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Human Resources: Frequently Asked Questions

NOTE: Refer to the separate Glossary of Medical Plan Terms for a definition and explanation of specific medical plan terminology referenced in the FAQs.

2014 MEDICAL PLAN CHANGES

What are the plans being offered in 2014?

For 2014, the Institution will offer a choice of three (3) medical plans:

- Low Deductible Health Plan with an annual deductible of $500 for employee-only coverage and $1,000 for employee-plus* coverage.
- High Deductible Health Plan with Health Reimbursement Account (HDHP-HRA) with an annual deductible of $2,000 for employee-only coverage and $4,000 for employee-plus* coverage.
- High Deductible Health Plan with Health Savings Account (HDHP-HSA) with an annual deductible of $1,500 for employee-only coverage and $3,000 for employee-plus* coverage.

Neither the Access Blue plan nor PPO out-of-state plan will be offered under WHOI's medical plan options beginning in 2014.

* 'Employee-plus' coverage includes the enrollment options of *Employee + Spouse*, *Employee + Child(ren)*, and *Family*

Why is changing the medical plan options needed?

Due to rising healthcare costs and ongoing challenges with added costs under Health Care Reform, the Institution can no longer sustain the current medical plan offerings. Medical costs are a significant part of the Institution's budget – for 2013, the Institution will spend close to $6.0M in its share of employee medical premiums, with employees contributing another $2.5M for their share of the premiums. If the Institution does nothing to address cost containment, our medical plans will become increasingly expensive to the point where the Institution will not be able to sustain a competitive cost-share level.

What is a medical loss ratio and how does it impact our medical plan premium rates?

A medical loss ratio is the ratio of the annual claims paid by an insurance company to the premiums received. The medical plan carrier sets an expected loss ratio for each medical plan. For a plan to run efficiently, the carrier must receive enough in premiums to cover the claims paid under the plan, plus additional leftover to cover their administrative overhead expenses. When claims exceed the premiums paid, this is referred to as a "negative loss ratio" or "negative claims experience." When this happens, the medical carrier will factor this into our annual renewal rate, which is applied to all medical plans across the board, referred to as our "composite rate." For example, for WHOI's 2013 medical renewal, our HDHP had a positive loss ratio where claims fell well below premiums paid. On its own, the HDHP would have resulted in a rate decrease for 2013, benefiting over 50% of the population enrolled in our medical coverage. However, because the Access Blue and PPO medical plans had a negative loss ratio, all medical plans were subject to a 7.4% rate increase for 2013.

By eliminating the Access Blue and PPO plans, won't those high claims just move over to another plan causing the same affect?

It is expected that the claims utilization will continue under the other plan(s), however, it is not expected to have the same effect on the cost of claims or renewal because the claims will be spread across a larger enrolled population into a larger risk pool. Further, the claims will move to a plan that is subject to a deductible, shifting some of the upfront claims cost to the employee.

Will WHOI be changing the medical plan carrier for 2014?

This is a possibility. In addition to our current carrier, Blue Cross Blue Shield (BCBS MA), two other carriers: Cigna (paired with Tufts) and UnitedHealthcare (paired with Harvard Pilgrim) will submit their proposals. It has been many years since WHOI has looked at other carriers. When we did, we found that Tufts and Harvard Pilgrim did not have large provider network coverage on the Cape; however, due to the expanded networks provided by Cigna and UnitedHealthcare, we feel it is time we revisit their services. Additionally, going to bid helps leverage our negotiations for competitive pricing. The decision to change carriers will rely heavily on provider network size and access, tools and resources to support employees with the plan offerings, and the cost to employees and the Institution. Of course, we will also expect the same, if not better, level of services from another carrier. Information on the three carriers being looked at will be shared with employees prior to a decision being made.

I am concerned about losing access to my current providers if we change medical plan carrier. Is there a way to check now if my current providers will accept insurance from the other potential carriers being looked at?

Yes, you can inquire with your providers now to see if they accept insurance from the other potential carriers. Here is some additional information to assist you.

Blue Cross Blue Shield of MA - select the 'Blue Care Elect (PPO/EPO)' network

https://findadoctor.bluecrossma.com/

Cigna – select the 'Open Access Plus Carelink' (OAPC) network:

www.cigna.com

UnitedHealthcare – select the 'Harvard Pilgrim Choice Plus' network:

www.uhc.com/find_a_physician.htm

I understand WHOI will be changing how we insure our medical plans, from a fully-insured to self-insured arrangement. How will this impact the employees and the Institution?

Effective January 1, 2014, the Institution will be transitioning from a fully-insured to self-insured health insurance program. Moving from a fully-insured to self-insured arrangement shifts the risk from the insurance carrier to the employer who will be paying the medical claims. Based on our historical medical claims experience over the last 10 years, there is potential for significant cost savings of 4-5% to the Institution and employees over the long term. This change represents an alternative for how the Institution will finance the medical plan coverage and will be transparent to employees and their enrolled family members. Covered members will continue to hold a medical insurance card and the insurance carrier will continue to have control of processing our medical claims, as well as providing access to the network of physicians and hospitals.

