Employee Benefits Report

PomeroyGroup
INSURANCE BROKERS & CONSULTANTS

3134 N. 7th Street, Phoenix, Arizona 85014 | (602) 265-8900 Main (602) 230-0398 Fax | info@pomeroygroup.com

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No Surprises Act Fails to Remove All Surprises

A new document designed to clarify the No Surprises Act regulations addresses some medical billing issues but leaves other important guidance to be determined later.

The No Surprises Act (NSA) is a part of the Consolidated Appropriations Act of 2021 (CAA). It provides federal protections to patients who get bills for receiving care out of network — in circumstances when they did not know the service was out of network. One of the key points of the NSA provisions is removing the patient from disputes between payers and providers.

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This Just In …

Agent commissions are now more transparent.

The federal budget act, the Consolidated Appropriations Act of 2021, features a section requiring health insurance agents and brokers to detail their services to ERISA-covered group health plans, including their direct and indirect commissions if they are expected to total $1,000 or more. This portion of the law went into effect December 27, 2021, and pertains to employer-sponsored health plans as well as enrollees in short-term medical plans. The law does not apply to welfare plans that don't provide health care, such as life

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A study by the Office of the Assistant Secretary for Planning and Evaluation Office of Health Policy found that surprise bills occur frequently and can have a negative effect on a person's budget. "On average, 18 percent of emergency room visits by people with large employer coverage result in one or more out-of-network bills and nearly 20 percent of patients undergoing in-network elective surgeries or giving birth in a hospital received surprise bills," according to the study.

Surprise bills averaged more than $1,200 for anesthesia; $2,600 for surgical assistants; and $750 for childbirth.

President Donald Trump signed the NSA as part of the Consolidated Appropriation Act of 2021 on Dec. 27, 2020. Most sections of the legislation went into effect on Jan. 1, 2022, and the Departments of Health and Human Services, Treasury and Labor have responsibility for issuing regulations and guidance to implement several of the provisions. Prior to the law going into effect, the Office of the Assistant Secretary published an issue brief about the NSA to explain:

- Why the rule is needed
- State-level approaches
- Key provisions of the rule
- Implementation
- How it will impact consumers
- The process for resolving disputed.

While the NSA gives employers some direction on how to navigate the new law, there remains some controversy about the Act's interpretation. For instance, the brief does not address:

- Proposed arbitration rules
- Concerns of 152 lawmakers who signed a letter arguing that the rules "do not reflect the way the law was written, do not reflect a policy that could have passed Congress, and do not create a balanced process to settle payment disputes."
- How to protect consumers against "exorbitant charges and balance billing when using ground ambulance services."

The brief can be found at https://tinyurl.com/2p8cv9ke

What You Need to Know

The No Surprises Act requires providers and health plans to assist patients in finding health care cost information.

The NSA protects patients from receiving surprise medical bills when there are gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including by air ambulances.

In general, the NSA provides that an employee who has either private or employer-sponsored health care coverage, and who receives a bill for medical services received during an emergency from an out-of-network provider, will only be liable for paying deductibles and in-network cost-sharing amounts.

Providers and insurers will need to work together to negotiate reimbursement to the provider. If a dispute arises, the NSA states that this will be handled using an independent dispute resolution process. The legislation does not set a benchmark for how much reimbursement should be for services. ■

and disability plans.

Agents must provide employer groups with a fully documented description of the services they provide, although the exact method of reporting this information or the types of forms to be used have not been determined by the Department of Labor.

Your agent must alert you to any change in compensation no later than 60 days after identifying the change and within 90 days upon receiving a written request for plan information.

Health insurers offering individual and short-term health insurance coverage are required to disclose to enrollees and to the HHS all compensation provided to agents and brokers associated with plan selection and enrollment.

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Early Retirees Need Health Coverage Options

It's a dream come true for many Americans when they realize they can retire early.

Normally, retirees can take advantage of Medicare, which is the federal health insurance program for people 65 or older (though it may also cover younger people with disabilities or people with End-Stage Renal Disease).

But when people retire early, they are too young for Medicare. What are their options?

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act), in general, requires employers with 20 or more employees offering health plans to provide employees and certain family members the option to extend their plan for up to 18 months when coverage would have lapsed, such as upon retirement. The downside with COBRA is that employers are not required to subsidize the costs of the plan as they normally would. Consequently, the coverage may be unaffordable. In addition, employees might have to pay an additional 2 percent administrative fee.

