Einstein
Advanced Health Insurance Solutions

NEWSALERT

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Pandemic Effect

Voluntary Benefits Uptake Spikes Among U.S. Workers

A NEW STUDY has found that in response to the COVID-19 pandemic nearly half of U.S. workers added one new supplemental health-related benefit on top of their group health coverage.

The 2021 "Aflac WorkForces Report" found that 44% of employees bought one additional benefit, with life insurance policies the most popular.

"Anxieties over the past year brought questions about health coverage – especially about whether current coverage is enough for workers and their families," Aflac wrote in its report. "The survey found that employees sought ways to help offset the financial burdens they experienced, including through supplemental insurance."

Interestingly, the largest uptake of these benefits was among millennial workers.

With the pandemic still not over, the report predicts that the trend will continue.

Overall views of supplemental benefits have also improved since the pandemic started. Aflac reasoned that COVID-19 got people thinking more about what would happen if they get gravely ill from the virus or die. The survey found that:

- One-third of employees say supplemental insurance is more important now due to the pandemic.
- 51% of all American workers view supplemental benefits as a core component of a comprehensive benefits program.
- 90% of employees believe the need for supplemental insurance is increasing.
- 48% employees (and 63% of millennials) are highly interested in purchasing supplemental insurance to help cover the financial costs related to COVID-19 or other pandemics.

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The Most Popular Voluntary Benefits

The percentages of workers who have purchased a voluntary benefit since the pandemic started:

- **Life insurance:** 22% overall and 34% of millennial workers.
- **Critical illness insurance:** 16% overall and 23% of millennial workers.
- **Mental health resources:** 14% overall and 21% of millennial workers.
- **Hospital insurance:** 14% overall and 21% of millennial workers.
- **Accident insurance:** 12% overall and 19% of millennial workers.
- **Disability insurance:** 10% overall and 16% of millennial workers.
- **Cancer insurance:** 4% overall and 6% of millennial workers.

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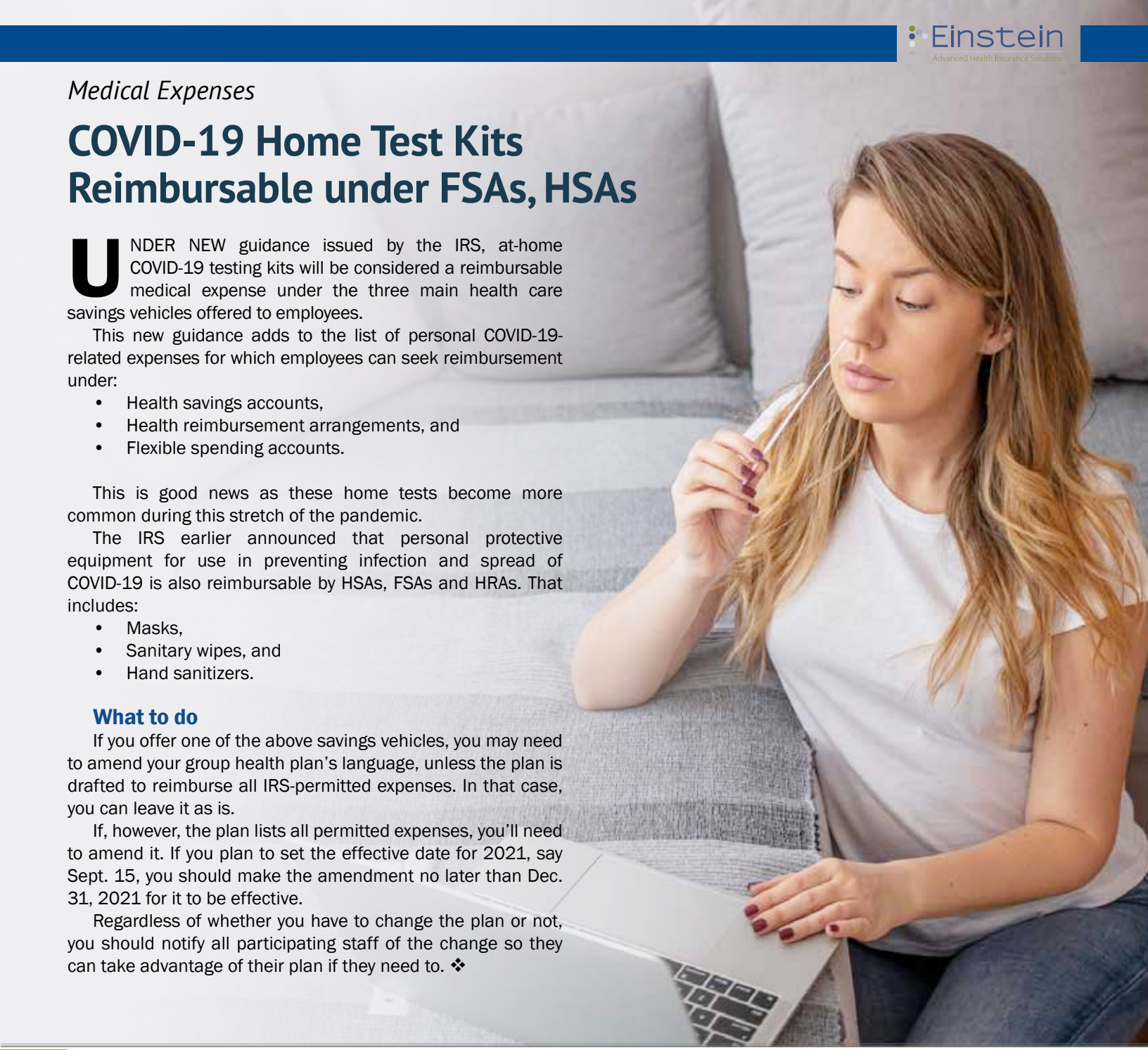
Medical Expenses

