MEDCOST®
BENEFIT SERVICES

OPEN ENROLLMENT GUIDE

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INTRODUCTION

This comprehensive guide contains best practices and useful tips to help you make open enrollment a great success. These recommendations will be beneficial for more than just your medical coverage; you can apply these same principles to open enrollment for Flex, COBRA, dental, etc. Even if MedCost doesn't administer those programs for you, we hope these suggestions will be helpful as you prepare for the open enrollment period.

We are here to support you and your open enrollment in any way necessary. Please contact your MedCost Benefit Services Account Manager if you have any questions about open enrollment best practices.

PLANNING

Create a realistic schedule for plan renewal and open enrollment.

Best practice is for your open enrollment period to end no later than 45 days prior to the end of your plan year or renewal date. For example, if you have a renewal of November 1, your open enrollment should be completed no later than September 15. **Please note that for clients with a January 1 renewal date, MedCost will announce the deadline to submit enrollment data.** Once you determine the ending date of open enrollment, back up from there to schedule open enrollment meetings, print forms or materials, distribute or mail open enrollment packets, etc.

Some important things to consider:

- **Are your plan options changing?** This is especially important if you are adding or deleting a plan because it would require MedCost to make internal changes to support your new benefits. Be sure to notify your Account Manager and allow time for those changes.
- **Are you including benefit options from other vendors?** Many benefit options available through your broker or other vendors (such as specialty drug, discount pharmacy, or dialysis management programs) may require data feeds between the vendor and MedCost to ensure that members receive accurate information when they check balances or view EOBs. A data exchange may also be necessary for stop loss purposes. It is important to notify your Account Manager of all benefit options available to your members, even if they are provided by an entity other than MedCost. Please note that it may take up to 90 days to implement a new vendor relationship.
- **Will your members need new ID cards?** If so, verify with your Account Manager when the final information for ID cards is due and adjust your schedule accordingly. New ID cards are typically issued due to the addition of new provisions or services, plan option or deductible/copay changes, change in pharmacy vendor, etc. Your Account Manager can assist you with determining if benefit changes or additions will generate the need for new ID cards.
- **Have you considered any increased annual dollar limitations set by the government which could affect your plan options and/or require a plan amendment?** Each year, the Department of Health and Human Services sets out-of-pocket maximum dollar limits for non-grandfathered health plans. Similarly, the IRS sets annual contribution, minimum deductible, and out-of-pocket maximum dollar limitations for health savings accounts and high-deductible health plans. MedCost shares this information with clients when the limits are announced, but the limits for your plan members are not automatically increased unless your plan documents include specific language to do so. In many cases, plan changes such as increased limits must be approved by the plan sponsor by way of a plan amendment. If you want to implement new limitations for your plan, please contact your Account Manager. Upon your request and amendment to your plan, MedCost will update your plan accordingly.
- **Will you have a passive annual enrollment this year?** A passive open enrollment only requires action from employees if they are making changes to their current benefit elections. However, it is important that employees carefully review the plan options and materials to ensure that their elections are accurate and meet their changing needs.

Stick with the open enrollment deadline you set.

Open enrollment should be a finite time period, not an ongoing process. Announce the deadline and remind employees of it several times during the open enrollment period. It is then the employees' responsibility to complete the required enrollment process by the deadline. And, when it's over, it's over—no extensions (unless required by government regulation).

DATA QUALITY AND COLLECTION

Good Data In Equals Good Data Out – The Importance of Data Quality

One best practice for open enrollment is also a best practice in general—data quality. Our world is data-driven, and the quality of data input directly affects the quality of data output. Incomplete or inaccurate data entered into any system can cause a number of frustrating issues, for your employees and your company's administrative staff alike. Inputting and outputting totally perfect and complete data may seem like an impossible goal. You can increase the likelihood of a smooth enrollment by following these guidelines.

Make sure you are collecting all required information for each plan participant.

Incomplete and missing information are two of the most common problems that occur during open enrollment. Collect all required information for each plan participant (employee or dependent). MedCost Benefit Services requires the following information for each plan participant:

- Last Name, First Name and Middle Initial,* including suffix
- Social Security Number**
- Address (important for mailing ID cards or other benefits documents *and* to ensure participant is assigned to the appropriate network)
- Date of Birth**
- Gender
- Hire Date (required for employee only)
- Coverage Effective Date
- Product Coverage (Medical, Dental, Flex, Vision)
- Date of Termination, if applicable, and Reason for Term (especially needed for COBRA)
- E-mail address (not required, but very useful to promote programs and services available through your benefits plan)

You may want to compare this list to your own benefits enrollment form(s) or capture system to ensure there are fields for all of these data elements. If not, consider making changes to capture this information.

*This information must be entered exactly as it was provided in previous enrollments. If you discover an error, now is the time to make those changes. Name changes and/or suffix additions/deletions could inadvertently generate a new ID card.

**Unique and accurate identifying information must be entered for each dependent. Using member information to represent a dependent will create errors/issues with enrollment.

