ECG

NEWSALERT

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Group Health Insurance

What to Do When Remote Workers Move Out of State

ONE FALLOUT from the COVID-19 pandemic has been an increase in the number of Americans who are working from home permanently.

With so many people being freed from the yokes of the office, some have chosen to move to other states for lifestyle or cost reasons. But while these arrangements can be great for workers, they can make it difficult when it comes to your group health insurance.

One of the main stumbling blocks is that most group plans are local or regional at best, as they contract with providers and hospitals in the area where an employer is located.

For employers that suddenly have staff now working far afield from their headquarters, securing health insurance coverage in other states can create headaches.

And to make matters worse, some employees don't bother telling their employers they are moving, which can render their coverage obsolete if they locate to a place out of their insurance policy's coverage area.

Remote employees who fail to inform their employers when they relocate could suddenly find themselves in an area with no access to their insurer's preferred network and they could have their claims denied if they seek out medical care.

What you can do

Many insurance companies don't have the same type of network in every state, and even among those that do, health care providers may not offer the most cost-efficient networks for out-of-state employees.

Some carriers offer national group health plans, which comply with different state regulations and have good networks in most states. In these types of plans, all of the employees in your organization receive the same group benefits regardless of where they live and work, and they all have access to the same quality coverage.

But there are just a handful of carriers that offer this type of group coverage. Talk to us if you want to know more.

Another option is to find local coverage for remote employees, but if you don't have many employees in a region, you may not be able to find preferable rates for their group coverage.

A third option is to set up a taxable stipend or a health reimbursement arrangement that your employees could use to purchase their own health insurance. An HRA can be used for qualified medical expenses, including health insurance premiums if it's set up properly (for more information on HRAs, see article on page 3).

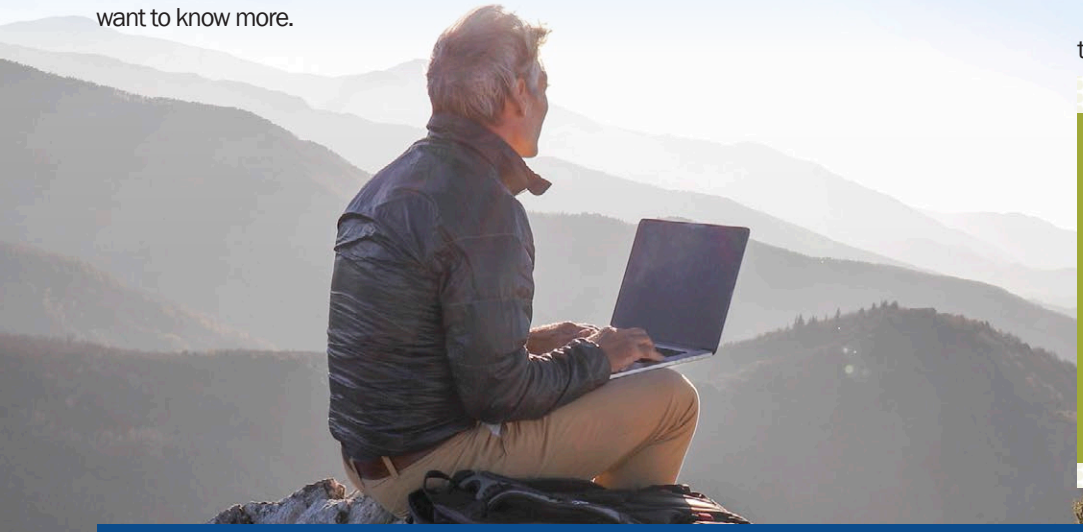
A stipend is a fixed amount of money paid to an employee in addition to their salary, designed to cover extra costs the employer allows, such as health insurance.

The takeaway

As more U.S. companies have workers spread across many states, securing health insurance for them is crucial.

The health insurance you choose will depend largely on your budget and coverage preferences, and what is available to your staff in the state they are working in.

Also, require emplloyees to inform you if they move to another city or state. ❖



ECG
Einstein Consulting Group

Missouri: 1120 S. 6th Street (Suite 201)
St. Louis MO 63104
Illinois: 280 North Main Street,
Breese, IL 62230

Phone: 877.324.2114
Fax: 888.274.1538
Email: info@ecgins.com

Coverage Changes

COVID Test Kit Rules for Group Health Plans Explained

STARTING JAN. 15, the nation's health insurers have been required to cover the cost of up to eight at-home rapid COVID-19 tests per month for their health plan enrollees.

