Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Emergency Regulations

Rules Allowing Mid-Year Changes Will Sunset

A TEMPORARY RULE that allowed covered employees to make mid-year election changes to their health plans and revisit how much they set aside into their flexible spending accounts (FSAs) will sunset at the end of the year.

The rules gave employers the option to allow their employees to make changes to their health plans, including choosing a new offering, but did not require that they allow them to make these changes.

The more relaxed rules were the result of provisions in the Consolidated Appropriations Act, 2021, which was signed into law in December 2020 by President Trump, and subsequent regulatory guidance by the IRS.

In response to the COVID-19 pandemic, the IRS liberalized the rules for cafeteria plan mid-year election changes for health plans and FSAs in the 2021 plan year, during which employers may permit workers to make election changes without affecting their status.

Now however, all plans that take effect on or after Jan. 1, 2022 will revert to the old rules that bar mid-year election changes and limit the grace period for spending unused FSA funds to just two and half months after the end of the prior policy year.

THE RULES THAT WERE RELAXED:

- Allow employees who had declined group health insurance for the 2021 plan year to sign up for coverage.
- Allow employees who have enrolled in one health plan option under their group health plan to change to another plan (such as switching insurance carriers or opting for a silver plan instead of a bronze plan).
- Allow participants to enroll mid-year in an FSA, increase or decrease their annual FSA contribution amount, or pull out of the plan altogether and stop contributing.
- Employers have been permitted to modify their health FSAs to include a grace period of up to 12 months to spend unused funds from the prior policy year.
- Allow for a higher carryover amount than the typical $500.

The takeaway

The rules coming to an end will only affect those employers who opted to allow their employees to make changes to their health plan choices and/or their FSAs. If you didn't make this move, there is nothing you need to do.

If you did permit your staff to make these mid-year changes, you will need to communicate to them as soon as possible, and before and during open enrollment, that mid-year changes will not be possible in 2022.

When telling them about the rules change, make sure to inform them of the permanent rules and when they take effect again.

Also, if you extended the grace period and/or the carryover amount for FSAs, inform them that the carryover grace period will revert to two and half months and that the maximum carryover amount will revert to $500. ❖

SUNSETTING: *The rules that are coming to an end were meant to give covered workers a chance to bolster their health coverage during the pandemic.*

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Out-of-Pocket Costs

New Health Plan Transparency Rules Explained

REGULATIONS ARE slated to take effect over the next few years that will greatly increase the transparency requirements for group health plans.

The regulations issued in 2020 will require health insurers in the individual and group health markets to disclose cost-sharing information upon request, make cost-sharing information available on their websites and disclose negotiated rates with in-network providers.

The rules are designed to help health plan enrollees choose the plan that is best for them and their family, as well as to give them a full picture of what they can expect to pay for services as part of their deductibles, copays and coinsurance.

There are two parts to the rules: one focuses on personalized cost-sharing information and the other focuses on other pricing and information that insurers are required to post on their websites.

Personalized cost-sharing information

The new rules require health plans to provide personalized estimates for enrollees upon request, so they can calculate their potential out-of-pocket expenses prior to receiving medical treatment.

The following must be provided to a plan enrollee upon inquiry ahead of receiving care:

Estimated cost-sharing liability – This covers how much the enrollee would have to pay out of pocket under their plan for deductibles, coinsurance and copays for a specific medical service. These estimates must be specific to the individual that's inquiring and not a general estimate.

Accumulated out-of-pocket payments – Enrollees can inquire to their health plans about how much they've paid out towards their deductibles and their plan's out-of-pocket maximums as of the date requested.

In-network rates – Upon request, the plan must divulge how much the enrollee will have to pay out of pocket in relation to the rates it has negotiated for a specific procedure by an in-network provider.

The plan or insurer must disclose the negotiated rate, expressed as a dollar amount, even if it is not the rate the plan or insurer uses to calculate cost-sharing liability. The plans must also disclose out-of-pocket liability for an individual as well as the negotiated rates for prescription drugs. The health insurer does not have to disclose drug discounts or rebates as part of the inquiry.

Out-of-network allowed amount – The insurer must disclose the maximum amount its plan will pay for an "item or service" from an out-of-network provider.

Notice of prerequisites to coverage – If the service the enrollee is inquiring about prior authorization, concurrent review or step-therapy, the insurer must include this information in the answer to the request.

All of the above will take effect in two phases:

- Jan. 1, 2023: Insurers will be required to provide personalized cost-sharing information on 500 specific services.
- Jan. 1, 2024: Insurers will be required to provide personalized cost-sharing information on all specific services.

Publicly available cost-sharing information

The new regulations also require health plans (not including grandfathered ones) and health insurers to post on their websites machine-readable files with detailed pricing information. They must post this information starting Jan. 1, 2022.

