Einstein
Advanced Health Insurance Solutions

NEWSALERT

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COVID-19

Insurers Don't Have to Pay to Test Returning Workers: HHS

NEW GUIDANCE from the Trump administration absolves insurers of the responsibility of paying for COVID-19 tests that are required for workers who are returning to the job.

The guidance, released by the departments of Health and Human Services, Labor and Treasury, means that employers will likely either have to foot the bill themselves as they screen workers during the pandemic or pass those costs on to their workers. But in states that require employers to test workers, passing testing costs on to staff is usually not an option.

There had been some confusion about who would pay for the tests after the Families First Coronavirus Response Act required insurers to cover COVID-19 tests without patient cost-sharing. The new guidance has added a new caveat to that rule: that insurers cannot require health plan enrollees to pay for the test if it is deemed "medically appropriate" by a health care provider.

"Testing conducted to screen for general workplace health and safety (such as employee "return to work" programs), for public health surveillance for SARS-CoV-2, or for any other purpose not primarily intended for individualized diagnosis or treatment of COVID-19 or another health condition, is beyond the scope of section 6001 of the [Families First Coronavirus Response Act]," the guidance states.

Groups protest rule

Employer and consumer groups have objected to the guidance, with the advocacy group Families USA arguing that the nation's workers should not be saddled with additional costs during these economically uncertain times.

Employers can require employees to be tested before returning to work, but the Pacific Business Group on Health said it would be highly unusual for a large employer to require testing for employees without paying for the tests in full.

Democrats have asked the administration to withdraw the guidance, but the White House has said it won't and that it would like to see Congress come up with a solution in its next economic stimulus package for the coronavirus pandemic.

Insurance companies may opt to pay for such tests anyway, as a precautionary measure. America's Health Insurance Plans, however, is calling on more government support to cover the costs, which it says could be between $6 billion and $25 billion annually. ❖

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Employee Benefits

Changes on Tap for Group Health Plans in 2021

WHILE MOST business owners and executives have been fretting about the COVID-19 pandemic and the effects on the economy, and the survival of their business, now is a good time to conduct a review of group health plans in light of changes and new rules for 2021.

Here are the main changes that will affect your health plan in the new year:

Out-of-pocket limits

The out-of-pocket limit amounts for 2021 are:

- $8,550 for self-only coverage.
- $17,100 for family coverage.

The out-of-pocket limits for high-deductible health plans with attached health savings accounts for 2021 are:

- $7,000 for self-only coverage.
- $14,000 for family coverage.

New preventative care recommendations

ACA-compliant health plans are required to cover preventative care services with no out-of pocket costs and new ones that become effective in 2020 and 2021 including:

- Perinatal depression prevention
- HIV prevention pill for healthy people at risk
- Updated recommendation for prevention of certain cancers
- Updated recommendation for breast cancer medication used to reduce risk
- Updated recommendation for hepatitis screening
- Updated recommendation for screening for drug use.

Flexible spending accounts

This year, the IRS issued a notice that increased the maximum allowable amount of unused funds at year end in FSAs that can be carried over to the next year.

The notice increases the maximum $500 carryover amount for 2020 or later years to an amount equal to 20% of the maximum health FSA salary reduction contribution for that plan year. That means the health FSA maximum carryover from a plan year starting in calendar year 2020 to a new plan year starting in calendar year 2021 is $550.

Additionally, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) allows employers to remove restrictions that funds in FSAs, health reimbursement accounts and HSAs cannot be used for over-the-counter medications. This is not a requirement that employers relax this rule for their FSA plans, but it allows them to choose to do so.

Summary of benefits and coverage

There are new Summary of Benefits and Coverage (SBC) materials and supporting documents that must be used for all plans that incept on or after Jan. 1, 2021.

Please remember that any changes to benefits in your group plan must be reflected in the SBC plan document and summary plan description.

The takeaway

2021 is fast approaching and with all the chaos of 2020, it would be wise to get a head start on understanding changes in store for the plans you offer. This would benefit both you and your employees. ❖

Affordable Care Act

Grandfathered Plans Get More Leeway on Cost-Sharing

THE TRUMP administration has proposed a new rule that would give more leeway to group health plans that have grandfathered status under the Affordable Care Act.

Under the proposed rule, these plans could increase their cost-sharing requirements for enrollees at a higher level than they can now, without losing their grandfathered status.

Grandfathered plans were in existence before the ACA took effect in March 2010 and as long as they are continually offered with only a small amount of certain changes, they do not have to comply with a number of the law's provisions. The only ACA provisions that apply to grandfathered plans are:

- A ban on pre-existing condition exclusions.
- A ban on excessive waiting periods.
- A ban on lifetime and annual dollar limits.
- A ban on policy rescissions.
- The requirement that plans must cover dependents up to age 26.
- The requirement that plans must provide enrollees a summary of benefits and coverage.

