says.

**My employer keeps bugging me about taking a health risk assessment and joining a walking club. Does this have anything to do with my health insurance?**

“Most large employers are giving employees the chance to earn back some of their increased cost-sharing by participating in health improvement programs,” Darling says. Lower insurance premiums, cash and gift cards are going to employees who agree to take a health risk assessment or participate in smoking cessation classes, for example.

“On the high end you might see employers reduce premiums by as much as \$500 over the course of a year,” Thompson says.

### **I missed my open enrollment period, but I’m not happy with the plan I have. Is there anything I can do?**

If open enrollment has closed and you’ve defaulted into a plan you don’t want, talk with your company’s human resources department, Darling says.

“My experience is unless [the excuse] is completely ridiculous or flaky, they want to be helpful,” Darling says. If nothing else, she says, “It can’t hurt to try.”

### **Medicare**

Seniors have many decisions to make during Medicare’s annual open enrollment period. Here are answers to common questions about the government-funded insurance program for people 65 or older.

### **If I’m happy with my current plan, do I need to do anything?**

If you’re in original Medicare with a Medigap plan and have retiree coverage that pays for your prescription drugs, you don’t need to do anything during open enrollment, says Joe Baker, president of the Medicare Rights Center in New York City. However, if you are enrolled in a Medicare Advantage plan (which usually combines hospital, outpatient care and drug coverage into one plan administered by a private company) or have original Medicare with a Plan D prescription drug plan, you should review your coverage.

Even if you’re happy, shop around, says David Lipschutz, an attorney in the Washington, D.C., office of the Center for Medicare Advocacy, a nonprofit, nonpartisan organization. “Plans can change, and some do change significantly from year to year,” he says.

### **Should I expect the premiums to go up next year?**

Here’s a rare bit of good news: On average, Medicare Advantage premiums will be 4% lower in 2012 than in 2011, according to the U.S. Department of Health and Human Services. “In general, premiums are going down and benefits are getting better,” Lipschutz says.

In addition, the cost of basic Part D coverage is expected to be slightly lower next year than it was this year — \$30 per month for 2012 versus \$30.76 in 2011. And the Obama administration recently announced that premiums for Medicare Part B (outpatient care) will increase much less than expected for 2012, adding only \$3.50 more per month to the cost for most seniors.

But there’s a caveat, says Elaine Wong Eakin, executive director of California Health Advocates, a Sacramento-based nonprofit Medicare advocacy organization: “The average going down does not mean every plan’s premium goes down.”

In fact, a recent analysis of Medicare prescription drug data by Avalere Health, a Washington D.C.-based healthcare advisory firm, found that premiums for six of the top 10 Part D drug plans are increasing next year; 45% of all beneficiaries enrolled in a Medicare Part D plan are in one of the top three plans, two of which will raise premiums in 2012.

### **Will health reform cause any changes to my Medicare benefits?**

Yes, there are a number of changes you’ll see as a result of the Affordable Care Act. The first is that open enrollment dates were pushed up by nearly a month, starting on Oct. 15 and ending on Dec. 7.

Next, seniors who reach the gap in prescription drug coverage, often referred to as the “doughnut hole,” will get a price break. In 2012, there is a 50% discount on brand-name drugs and a 14% discount on generics.

Health reform also places an emphasis on wellness. “This year for the first time, Medicare Advantage plans are required to cover preventive care with zero cost sharing,” Baker says. That means annual wellness visits, diabetes and cancer screening and flu shots are available with no co-pay, deductible or co-insurance.

To review a list of free preventive services, go to [Healthcare.gov](http://Healthcare.gov), click on the tab for “The Health Care Law and You,” select “Key Features of the Law,” then “65 and Older” and finally “Medicare Preventive Services.”

In addition, Medicare Advantage plans are now required to limit total out-of-pocket costs to \$6,700 for the year. Be aware, however, that drug costs do not count toward that total. Only deductibles, co-pays and co-insurance for outpatient and hospital-related services apply.

Finally, there’s a new five-star rating system for Medicare Advantage and Part D plans. As a way of encouraging enrollment with highly rated carriers, the government is allowing people to switch to a five-star plan any time during the year, even if it’s not during open enrollment. However, only nine health plans received five stars for 2012, so one may not be available in your area.

But don’t be too taken by the stars, Baker advises. “Just because it’s five-star doesn’t mean it’s the right plan for you. I wouldn’t choose a plan on stars alone. You need to do your homework.”

**I was notified that my Medicare Advantage plan is closing for 2012. What happens to my coverage now?**

According to Lipschutz, it’s common for an individual insurance company with multiple plans in a single market to shut some of them down. If that happens, the company may enroll you in another one of its plans by default, though you may opt out of that selection. In other cases, you won’t be moved automatically, so you’ll be required to make a choice. Failure to take any action could land you back in original Medicare, which, alone, doesn’t cover the cost of prescription drugs. For drug coverage you must choose a Part D plan.

Nearly 302,000 Medicare beneficiaries across the country will be affected by Medicare Advantage plans closing in 2012, half of which are in California. The availability of alternative plans will vary widely throughout the state, according to Wong Eakin. If your plan isn’t renewing for next year, you’ll be given additional time to choose another plan between Dec. 8 and the end of February.

**I’m trying to help my mom make decisions about which plans to choose. Where can we get help?**

There are a number of resources available. The Plan Finder tool on <http://www.Medicare.gov> will allow you to compare Medicare Advantage and drug plans available in your area. You can also compare and purchase plans at [PlanPrescriber.com](http://PlanPrescriber.com), a Maynard, Mass.-based online provider of free Medicare education and plan comparison tools, or talk with an agent by calling (800) 404-6968.

Another source of free, unbiased help is your State Health Insurance Counseling and Assistance Programs (SHIP). You can find your local program by visiting the Medicare Helpful Contacts page at [Medicare.gov](http://Medicare.gov) or by calling (800) MEDICARE.

The Medicare Rights Center, a national, nonprofit consumer organization, offers counseling and advocacy services. You can use its interactive tool to get answers to many of your Medicare questions at <http://www.medicareinteractive.org>.