Phased Retirement

Many large firms used to offer formal phased-retirement plans that included health insurance, but now only one in 10 employers does, according to NerdWallet. Alternatively, companies offering early retirement health insurance usually provide an alternate program with fewer benefits or the company health insurance at a higher premium than they offer to current employees.

Spouse

Early retiring employees with an employed spouse or partner who has employer-sponsored health coverage may be able to obtain coverage through their spouse or partner's plan.

Private

Early retirees may wish to apply for private insurance, though prices are likely to be a lot more than they've been paying.

Short-Term

Short-term health insurance is intended as temporary for people who have a health insurance coverage gap. Coverage varies from one month to one year and, depending on the state, there is an option to renew for up to three years.

Short-term plans are cheaper than standard health insurance, but they aren't the same as major medical insurance. The plans have limited benefits and can lead to substantial out-of-pocket costs. They also are not Affordable Care Act (ACA) compliant. They don't cover the 10 essential minimum benefits and anyone with a pre-existing condition, such as diabetes or cancer, will not be accepted for coverage. There are also limits on the number of covered doctor visits and prescription drug coverage. There's no coverage for maternity.

On the positive side, someone can enroll anytime and there is no waiting period. Coverage may be effective as early as the day after the application is made. Most short-term plans have open networks, which means policyholders can select the doctor or hospital of their choice.

Marketplace

The ACA Health Insurance Marketplace offers major medical coverage including the 10 essential health benefits required by the ACA. These benefits range from emergency to laboratory services. No one who applies can be denied coverage for having a pre-existing health condition.

Costs for marketplace plans vary, depending on the applicant's location and the level of coverage. The downside is that ACA plans can be very expensive if the applicant does not qualify for a subsidy. However, anyone whose income is between 100 percent and 400 percent of the federal poverty levels may be eligible for a Premium Tax Credit (PTC). You may also be eligible

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for some PTC if your income exceeds 400%.

One important limitation with an ACA Marketplace plan is that the networks are more narrow, so applicants may not be able to get their preferred providers.

Direct Primary Care

Direct primary care, often referred to as concierge care, is a way for early retirees to get coverage for basic doctor services. This type of coverage is growing in popularity because patients get same-day visits, 24-hour availability, low waiting room times, and house calls.

Patients pay a monthly membership fee that covers basic primary care services. There are no monthly health insurance premiums or copays. Direct primary care does not extend beyond primary services, however. People who get this type of coverage should also enroll in a high deductible health plan (HDHP), to cover catastrophic care, such when a patient requires emergency, serious, or extensive care.

Regardless of which coverage type your employee favors, it will be to their advantage to talk to an insurance agent or broker to make an informed choice. ■

New Saving Incentive for Grandparent-Owned 529 Plans

The Consolidated Appropriations Act has made it easier for grandparents to save money for grandkids in an employer-sponsored 529 plan — starting with the 2023-2024 academic year.

A 529 plan is a tax-advantaged em ployer-offered savings account employees can use to save for Kindergarten through grade 12 tuition, or for higher education and trade schools for themselves or a child. The funds typically are invested in stock and bond funds and 529 account owners don't have to pay capital gains taxes on earnings when withdrawn for qualified education expenses.

Saving for college has become an imperative for many families as parents have taken on more than $100 billion of the $1.7 trillion U.S. student debt, according to SavingforCollege.com, the U.S. Federal Reserve and the Federal Reserve Bank of New York. To help their children with college costs, many parents have taken out equity loans or reduced their 401(k) contributions. For

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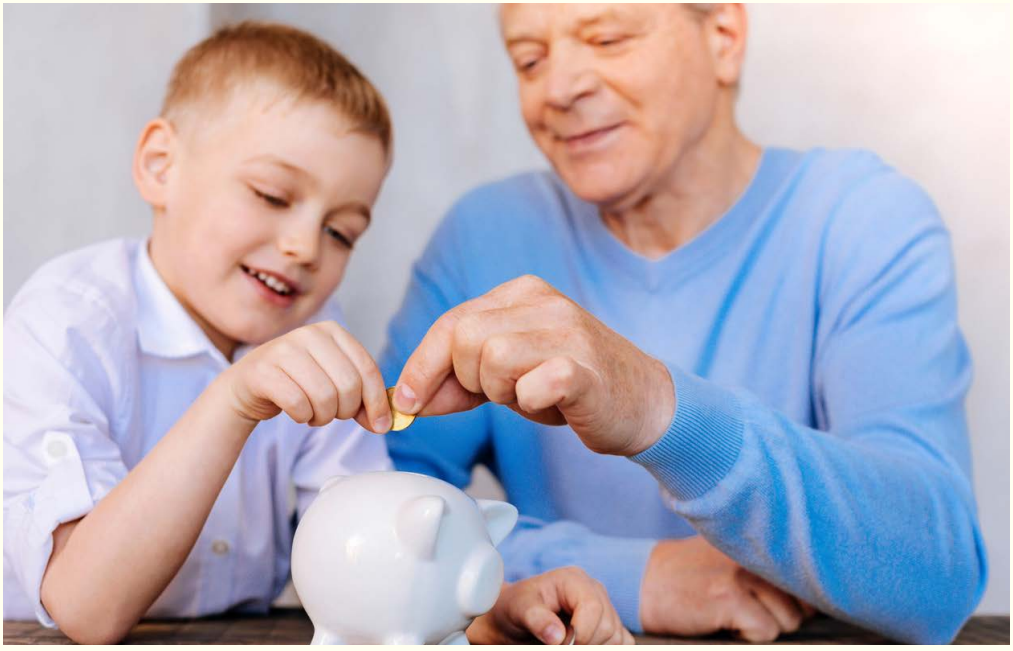