The website must include the following information, which has to be updated on a monthly basis:

- Rates for all covered items and services that the plan has negotiated with its in-network providers.
- Historical payments the insurer has made to out-of-network providers, as well as the billed charges.
- The plan's in-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level. ❖

Policy Pricing

Health Insurers Not Factoring In COVID-19 Effects

IN A GLIMPSE of what we may expect in terms of premiums, a new study by the Kaiser Family Foundation has found that most insurers are not factoring in added costs or savings related to COVID-19 for their 2022 health coverage rates for personal health plans in 13 states and the District of Columbia.

The insurers expect health care utilization to return to pre-pandemic levels by 2022, according to the analysis by KFF.

While the analysis focused on the individual market, KFF found that insurers were making similar assumptions about how COVID-19 would affect their group market costs and pricing.

Despite them not expecting significant effects from COVID-19, there are other issues that are on health insurers' radars that are likely to increase rates, including the costs of treatment that was delayed in 2020, the continued use of telehealth services and new federal regulations in response to the pandemic.

A survey by PricewaterhouseCoopers found that employers are expecting an average rate increase of 6.5% for group health coverage.

It's clear that most insurers are viewing the COVID-19 pandemic as a one-time event, with limited, if any, impact on their 2022 claims costs. KFF referred to the pandemic's effect on rates as "negligible."

The foundation looked at rate filings of 75 insurers and only 13 of them stated that the pandemic would increase their costs in 2022, but even then, most of them predicted an effect of 1%. The reasons those 13 insurers cited for the expected higher costs include:

- Costs related to ongoing COVID-19 testing, treatment and vaccinations.
- Anticipated vaccination boosters.

Delayed treatment, policy changes

While most insurers don't expect to be paying out excessive amounts for treatments and medications related to COVID-19 infections, they are concerned about the increased flow of patients seeking treatment for procedures they postponed last year.

Those postponements have led to pent-up demand, driving higher utilization in 2021, which some health plans expect will spill over into 2022.

As a result, some insurance companies have filed rates that include a "COVID-19 rebound adjustment" to account for the services that were deferred in 2020.

Other carriers have filed for rate increases based on predictions that those delayed services will lead to an exacerbation of chronic conditions. Some are also predicting that COVID-19 "long-haulers" could push claims costs higher.

On top of all that, insurers this year have had to make decisions about benefits, network design and premium pricing in the face of the pandemic and federal policy changes that could dramatically expand coverage under the Affordable Care Act.

Other concerns

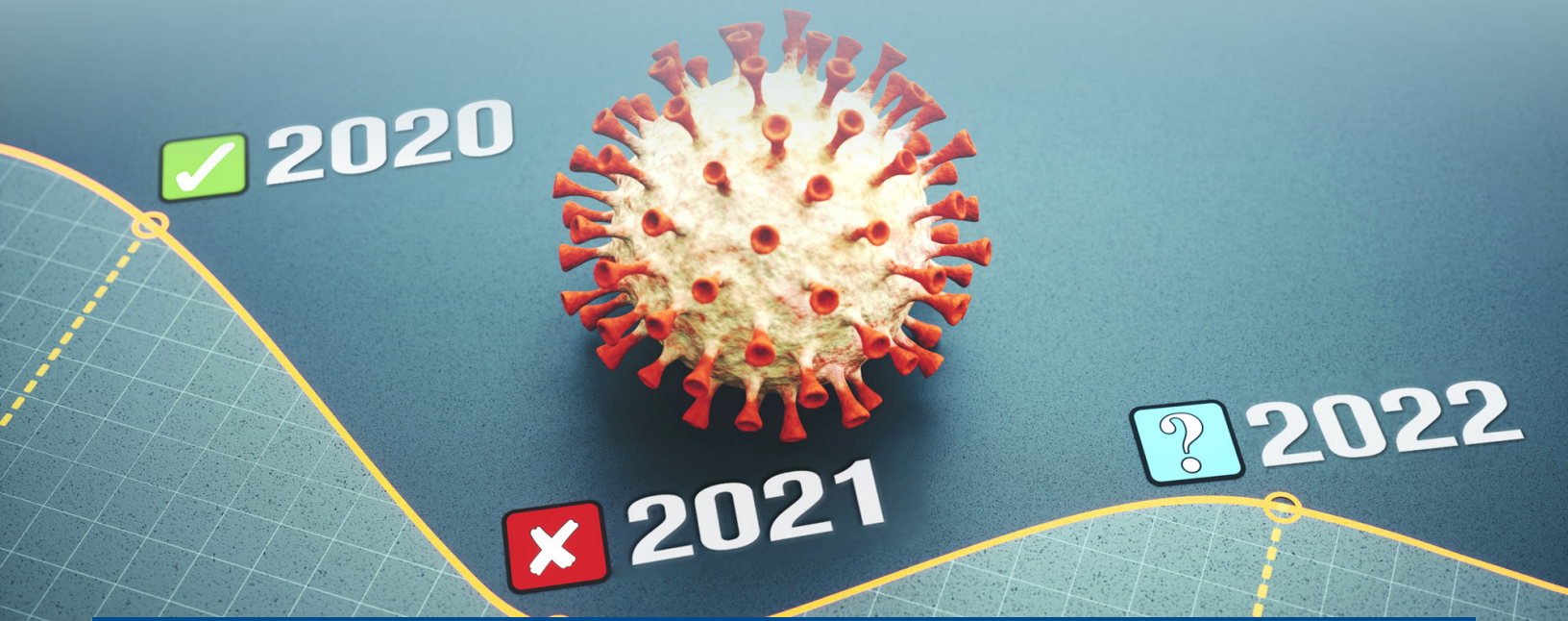
Some insurers are concerned about the costs associated with the explosive growth of telehealth services during the pandemic. These tele-visits boomed as people were avoiding doctors' offices due to stay-at-home and social distancing orders, and to reduce the chances of COVID-19 transmission.