Grandfathered plans do not have to comply with a number of major ACA provisions, including:

- Covering essential health benefits without cost-sharing.
- Covering preventive services without cost-sharing.
- Capping out-of-pocket costs for enrollees.
- Patient protections like the right to choose a primary care provider designation, OB/GYN access without a referral and coverage for out-of-network emergency department services.

All of the above is left untouched by the proposed rule, issued by the departments of Health and Human Services, Labor and Treasury. Here are the changes on tap:

THE CHANGES

1. A "special rule" for high-deductible health plans. Under the proposed rule plans would not risk losing their grandfathered status if they increase fixed-amount cost-sharing requirements for enrollees, as long as they have to make the change to comply with HDHP rules that require a minimum deductible.

The concern is that annual deductible cost-of-living adjustments that are set by the Centers for Medicare and Medicaid Services will start increasing at a higher rate than grandfathered plans are allowed to increase their own cost-sharing requirements.

This way, even grandfathered plans can increase fixed-amount cost-sharing requirements at whatever level is required to meet a future deductible requirement.

2. New way to calculate "maximum percentage increase." The proposed rule would allow grandfathered plans to use an alternative method for calculating the maximum percentage increase for fixed-amount cost-sharing requirements.

Currently, grandfathered plans cannot increase cost-sharing requirements by more than $5, or a percentage equal to medical inflation (an amount published annually by the Department of Labor) plus 15%, whichever is greater.

The proposed rule would permit plan sponsors to use the "premium adjustment percentage" published annually by HHS as an alternative method for measuring permitted increases in fixed-amount cost-sharing.

The departments stated that the premium adjustment percentage might be a more appropriate measurement of changes in health care costs for the private sector because, unlike the medical inflation amount, it does not reflect changes in price for self-pay patients and Medicare.

Critics say it could mean that plans are able to increase copays at a higher rate than they currently can. ❖

Litigation Risks

Protecting Your Firm from Employee Benefit Lawsuits

EMPLOYMENT PRACTICES and employee benefit-related lawsuits are on the rise – and employers have to be eternally vigilant when it comes to meeting their compliance obligations as plan sponsors.

Take the case of Visteon, a global automotive industry supplier, which outsourced its payroll and enrollment/disenrollment functions to outside plan administrators.

But because of internal mistakes at the firms that Visteon outsourced these noncore HR functions to, some of its former employees who should have received COBRA eligibility notices after leaving the firm never received them. At first it was just a handful, but ultimately 741 co-workers signed on to a class-action lawsuit.

Visteon argued in court that it was not its own mistakes that had caused the error, and that it had made a good-faith effort to hire outside experts to take over this function for them.

Payroll and enrollment, after all, are not core competencies for an auto parts supplier, the company said, and it had been relying on the expertise of these other payroll companies to properly execute these functions and provide these notices.

The court didn't buy Visteon's argument. Rather, it held the company responsible in 2013 for poor internal tracking systems, negligence in overseeing its third party administrators, and failure to accept responsibility for its COBRA notification efforts.

That exposed them to the statutory penalty of $110 per worker per day for failure to provide notification.

In the end, for doing what tens of thousands of employers are doing nationwide – relying on third party administrators to handle payroll functions that are regulated under COBRA – Visteon was slapped with $1.8 million in penalties.

PROTECTING YOUR BUSINESS

- Carefully monitor your plan third party administrators. Insist that they document their own compliance practices to you. Don't take their word for it.
- Reconcile your own lists of recently departed employees with your payroll company's COBRA notifications.
- Understand that your commercial general liability insurance policy usually will not cover you against liability arising from improper administration of employee benefit plans, ERISA, COBRA, USERRA, wage and hour laws, Title VII related lawsuits, and the like.
- Consider employment practices liability insurance. This coverage will often protect against lawsuits like this and cover legal expenses, and even judgments.
- Conduct regular reviews with advisers on investments in pension and 401(k) plans. Investments should be reviewed at least annually – and quarterly is not unusual.
- Ensure that fees paid to 401(k) and other plan administrators are not excessive. You don't have to go with the cheapest provider (that can be trouble, too). But if you do choose a higher-fee vendor, document why you made that decision so that you can show your reasoning in court and defend your decision-making as sound and prudent.
- Invest in data security and HR compliance expertise.

Employers are frequent lawsuit targets

As much as companies rely on their employees to generate profits, simply having them around and administering their benefit plans potentially exposes employers to significant possible liability.

According to a survey by insurer CNA, employment-related disputes are the fastest-growing category of civil lawsuits in America.

Employers face risk from the potential of lawsuits employees may bring for alleged failure to fulfill their fiduciary duties as sponsors of retirement plans under ERISA, for example, or for accidental or unauthorized leaks of personally identifiable information, which carries significant penalties under HIPAA.

Sponsors of defined contribution pension plans, such as 401(k)s, are particularly frequent targets of lawsuits for various fiduciary failures, errors or omissions. ❖