Insurers are taking different approaches to the mandate and, as an employer, you should communicate with your covered staff about this new benefit, how it works and other advice.

According to frequently asked questions posted by the Department of Labor, coverage for over-the-counter test kits must be covered by insurers without cost-sharing and without a doctor's order or prescription.

Rules for Insurers, Health Plans

- May require enrollees to submit reimbursement claims for OTC COVID-19 tests (the DOL, however, "strongly encourages" plans to reimburse pharmacies directly instead).
- Must reimburse plan enrollees for tests they purchase outside of their preferred network up to $12 per test if they also offer coverage for OTC tests through a pharmacy network. Health plans are authorized to provide a more generous reimbursement from tests purchased through a non-preferred provider.
- Can limit the number of OTC tests covered without cost-sharing, as long as they cover eight per month per enrollee with no cost-sharing. That means a family of three on a family plan can be reimbursed for up to 24 tests per month.
- Cannot limit the number of covered tests if they are ordered by a doctor after a clinical assessment.
- Can require enrollees to attest that tests they are reimbursed for are for personal use and not work, that they are not being reimbursed for the tests by other sources and that they won't resell the tests.
- Can require that enrollees provide receipts as proof of purchase.

Action items

Contact us or your group health insurer for guidance on how it will handle payment for OTC tests. It is important to:

- Check that it has pharmacy and retailer networks in place where covered individuals can obtain the OTC tests.
- Check if it has a direct-to-consumer shipping program for kits.
- Check if it has systems in place to handle claims and for reimbursing either participants or participating pharmacies that have point-of-sale test kits available.
- Ask the insurer whether it has any purchase or reimbursement limits if tests are purchased at a non-network pharmacy or retailer.

Once you have those details in hand, hold a meeting with your staff covering the following:

- An explanation of the new benefit and how their insurer will reimburse or pay for the kits.
- Go over the claims and reimbursement process if they pay out of pocket at a non-participating pharmacy.
- Provide a list of network pharmacies and retailers that will offer point-of-sale test kits that the insurer pays for direct. Also provide information on any direct-to-consumer purchase options.
- Tell them about any reimbursement limits if they purchase from non-preferred pharmacies, or other limits (like the eight tests per month limit).
- Advise your staff to keep receipts for any at-home test kits they have purchased since Jan. 15. They should also save the boxes the test kits come in as some plans may require them as proof of purchase. ❖

Employee Concerns

HRAs Can Help Your Staff Pay for Medical Expenses

AS RISING health insurance premiums and out-of-pocket costs for health care are burdening workers, more employers are looking for ways to help their staff put aside money for those expenses.

While health savings accounts have grown in popularity, you can only offer them to employees who are enrolled in high-deductible health plans. Fortunately, there is another option: a health reimbursement arrangement (HRA).

Employers fund these accounts, which reimburse your staff for qualified medical expenses and, in some cases, insurance premiums.

You can claim a tax deduction for the funds you transfer to your employees' HRAs, and the funds they withdraw from the accounts to reimburse for medical-related expenses are generally tax-free.

Unlike HSAs and flexible spending accounts, though, HRAs are solely funded by employers. Also, unlike HSAs, they are not portable if an employee moves to a new employer.

In addition, federal regulations dictate what types of health care expenses HRAs can reimburse, and those rules vary depending on the type of HRA you offer.

Depending on the type of HRA, funds may be used to reimburse:

- Health insurance premiums,
- Vision and dental insurance premiums,
- Coinsurance, copays and out-of-pocket medical outlays, and
- Qualified medical expenses.

How HRAs work

You decide how much you want to fund your employees' HRAs. Under federal regulations, you must fund all like employees' HRAs with the same amount. So, if you have 12 sales reps, each one would have to get an HRA funded with the same amount, but managers and supervisors could receive a different sum.

Employees can only withdraw funds from their account to reimburse for a legitimate expense they have already paid for. Another option is to provide them with an HRA debit card, which they can use to pay for qualified medical expenses.

Once they have depleted the funds in their HRA for the year, they have to pay for medical expenses out of pocket.