If me or my spouse are age 65 or older and eligible for Medicare, can we still enroll in the group medical plans offered by the Institution?
Yes, as long as you are actively employed as a benefits-eligible employee, you can remain covered by our group medical plans and should waive coverage with Medicare. You should be aware that there are strict IRS rules that prohibit contributions into a Health Savings Account for employees who are age 65+ and enrolled in Medicare coverage. For more information on this topic, please refer to the separate webpage with details and applicable rules for Health Savings Accounts at http://www.whoi.edu/HR/page.do?pid=122717.

HIGH DEDUCTIBLE HEALTH PLAN QUESTIONS

What is a High Deductible Health Plan and how does it work?

A High Deductible Health Plan or "HDHP" is a type of health insurance plan that has a higher annual deductible than a traditional medical plan. In exchange for potential higher out-of-pocket costs, HDHP plans offer lower premium rates than traditional medical plans. Under an HDHP, members are required to pay the upfront deductible before the insurance begins to make payments for claims. However, once the annual deductible is met, many services are covered in full or require an office visit co-payment.

If enrolling in the HDHP plan, do employees have the choice between a Health Reimbursement Account (HRA) and a Health Savings Account (HSA)?
Yes, employees will have the choice between two separate High Deductible Health Plans: the HDHP-HRA and the HDHP-HSA. Because there are strict IRS rules for HSAs, an HSA can only be offered with a High Deductible Health Plan that meets certain plan design requirements. *That said, the two high deductible plans will be different and should be carefully compared by employees in order to choose the plan that best meets their healthcare and financial needs.*

What is the difference between a Health Reimbursement Account and a Health Savings Account?
A Health Reimbursement Account (HRA) is an account owned and managed by the employer to reimburse employees towards out-of-pocket deductible expenses incurred under the HDHP-HRA plan. If no deductible expenses are incurred, no reimbursement is made to the employee. Employees do not make any contributions to the HRA; it is strictly used as a reimbursement vehicle.

A Health Savings Account (HSA) is owned and managed by the employee. Both the employer and employee can make pre-tax contributions to the HSA. Unlike the HRA, the employer contribution is made whether or not any deductible expenses are incurred. Unused account balances roll over and continue to accumulate. Funds in an HSA account can be invested in an interest-bearing account once the account balance reaches $2,000. All employer- and employee-contributed HSA contributions are non-taxable going in and upon distribution as long as the HSA funds are used for eligible medical expenses and for eligible dependents.

For more information, please see the separate comparison chart highlighting the key differences between an HRA and HSA.

If I am enrolled in one of the High Deductible Health Plans, can I also participate in the Healthcare Flexible Spending Account (Health FSA)?
Yes, however the type of Health FSA will depend upon the HDHP plan you are enrolled in.

If enrolled in the HDHP-HRA plan, you can participate in the traditional Health FSA plan; however, you will want to evaluate your situation carefully before electing a Health FSA amount. The Health FSA cannot be used for deductible expenses that are reimbursed by the HRA.

If enrolled in the HDHP-HSA plan, you can participate in a 'limited purpose' Health FSA plan that can only be used for certain expenses as dictated by the IRS, like dental and vision. More specific information on a Limited Purpose Health FSA will be provided in greater detail as we get closer to rolling out the 2014 medical plans.

Will WHOI continue to contribute 75% of the premium for the High Deductible Health Plan(s) in future years?
As part of WHOI's long-term commitment to provide a balanced total compensation package, it is WHOI's intent to continue to cover 75% of the premium cost for both the HDHP-HRA and HDHP-HSA premiums in 2014. However, due to uncertainty of annual medical renewals and budget constraints, the Institution cannot make any guarantees for future years. This will continue to be evaluated on an annual basis.

Will WHOI continue to fund 50% of the annual deductible under the HDHP-HRA plan and, if so, will it continue to apply to the first 50%?
For 2014, WHOI will continue to fund up to the first 50% of the annual deductible through the HRA. The annual deductible under the HDHP-HRA plan is $2,000 for employee-only coverage and $4,000 for employee-plus coverage. This means, for individual coverage, the HRA will reimburse up to the first $1,000 of incurred deductible expenses; and up to the first $2,000 for employee plus coverage. Again, it is WHOI's intent to continue to offer this benefit as part of the HDHP-HRA option, but it will need to be reviewed on an annual basis.

Will WHOI provide a contribution to the Health Savings Account (HSA) that is tied to the HDHP-HSA plan?
Yes, for 2014, WHOI will provide the same level of contribution as towards the HRA to fund the equivalent of 50% of the annual deductible under the HDHP-HSA plan. The annual deductible under the HDHP-HSA plan is $1,500 for employee-only coverage and $3,000 for employee-plus coverage. WHOI will provide an HSA contribution of $750 for individual coverage and $1,500 for employee plus coverage. The timing of WHOI's contribution is yet to be determined. For example, WHOI may contribute to the HSA annually, semi-annually, quarterly or monthly. Employees will be allowed to make their own contributions into their HSA on a bi-weekly basis through their paycheck.