COVID-19 Home Test Kits Reimbursable under FSAs, HSAs



UNDER NEW guidance issued by the IRS, at-home COVID-19 testing kits will be considered a reimbursable medical expense under the three main health care savings vehicles offered to employees.

This new guidance adds to the list of personal COVID-19-related expenses for which employees can seek reimbursement under:

- Health savings accounts,
- Health reimbursement arrangements, and
- Flexible spending accounts.

This is good news as these home tests become more common during this stretch of the pandemic.

The IRS earlier announced that personal protective equipment for use in preventing infection and spread of COVID-19 is also reimbursable by HSAs, FSAs and HRAs. That includes:

- Masks,
- Sanitary wipes, and
- Hand sanitizers.

What to do

If you offer one of the above savings vehicles, you may need to amend your group health plan's language, unless the plan is drafted to reimburse all IRS-permitted expenses. In that case, you can leave it as is.

If, however, the plan lists all permitted expenses, you'll need to amend it. If you plan to set the effective date for 2021, say Sept. 15, you should make the amendment no later than Dec. 31, 2021 for it to be effective.

Regardless of whether you have to change the plan or not, you should notify all participating staff of the change so they can take advantage of their plan if they need to. ❖

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Educate Your Staff About the Value of Supplemental Benefits

The takeaway

In light of these findings, it's more important than ever that employers offer more than group health coverage and provide their workers with a slate of voluntary benefit offerings, many of which do not cost the employer much extra.

In fact, the study found that 70% of employers believe supplemental insurance helps them recruit employees and 75% say it helps with retention.

But keep in mind that may employees believe they already have enough coverage to meet their needs. Educate them about the health-related expenses that group health insurance doesn't cover, such as death benefits and long-term care.

One way you can put together a slate of offerings that your workforce needs and is interested in, is to conduct a study of your staff to see which options they would most prefer.

And finally: Introduce your benefits consultant (in person or virtually) prior to or at the start of open enrollment.

That way, employees become familiar with them and can be more comfortable asking questions about the various coverages they can choose from. ❖

Compliance Reminder

Large Employers Must File ACA Forms, Not the Insurers

ONE MISTAKE more and more employers are making is failing to file required Affordable Care Act tax-related forms with the IRS.

If you are what's considered an "applicable large employer" (ALE) under the ACA, you are required to file with the IRS forms 1094 and 1095, often separately and before your annual tax returns are due.

Under the ACA, employers with 50 or more full-time and "full-time equivalent" workers are considered an ALE and are required to provide affordable health insurance to their staff that also covers 10 essential benefits as prescribed by the law. This is what's known as "the employer mandate."