Any HRA money that is unspent by year-end may be rolled over to the following year, although an employer may set a maximum rollover limit that can be carried over from one year to the next.

Types of HRAs

There are a number of different HRAs:

Integrated HRA – This type of HRA requires employees to also be covered by a group major medical plan. It generally reimburses out-of-pocket medical expenses.

Dental/vision HRA – This type of HRA limits reimbursements to only dental and/or vision expenses.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) – This type of HRA is only available to employers that have fewer than 50 employees. The maximum annual reimbursement amount is $5,450 for self-only employees ($454.16 per month) and $11,050 for employees with a family ($920.83 per month).

QSEHRAs are typically used to (legally) allow employers to reimburse their workers for individual health insurance premiums, in addition to other out-of-pocket expenses being reimbursed.

Individual Coverage HRA (ICHRA) – This type of HRA is available to employers of all sizes, and employees must be covered by an individual health insurance plan to be eligible.

The primary intent of the ICHRA is to allow for the reimbursement of individual health insurance premiums, but other out-of-pocket expenses, such as copays and deductibles, can also be reimbursed.

Employees can use these HRAs to buy their own comprehensive individual health insurance with pretax dollars either on or off the Affordable Care Act's health insurance marketplace.

Excepted Benefit HRA (EBHRA) – This HRA will allow for the reimbursement of COBRA premiums, short-term medical plan premiums, dental and vision expenses. The annual reimbursement limit for an EBHRA is $1,800 (adjusted for inflation).

The takeaway

An HRA is another tool in helping you retain and attract talent.

In fact, you can even pair an HRA with an HSA, as long as the HRA is HSA-qualified.

In these instances, you would need to offer a "limited-purpose HRA" that only reimburses employees for expenses that are exempt from the HSA deductible requirement.

These expenses are:

- Health insurance premiums
- Long-term care premiums
- Dental expenses
- Vision expenses. ❖

Study Findings

Small-Group Market Remains Stable under the ACA

A NEW REPORT has concluded that the Affordable Care Act, which took full effect in 2013, did not result in a significant change in the number of employers offering health insurance, although the rate at which small employers offered coverage declined slightly by 2.6 percentage points between 2013 and 2020.

The study by the Urban Institute found that the small-group health insurance market remained relatively stable during those seven years, a period marked by employers continuing to shift more of the premium burden to their employees.

As of 2020, about half of small employers (companies with fewer than 50 employees) offered health insurance to their staff, while 99% of large companies offered health plans.

Employers with fewer than 50 workers are not subject to the ACA's employer mandate, which requires firms with 50 or more employees to provide affordable health insurance that covers a slate of benefits mandated by the landmark law.

The study found that smaller employers are still less likely to offer health coverage than their larger peers. The share of employers of workers with group health coverage in 2020 was:

- 81% for companies with 25-99 employees.
- 56% for companies with 10-24 employees.
- 30% for companies with fewer than 10 employees.

The study authors wrote that whether small firms offer health insurance coverage varies substantially. "Though many small firms such as restaurants and retail stores primarily employ low-wage and part-time workers, other small firms, such as professional services firms, primarily employ full-time and high-wage workers.

"Thus, average trends for all small firms may hide differences among them," they said.

Premiums growth

The average annual inflation rate for group health premiums remained steady between 2013 and 2020, with average increases of 3.2% in the small-group market and 3.7% in the medium- and large-group markets.

Despite that, most employers continued shifting the premium costs to their employees:

- Workers in firms with 1,000 or more employees contributed on average 26% in 2013 for family plans, and the same in 2020.
- Workers in firms with between 100 and 999 employees contributed on average 30.5% in 2014 and 32% in 2020.
- Workers in companies with fewer than 50 employees paid 29% of premium costs in 2013 for family plans, a rate that had risen to 35% in 2020.
- Employees working in firms with fewer than 10 employees have had the lowest contribution rates across all firm sizes for both single and family premiums over the past two decades (the report made this assertion, but provided no data).

The present

Despite early concerns that the ACA would result in many small employers dumping coverage for their workers, the changes were muted at best.

In fact, offer rates among small employers have remained steady in recent years, except for the blip in 2020. And during the 10 years prior to the enactment of the ACA, the number of small employers offering coverage had been dwindling rapidly.

Small employers have had to continue offering health benefits to remain competitive in the job market, and that shows no signs of abating now. ❖