Where can I get more information about the HDHP plans and associated HRA and HSA accounts?

For more information, please refer to the separate dedicated web pages for specific details about the HDHP-HRA and HDHP-HSA plans.

HMO PLAN QUESTIONS

Why is WHOI eliminating the current HMO plan and replacing it with a new Low Deductible Health Pplan?

This is part of the Institution's cost containment strategy to mitigate future rate increases. Adding a deductible will lower the premium cost that is shared by the Institution and the employee. The new Low Deductible Health Plan is intended to further the Institution's ongoing efforts to engage members in healthcare decisions, making them more educated consumers.

How much is the deductible under the Low Deductible Health Plan and what services are subject to the deductible?

There is an annual deductible of $500 for individual coverage and $1,000 for employee plus coverage. Although a deductible means potentially more upfront cost to employees, there is limited upfront liability compared to a High Deductible Health Plan. Major services are subject to the deductible (e.g., hospital admissions, surgical procedures, diagnostic testing not part of routine exams, etc.). Many of the basic services such as office visits, emergency room visits, mental health visits, and Rx prescription drugs are not subject to the deductible and require a co-payment like under the current HMO plan.

How much will WHOI contribute to the Low Deductible Health Plan premiums?

For 2014, WHOI will contribute the same share as in the past years for the HMO plan, paying 60% of the premium and employees will pay 40%.

Will WHOI pay a portion of the annual deductible under the Low Deductible Health Plan like it does for the HDHP plan?

No, WHOI will not provide any reimbursement for out-of-pocket deductible expenses incurred by employees under the Low Deductible Health Plan. However, like they do now, employees will have access to participating in the Health Care Flexible Spending Account (Health FSA) to set aside pre-tax dollars to be used to pay for out-of-pocket medical plan expenses under the plan.

ACCESS BLUE PLAN QUESTIONS

Why is WHOI eliminating the Access Blue medical plan?

The Access Blue plan is currently utilized by 20% of the total enrolled population. Claims paid under this plan have been exceeding the premiums collected. This has been a consistent trend over the last few years and weighs heavily into our annual renewal rate affecting all of our medical plans across the board. Based on the Access Blue plan's historical trend and impact to our annual renewal rate, it is no longer a plan that can be sustained.

Why not just charge more to employees enrolled in the Access Blue plan vs. eliminating this plan as a choice?

The renewal rate for all the plans offered is based on a composite rate. Shifting more cost to the employee is not part of the strategy and goes against the goal of providing affordable health care coverage and maintaining a fair share contribution to employees. Further, pushing more cost to the employee will not help the Institution with its main strategic objective of mitigating future costs by keeping the renewal rate increases to a minimum. Based on the Access Blue plan's trend with a negative loss ratio, maintaining this plan will continue to have an adverse impact on our renewal rate impacting all of our medical plans, which ultimately affects all employees across all plans.

I prefer the Access Blue plan because I don't need a Primary Care Physician (PCP) or referrals to see a specialist. What option will I have if this is an important feature to me that I want to retain?

This will not be an issue because all of the medical plans in 2014 will *not* require a PCP or referrals, even with the new Low Deductible Health Plan. Further, all of the plans in 2014 will utilize the same national PPO network that includes more than 90% of all practicing physicians and hospitals across the United States (not limited to Massachusetts or New England like the current Access and HMO plans).

Will I still have access to the same doctors that I currently see under the Access Blue plan?

If the Institution stays with Blue Cross Blue Shield, you will have access to all of the doctors in their PPO national network which expands outside of Massachussets across the United States. However, understanding that we are going out to bid for a potential new medical carrier for 2014, the provider network may change, which could result in some disruption to employees. It is important to note that network coverage and individual employee disruption are key criterion in evaluating the carriers being considered. The Institution is conducting a comprehensive assessment to determine network disruption.

If I only use providers and hospital facilities in the local area, how would I benefit from the national PPO network?

For some employees, you may never need to go outside of the local area network. However, for other employees, this is desirable. For example, if a covered family member has a serious illness, they will have the option to seek the best care, which could be somewhere outside of Massachusetts. Also, for employees with dependents who are covered by their insurance but who reside outside of Massachusetts, under the national network, they will have access to care when needed without having to schedule appointments locally or go to the Emergency Room for a minor sickness.

PPO PLAN QUESTIONS

Why is WHOI eliminating the PPO medical plan for out-of-state employees and what other options will these employees have?

The PPO plan has minimal participation with only 3% of the total enrolled population. The PPO plan continues to have very high utilization and a negative loss ratio, with claims paid exceeding the premiums collected. Additionally, the PPO plan comes with a very high premium to the employee. With the existence of the HDHP plans, which utilizes a PPO national network and offers out-of-state coverage, coupled with a significant reduction in premium, there is no longer a need to maintain the out-of-state PPO plan. Many of WHOI's out-of-state employees have already migrated to the HDHP.

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