Filing these documents is not the responsibility of your health insurer as it's you that's arranging the employer-sponsored health insurance for your staff. Be aware that you can face penalties if you:

- Don't file the forms in a timely manner,
- Make mistakes when filing the forms, or
- Fail to file the forms altogether.

The IRS requires these forms to ensure that ALEs are providing health coverage to their employees and that the employer is complying with the employer mandate portion of the ACA.

The forms

Form 1095-C – This is basically the W-2 reporting form for health insurance. It tells the IRS which employers are providing coverage and which employees are covered through their employers.

Form 1094-C – This form provides information about health insurance coverage the employer provides.

THE DEADLINES

- **Jan. 31, 2022** – The deadline for furnishing individual statements (Form 1094-C) for 2021.
- **Feb. 28, 2022** – The deadline for filing paper returns of Forms 1094-C and 1095-C.
- **March 31, 2022** – The deadline for filing Forms 1094-C and 1095-C electronically.

Penalties

The general potential late/incorrect ACA reporting penalties are $280 for the late/incorrect Forms 1095-C furnished to employees, and $280 for the late/incorrect Forms 1094-C and copies of the Forms 1095-C filed with the IRS.

That comes to a total potential general ACA reporting penalty of $560 per employee when factoring in both of the above.

The maximum penalty for a calendar year will not exceed $3,392,000 for late/incorrect furnishing or filing. ❖

SHOOTING BLIND: *Don't assume the insurance company will file Forms 1094-C and 1095-C for you. If you don't file them, you could be in line for substantial penalties.*

Model Legislation

Law Could Help Policyholders Meet Drug Deductibles

A MODEL MEASURE written by state legislators that specialize in insurance policy would require health plans to include financial assistance that policyholders receive, as well as drug rebates, towards their pharmaceutical deductibles, copays and coinsurance.

Most health plans do not allow rebates and outside financial assistance to count towards a policyholder's drug deductible, which critics assert penalizes enrollees.

The model measure introduced by the National Council of Insurance Legislators (NCOIL), a bi-partisan organization of state elected officials who specialize in insurance law, would require them to count those outlays towards coinsurance and deductibles.

It's expected that some NCOIL members will introduce similar legislation in their home states in 2022 or in subsequent years.

If successful, such laws could be a boon for some patients who receive help from drug companies or whose drugs are eligible for rebates.

This is a significant move as pharmaceuticals become more expensive and lawmakers and policymakers wrestle with how to make them more affordable and stem steep annual cost increases.

The problem

Health plans' and pharmacy benefit manager (PBM) drug formularies have different cost-sharing amounts for different tiers of drugs. The lowest amount of cost-sharing is mostly for generic drugs, some of which are even available with no copays.

There are typically at least three tiers of drugs, with the higher reserved for brand-name drugs for which there are not always generic versions available. The top tier is usually reserved for the most expensive, specialty medications.

For expensive pharmaceuticals, some drug makers will sometimes work with patient advocacy groups to fund programs that offer financial support towards out-of-pocket expenses for patients that purchase their drugs.

Drug companies will also provide rebates. But often, PBMs and health insurers will receive those rebates and there have been questions as to how much of them they share. And they don't count those rebates towards the patient's out-of-pocket maximum.

The model legislation

The model legislation is just that: a model. NCOIL has put the proposed measure on its agenda for its Nov. 18 meeting.

It's expected that some NCOIL members – Republican and Democratic lawmakers from all 50 states – will write and help pass similar measures in their home states.

The preamble to the language in the measure states that it aims to address programs that keep cost-sharing assistance payments from counting towards a patient's annual out-of-pocket spending limit.

The draft's model language states: "When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a carrier/insurer/issuer or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person."

Insurance companies and PBMs say that the measure would be improved if it would limit its scope to only include drugs with no lower-cost or generic alternative. That way, it would keep pharmaceutical companies from steering patients to their more expensive drugs when there are lower-cost alternatives.

Right now, there is no pending legislation at the state level, but this could be the starting point to bring some financial relief to drug plan enrollees that are either high users of prescription drugs or have been prescribed expensive medications. ❖