DATA QUALITY AND COLLECTION

Stress the importance of complete and accurate information to your employees.

Remind employees that "good data in equals good data out"—decisions regarding their eligibility and coverage under the health plan, as well as that of their dependents, are made based on the information they provide during open enrollment. It's in every plan participant's best interest to review and verify new and existing data during open enrollment since it directly affects coverage for the upcoming plan year. Encourage your employees to fill out all fields in benefits enrollment forms and to ask questions if they don't understand something. This guidance is also true for retirees, employees on COBRA or disability, and employees who may be on a Leave of Absence. If time and resources allow, review all benefits enrollment information as it is submitted, and contact participants if anything is missing or obviously incorrect. You may also be required to provide proof of eligibility for a newly enrolled dependent. You should prepare accordingly. This could include items such as birth certificates, marriage licenses, and court orders for coverage. We will expect to receive all changes to all employees/members who may be eligible for coverage.

Additional Note about Addresses: A current and accurate address for each plan participant is needed to ensure: 1) each member is assigned to the appropriate network; and 2) there are no delays in receiving mailed items related to benefits enrollment, such as ID cards.

Promote member account utilization during open enrollment.

As an employer, you want to motivate employees to become more engaged health care consumers. Include information in your open enrollment materials about the many services your health plan participants can access by setting up a member account at www.MedCost.com and encourage health plan members to use their secure online account to help with plan decisions for the coming year. Members can view claims and check flex balances to determine if they need to allocate more or less money. They also can access a digital copy of their ID card and view EOBs online.

Be sure to collect employee email addresses

Although e-mail addresses are not technically required for plan participants, they are certainly important in promoting the programs and services available through your benefits plan. And, open enrollment is the perfect time to collect valid e-mail addresses for employees and their dependents (particularly spouses). One of the easiest ways to capture employee e-mail addresses is through the MedCost member website. If an employee sets up a MedCost member account, their e-mail address is automatically collected. Decision making about benefits is a family affair, so targeting messages directly to spouses and domestic partners can help with adoption and utilization. Consistent, repeated communication delivered across multiple channels has been shown to optimize participation in benefits plan programs.

MedCost does not need waiver forms from your employees—but you do!

For ACA reporting and Department of Labor requirements, you as the employer need to keep proof of waived coverage on file. Your business most likely has its own waiver form, but if not, MedCost has a generic waiver form available for our clients' use.

If you submit enrollment data on paper forms or by spreadsheet, MedCost only needs information on new hires, changes, and terminations.

It may seem counterintuitive, but full enrollment data is not required and can actually slow down the input process. Note: This does not apply to clients that electronically submit enrollment data via 834 transaction. *See the Technical Requirements for Open Enrollment 834 Files section within this guide for more information.*

Once you've collected enrollment data, submit it all to MedCost at one time.

Submitting information piecemeal or in multiple spreadsheets that have to be merged or compared to previous submissions only increases the chance for errors.

This section is applicable only to clients/client vendor partners that currently send enrollment data to MedCost via 834 file.

TECHNICAL REQUIRMENTS FOR OPEN ENROLLMENT 834 FILES

The Health Insurance Portability and Accountability Act (HIPAA) requires a standard format for the electronic exchange of health enrollment data, and 834 is the national standard. To ensure integrity for 834 files and minimize the risks associated with variations in data, **MedCost recommends that you share the following guidelines with your technology teams or partners:**

For plans with a January 1 renewal date, open enrollment data is due to MedCost no later than November 15, 2021.

Be sensitive to any structure changes—such as new product offerings, plan changes, division or department updates, additions or deletions—that could impact 834 files or mapping.

- Make MedCost aware of any upgrades or maintenance to your payroll system or platform that maintains your enrollment information that could impact 834 files or mapping.
- Make MedCost aware of any transition in payroll partnership.
- **Include OE_PROD_ as a prefix in the open enrollment production file name to distinguish it from standard eligibility files.**
- Include a termination date and reason for any member not electing coverage for the upcoming plan year. MedCost does not use "term by omission" methodology; a member's coverage is terminated only when we receive a specific termination date on the enrollment file.
- Make your Account Manager or our Eligibility team aware of when to expect your enrollment file(s).
- Send ancillary files (COBRA, retiree, flex) on the same day you send eligibility files. MedCost expects to receive these files on the same date, and any discrepancies in receipt dates could create inaccuracies in member ID cards. Each of these ancillary files should be distinctly identified.
  - » Submit flex coverages with plan year effective and termination dates rather than the date the member elected flex.
- Ensure that your open enrollment period has an open date and a closure date, after which no additional changes to benefit or demographic selections can be made for the upcoming plan year (unless required by government regulation). Exceptions will create potential delays in the receipt of member ID cards or inaccuracies.
- When enrolling via automated systems, encourage members to diligently review the accuracy of birth dates, suffixes, SSNs, and dependent demographics. Entering all zeros for subscriber birthdates will create inaccuracies on member ID cards. It also is important to include dependent addresses to ensure members are assigned to the appropriate network.
- Establish data integrity audit rules at the source HRIS system to help achieve optimal outcomes on the target MedCost system. MedCost will make best efforts to communicate any data integrity findings to assist in validating that issues can be resolved in a timely manner.