Kaiser Permanente in one of its filings wrote: "We anticipate the high utilization of telehealth services to persist beyond the lifespan of the outbreak into the foreseeable future."

Another insurer, MVP in Vermont, said that while it has seen costs associated with in-person ambulatory services increase this year and a return to in-person visits, it has not seen a reduction in use of telehealth services.

Finally, Blue Cross Blue Shield of Vermont in its filing predicted that the increased expenditures for mental health services (demand for which spiked in 2020 as people wrestled with isolation and depression aggravated by the pandemic) would continue in 2022 and beyond.

The insurer predicted that claims for mental health and substance abuse treatment would climb 20% from 2020 to 2022. ❖



Voluntary Benefits

High Deductibles Drive Interest in Critical Illness Cover

IF YOU want to provide your employees with the one voluntary benefit that can give them peace of mind should tragedy strike, critical illness coverage is the answer.

Demand has grown for critical illness insurance over the last year thanks to the pandemic and as a result of employees taking on more of the cost burden in their employer-sponsored health plans.

According to the Kaiser Family Foundation's "20120 Employer Health Benefits Survey," the average deductible for self-only plans of all types was $1,644 in 2020, up from $917 a decade earlier. And many employees have deductibles upwards of $6,000 if they are in certain high-deductible health plans, which have become increasingly common.

As a result, many employers have begun enhancing their voluntary benefits offerings to include critical illness or cancer coverage to help offset the risk for employees and increase satisfaction and retention.

Interest grows

In part, employee interest in critical illness insurance stems from the chain of events that may have cut back their benefits and caused their deductibles to skyrocket. They are looking for peace of mind should they be stricken by a serious illness.

In addition, advances in medicine and technology that have prolonged life also make critical illness coverage more attractive.

Finally, the COVID-19 pandemic put into sharp focus just how quickly someone can be sidelined by a sudden and serious illness.

Consider that out-of-pocket costs for treating a critical illness can start at around $15,000 and climb from there, and that lost income can be as much as $60,600, according to a 2020 MetLife study.

In other words, battling a critical illness could be just the tip of the iceberg. If someone's lucky enough to survive a critical illness, they may still suffer major financial damage due to high medical bills and restricted income.

To stave off debt, some people dip into, or deplete, their retirement savings and end up paying extra due to resulting taxes, fees and reduced health insurance subsidies.

However, other adults don't even have enough, or near enough, of a nest egg saved to cover all the costs.

Enter critical illness coverage

Critical illness coverage provides a lump-sum payment that a policyholder can use for any expense if they've been diagnosed with a serious illness.

Mostly, this insurance only pays out for one occurrence of a listed condition. And once that payment is made, the policy is terminated.

But insurers have started offering polices that cover a wider variety of conditions and allow beneficiaries to receive multiple payouts if they suffer from a reoccurrence or another condition entirely.

As a result, more employers are offering voluntary critical illness coverage. According to Mercer's "2020 National Survey of Employer-Sponsored Health Plans," more organizations are offering this insurance in a direct response to the COVID-19 pandemic.

And Willis Towers Watson's "2021 Emerging Trends in Health Care Survey" found that 57% of employers polled were offering critical illness coverage to their staff in 2021, and that 75% were planning to offer it by 2022 or beyond. That's an increase of nearly one-third.

Often offering this coverage costs the employer nothing or very little. Call us for more information on this valuable benefit that more workers are demanding.❖