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HDHP Reimbursement

Pre-Deductible Telehealth Cover Restored Until Dec. 31

AN EXPIRED provision that authorized high-deductible health plans to reimburse for telehealth and other remote health care services before the deductible has been met, has been revived.

The provision was extended from April 1 through Dec. 31 after President Biden signed the Consolidated Appropriations Act of 2022.

Due to the COVID-19 pandemic and ensuing emergency legislation, HDHPs had been required to cover telehealth services with no out-of-pocket costs for the health plan enrollee, but those rules expired at the end of 2021.

The extension was included in the budget bill as telemedicine has grown in popularity because it's convenient particularly for people who have to travel far to their appointments. It also expands provider choice and access, proponents say.

HDHPs are usually only required to cover preventative care and 10 essential services mandated by the Affordable Care Act with no out-of-pocket costs for the policyholder. All other medical care must be paid for by the enrollees until they meet their deductible.

If a health plan were to violate this rule, it would result in the enrollee being barred from contributing to their attached health savings account (HSA).

The HDHP exemption was initially codified by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), a sweeping relief package to keep the economy afloat at the start of the pandemic.

The technical language of the act stated that HDHPs remain qualified for the purposes of HSA contributions if they cover telehealth or remote medical services before the enrollee has met their deductible. The exemption expired on Dec. 31, 2021.

That means there was a gap of three months through March 31 when coverage for telehealth before meeting their deductible would result in an HDHP enrollee being ineligible from contributing to their HSA.

This could result in confusion among enrollees, so employers need to be prepared for this.

What employers should do

As a result of this change, you should review your plan documents and summary plan descriptions to see if they have been updated to reflect this new HDHP exemption starting April 1. If not, contact your insurer to get updated documents.

You should also inform your staff about the changes via usual company communications, memos and as an agenda item at your next company meeting. ❖

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

Temporary Shift

Employers See Staff Drop Coverage, Sign Up on Exchanges

A SURGE in federal government subsidies has led many people to drop their employer-sponsored health insurance and instead seek out coverage on government-run Affordable Care Act exchanges, according to a report by the Kaiser Family Foundation.

Subsidies, which were increased substantially by COVID-19 stimulus legislation, are so large for some who purchase coverage on exchanges that many of them can access ACA plans that cost just a few dollars a month, depending on their income, according to the report.

But the defectors are likely to return to their employer-sponsored health plans as the subsidies are set to expire at the end of 2022, which will likely make their employer-sponsored coverage more affordable. Only individuals who work for organizations that have fewer than 50 full-time workers have been able to make this switch and enjoy low premiums.

Individuals who work for employers that are large enough to qualify as "applicable large employers" are barred from jumping into the individual market as they do not qualify. They instead are required to sign up for their employer's group health plan or forgo coverage altogether.

What's happening

The American Rescue Plan, which took effect in 2021, expanded and increased tax credits available for purchasing coverage on federal- and- state-run exchanges through the end of 2022.

Before that, the law limited eligibility for premium tax credits through the federal and state exchanges to households whose income is from 100% to 400% of the poverty level.

The stimulus bill removed that cap for 2021 and 2022, as well as limit the amount anyone pays in premiums to 8.5% of their income as calculated by the exchange. That means someone who made 450% of the poverty level would receive a premium tax credit that would reduce the premium they pay to 8.5% of their income. In those cases, the total tax credit runs into the thousands of dollars for the year.

The premium tax credit is based on factors that include income, age and the benchmark "silver" plan in a person's geographic area. The amount they qualify for is basically advanced to them over the course of the year via reduced premiums. If they choose a bronze plan, they can greatly reduce their share of the premium.

These effects have been most pronounced for lower- to middle-income and single-income households.

However, the premium tax credit comes to an end on Dec. 31, 2022, and the premium tax credit regime reverts to the prior one.

How to handle next open enrollment

It's advisable that you assess your health insurance enrollment and see if any of your staff dropped their group health coverage and signed up for individual coverage on the exchange. If you are an applicable large employer, that should not have happened for the reasons mentioned above.

If you are a smaller employer not subject to the ACA, you should reach out to any employees who signed up on an exchange and advise them about the impending premium tax credit changes. Inform them that reverting to the old premium tax credit rules is likely to result in their share of the premium increasing substantially.

Remind them that your annual open enrollment is their only chance to secure group health coverage and that they should review their marketplace coverage as early as possible.

If they wait too long and miss your open enrollment deadline, they could be stuck with the more expensive marketplace coverage. ❖

REVERSE MIGRATION: *Employees that flew south to ACA marketplaces are likely to return to your group health plans once subsidies end.*

Getting It Right

How to Improve Your Benefits Communications

FOR MOST employers, the number one objective of their compensation and benefits planning is recruiting and retaining top talent.

And so many employers invest a great deal of money in premium, fees and matching contributions in order to provide a competitive compensation package for their employees.