these reasons grandparents have become interested in helping their grandchildren save for college through a 529 plan.

The 529 plans were created in the late 1990s to help parents. In 2019, the SECURE Act made it possible for families to also use the plans to pay K-12 tuition for their children, as well as for apprenticeships, college and trade schools and to pay for student loans.

Another big change came in 2021, when the Consolidated Appropriations Act called for changes to the Free Application for Federal Student Aid (FAFSA) process. It was assumed the changes would happen soon after, but the Department of Education announced in June 2021 that the proposed FAFSA simplification changes will be delayed. Instead, the provisions will happen in phases beginning in 2021 and lasting through 2025. A new FAFSA form that allows for changes affecting grandparents' contributions will not be released until October 1, 2022, for the 2023-2024 academic year.

That means that grandparent 529 plan distributions — as well as contributions made by non-custodial parents and friends — currently may count as untaxed income on a student's FAFSA. For instance, a grandparent who takes a $10,000 529 plan distribution to help pay for college can reduce their grandchild's aid eligibility by $5,000.

Generally, though, 529 plans have a minimal effect on financial aid. For instance, FAFSA ignores distributions from a parent-owned 529 plan.

Employer Contributions

Employers can make matching contributions, but these contributions will increase an employee's taxable wages. Still, many employees perceive this as free money and participation in a 529 usually increases when employers offer matching contributions. In addition, while contributions to a 529 plan are not deductible at the federal level, more than 30 states offer a tax deduction or credit for contributions.

There are some administrative complexities to consider. For instance, with some traditional state-sponsored 529 plans, an employee who wants to change a contribution usually has to log into the state-run 529 site, change their monthly contribution, print out a form, and give that form to their benefits administrator. The benefits administrator must manually adjust the employee's payroll deduction in their payroll software.

There are options, so it pays to do your research. Some companies, such as financial technology firms, offer 529 plans that integrate with state-run 529 plans and offer a simplified user and enrollment experience.

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DCAP – Use it or Lose It

Employers who are interested in implementing a Dependent Care Assistance Plan (DCAP) or adopting additional flexibility should consult legal counsel, as well as the Internal Revenue Service's (IRS) Notice 2021-26. The notice clarifies what amounts may be reimbursed under a DCAP on a tax-favored basis for 2022.

A DCAP functions much like a health flexible spending account and allows an employer or employee to contribute funds to an account that can be used to reimburse dependent care expenses on a tax-favored basis. Employee contributions to DCAPs are made through the employer's Section 125 cafeteria plan. Common eligible expenses include a nursery school, preschool or similar program below the kindergarten level; before- or after-school care; child-care centers; day camps; and in some cases, babysitters. Employees must decide, at the beginning of the coverage period, what they are going to contribute over the duration of the coverage period (plan year).

Regardless of who makes the contributions, the annual contribution amount in 2022 is limited to the lesser of:

- $5,000 for single individuals or married individuals filing joint tax returns ($2,500 for married individuals filing separately)
- The earned income of the employee/spouse

This amount is lower than the $10,500 that was allowed in 2021.

Income put into a DCAP must be used or forfeited. However, plans may allow a two-and-a-half month grace period during which employees can still incur expenses and submit claims to the DCAP. Employees who have money left over at the end of the plan year, including the grace period, must state as taxable income any amount reimbursed above $5,000 during the calendar year.

Employers should report DCAP contributions in Box 10 on employees' Forms W-2. ■