FLEX ACCOUNTS AND FLEX DEBIT CARDS

Submit flexible spending account information electronically or via spreadsheet.

If MedCost administers FSAs for your plan and you are not already passing all eligibility data to us electronically, the best way to submit your flexible spending account enrollment information is by spreadsheet. This allows us to upload your information directly into our system and ensures that pledge amounts are available and new members receive debit cards without delay.

The following FSA data elements are required for each participating employee and should be included in the spreadsheet:

- Group Plan Number
- Company Name
- Hire Date
- Effective Date
- Last Name, First Name and Middle Initial
- Social Security Number
- Date of Birth
- E-mail Address
- Mailing Address (separate address line 1 and 2 in file)
- City, State and Zip Code
- Type of flex spending account – dependent care or medical flex spending
- Pledge Amount – annual election amount
- Payroll Cycle

Increase to Healthcare Flexible Spending Account Limit

Each year, the IRS sets the dollar limitation under §125(i) on voluntary employee salary reductions for contributions to health Flexible Spending Accounts (FSA). MedCost shares this information with clients when the limits for the upcoming year are announced by the IRS. Note: MedCost does not automatically increase the limit for your plan members when an increase is announced because all plan changes must be approved by the plan sponsor by way of a plan amendment. If you want to allow your plan members to increase their annual elections up to the new IRS maximum limit, contact your MedCost Account Manager. Upon your request and amendment to your plan, MedCost will update your plan to implement the contribution election increase for your members. More information about FSAs can be found in Publication 969, available on IRS.gov.

Submit all enrollment data at one time.

As we mentioned previously, send all the flex account enrollment information at one time. Submitting information piecemeal or in multiple spreadsheets or installments that have to be merged or compared to previous submissions only increases the chance for error and may delay the receipt of debit cards for new enrollees.

FLEX ACCOUNTS AND FLEX DEBIT CARDS

Educate employees about the not-so-flexible guidelines of Flexible Spending Accounts (and flex debit cards, if applicable).

A flexible spending account is a great way for your employees to manage their health care and/or dependent care expenses. To monitor their FSA balances and transactions, employees have secure 24-hour access through the Member login on MedCost's website. Employees can have both types of accounts at once, make pre-tax salary contributions to either type, and use the tax-free benefit dollars to pay for eligible expenses. If your plan also includes a flex debit card, your employees can conveniently pay for health care expenses at thousands of merchant locations at the point of service, without waiting for reimbursement.

In addition to its many advantages, however, make sure your employees know about the guidelines for FSAs. The IRS has several requirements pertaining to FSAs, and those rules are not as flexible as the name implies.

Use it or lose it.

Flexible spending accounts are generally "use-it-or-lose-it" plans, meaning that contributions made during a calendar year can be used only for eligible expenses incurred during the same year. However, your plan may provide for either a grace period or a carryover. Regardless of what option your plan provides, it's best to encourage employees to carefully plan their eligible expenses before authorizing an allocated amount to an FSA. Once contributions begin, changes are allowed only in the event of a change in family status. **If your plan doesn't provide for a carryover, employees also need to be aware that any money remaining in an FSA account after the claim filing period at the end of the year (and after the grace period, if applicable) is forfeited in accordance with IRS regulations.** If employees need to know more about eligible expenses, direct them to the IRS's Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans." It includes information on eligible expenses under FSAs and is available for download from www.irs.gov.

To request a report of forfeited election amounts for your plan members, please contact your MedCost Benefit Services Account Manager.

Save all receipts for purchases made with a flex debit card.

The flex debit card deducts payment for an eligible health care expense directly from the employee's FSA account, so it virtually eliminates the paperwork—and the wait time—for reimbursement. And, depending on how your plan is structured, reimbursement payments may be direct deposited into employees' checking accounts. As a result, your employees may think that saving health care receipts is unnecessary. Some claims for reimbursement, however, may require substantiation. Encourage employees to save **all** receipts for purchases made with a flex debit card in case they receive a substantiation request from MedCost or their tax return is audited by the IRS.

Employees need to be aware that there may be tax consequences for failing to substantiate claims as required by the IRS. For more information, please refer to your plan documents. To request a report of unsubstantiated claims for your plan members, please contact your MedCost Benefit Services Account Manager. More information regarding flexible spending accounts, including FAQs, can be found in the Members section of www.MedCost.com under Benefits – Flex Spending Benefits.

Don't toss the debit card at the end of the year.

Remind employees not to discard their debit cards at the end of the plan year, even if they have already used the total allocated amount for their FSA. Debit cards are good for three years, so the same card will be used again to access FSA funds in the next plan year. The only exceptions to this would be if an employee no longer contributes to an FSA or if FSA participants receive new debit cards for the next plan year.

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