But too many employers stop there. They have a fantastic selection of benefits, and pay all the expenses of maintaining them for their employees – but they do not receive full value for their investment because the value of that benefits package has not been communicated to their workforce.

After all, it does no good to pay for the benefits for these employees if they don't know what they are, or they don't realize their value.

A recent survey from payroll firm ADP found that four out of 10 workers didn't understand their own benefit packages.

Here are several ideas to help you communicate the value of your benefits package to your employees.

Brand it, give the package a name

Prominent retailer Target calls their package "Bullseye Benefits," for example.

Then once it has a name, sell it to employees like your sales force would sell the benefits of your product or service. Set it up as something that differentiates your company from other employers.

That way, every change you make to the plan gives you a chance to talk up your value package to your employees. For example, "We're excited to announce an enhancement to your Loyal Employee Rewards Package."

Create posters, flyers and brochures that all use your branding to describe your employee benefits package. You'll know you're doing it right when employees begin to use the term among themselves, and brag about it to their friends and acquaintances. That will make recruiting new talent much easier.

Employ multiple media

Not everybody spends a lot of time online. And not everyone is going to open their mail. Different people connect with different forms of communication. If you have a message to get out, get the word out in at least three ways across digital and print media.

Getting the Message Out

Employers are communicating benefits as follows:

- Print mailers sent to employees' homes: 89%
- E-mail: 73%
- Print materials distributed at work: 69%
- Internal websites/intranets: 66%
- External websites: 58%

Source: International Foundation of Employee Benefit Plans

Leverage vendor websites

These are excellent for communicating a lot of technical information about a specific benefit and how it works. It's also great as a data capture technique.

The downside: Unless you have a custom portal, it's somebody else's brand on those benefits, not yours. So if you use a vendor website, do something else in addition to that, to put your own stamp on your employee benefits.

Set up in-service workshops

You can have these every time you roll out a new benefit, or at the beginning of open enrollment. If you are adding one brand-new benefit, use the opportunity to talk up the package as a whole. Spend a few minutes going over the entire package before focusing too much on the new one.

Don't rely on HR to do all the communicating

It's HR's job to prepare the materials and support. But management and executives should be visible and up front in selling the benefit package to rank and file employees.

Communicate the total value as much as you can

For example, send out a total compensation statement every quarter or every six months. Include premiums paid on employees' behalf.

For many smaller employers, it can be tough to execute an entire benefits communications strategy alone. However, we are standing by and ready to support you. ❖

Legislation

Measure Would Cap Insured Out-of-Pocket Insulin Cost

THE U.S. House of Representatives has passed legislation that would cap the out-of-pocket cost of insulin at $35 a month for people with group or private health insurance.

While the measure still has to face a vote in the Senate, it has broad backing after the cost of insulin has skyrocketed in recent years. People who used to pay less than $100 a month for the vital medication are sometimes paying more than $1,000, depending on their health insurance coverage.

More than 37 million Americans have diabetes, and this legislation could be a game-changer for the estimated 7 million who have to take insulin to control their condition.

In the past decade, the cost of insulin has tripled in the United States, with average out-of-pocket costs rising to about $666 a month. But some people need specific brands and can pay more than $1,000 a month for their brand.

For example, David Tridgell, a Minneapolis endocrinologist, wrote an op-ed in *The Washington Post* citing the costs typical diabetics face:

- Patients with Type 1 diabetes tend to use two or three vials of insulin per month. At the current cost of one vial of Humalog 50/50, these patients would spend $780 to $1,170 on their insulin every month.
- Type 2 diabetes patients sometimes need six or more vials a month, which would run up the costs to $2,341 or more every month.

It can be especially costly for individuals enrolled in high-deductible health plans, in which enrollees have to pay the list price for their insulin until their deductible is met.

This could mean thousands of dollars out of pocket before the insurer will cover the drug. Because of the soaring costs, many people report reducing dosages or rationing to make their insulin last longer.

Diabetes can lead to other serious health complications including kidney failure, heart disease and loss of vision.

How it would work

HR 6833 would bar private health insurers, health plans and self-insured employers from applying a deductible on insulin and require that diabetics pay no more than $35 or the amount equal to 25% of the negotiated price of the selected insulin product, whichever is lower.

For no more than $35 a month, the Affordable Insulin Now Act would require private group or individual plans to cover both vial and pen dosage forms and any of the following insulin types:

- Rapid-acting,
- Short-acting,
- Intermediate-acting, and
- Long-acting.

Medicare Part D plans, Medicare stand-alone drug plans and Medicare Advantage drug plans would be required to charge no more than $35 for whichever insulin products they cover in 2023 and 2024, and for all insulin products beginning in 2025.

HR 6833 passed on a vote of 232 to 193, with 12 Republican representatives voting with the Democrats. The measure has been sent to the Senate. If it passes the Senate and is signed into law, it would take effect in 2023.

We'll keep you posted if this bill lands on President Biden's desk and he signs it. ❖