Life & Health Insurance Advisor

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Medical Billing Spring 2021 Volume 14 • Number 1

Congress Takes the Surprise Out of Surprise Billings

Congress is putting an end to surprise billing by hospitals.

Consumers can look forward to January 2022 as an end to unexpected — or "surprise" — medical bills. Congress passed a bill in December to stop this practice.

Surprise medical bills, also referred to as balance billing, occur when patients are billed for care received from out-of-network providers where insurance covers none or only a small portion of the costs. This sometimes happens accidently. Patients often

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Permanent Life Insurance Cash Value Accounts Get a Boost

A revision of the federal tax code will make it easier for permanent life insurance policy holders to contribute more money to their cash-value accounts.

Permanent life insurance policies feature both a death benefit and a savings component, but lawmakers in 1984 were concerned that investors were treating permanent life insurance policies too much like investments. So, to regulate that they implemented an interest-rate floor to determine whether permanent life insurance policies are too much like investments to qualify for tax advantages granted to insurance policies.

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choose in-network hospitals, only to later discover that a provider working at the hospital is not in-network.

The legislation comes after two years of debate and negotiation between members of Congress, hospitals, insurers, patient advocacy groups, physicians and air ambulance companies. The bill also includes a package providing coronavirus economic relief and government funding for the rest of the fiscal period.

Here are some highlights of the bill:

Fewer surprise bills

Consumers no longer will be billed for out-of-network costs when they:

- Seek emergency care — Patients who come to an out-of-network facility for a medical emergency will be covered for all care they receive until discharged or stabilized enough to be transferred to an in-network benefit level facility.
- Are transported by an air ambulance.
- Receive non-emergency care at an in-network hospital where they are unknowingly treated by an out-of-network physician or laboratory. Most hospital-based specialists, such as anesthesiologists, neonatologists, radiologists and surgeon's assistants, fall into this category.

Patients will still be required to pay the in-network deductibles and copayments. Plus, they will need to pay the costs of any out-of-network providers they choose to see. The legislation also doesn't cover ground ambulance services.

The Department of Health and Human Services will create a provider-patient bill dispute resolution process for those who are uninsured and for whom everything is out of network.

When Balance Billing is Allowed

Physicians can balance-bill their patients if they get the patient's consent in advance and it is a non-emergency situation. For instance, a patient might want to see an out-of-network physician, perhaps a surgeon or obstetrician, who has been recommended by a friend. However, certain types of physicians are barred from this practice, including anesthesiologists, radiologists, pathologists, neonatologists, assistant surgeons or laboratories.

To get permission to balance bill, the physician must provide a cost estimate and get patient consent at least 72 hours before treatment. If it's not possible to give 72 hours notice, patients must receive the consent information the day the appointment is made.

Negotiated Payments

Once the decision was made that patients won't have to pay, lawmakers agreed that providers and insurers will have to decide who will cover the higher fees.

Insurers and providers now have 30 days to negotiate payment of out-of-network bills. If the insurer and health care provider cannot reach a resolution, they must work with an independent arbitrator. The Department of Health and Human Services will set up the arbitration system.

However, during the last decade, rates have dropped so low, the 1984's four percent minimum limit was well above long-term government-bond yields.

The new law, which took effect Jan. 1 for new life insurance sales will allow policy owners to put more in the savings portion.

One of the benefits of a permanent-life policy is that the owner can defer taxes on their investment gains, and their beneficiaries receive the death benefit tax-free. Policy holders also can use money from the policy savings account to help fund the policy's future costs or for other uses. The 1984 rule, Section 7702, effectively stopped policyholders from putting huge sums of money into policies to avoid tax bills.

Physicians and hospitals will be barred from using their "billed charges" during arbitration because these charges usually are much higher than negotiated rates and may bear little relation to the actual cost of providing the care.

In addition, arbitrators will not be allowed to consider Medicare or Medicaid prices during arbitration, because those payments often are far lower than the negotiated rates paid by insurers and self-insured employers. Instead, the arbitrators will be allowed to consider the median in-network prices paid by each insurer and factor in the extent to which circumstances necessitated receiving care from an out-of-network services provider.

Policy analysts believe this new law will ultimately result in prices falling back to within

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in-network norms.

The "No Surprises Act" won't go into effect until January 2022, giving the Secretary for Health and Human Services time to craft enforcement rules and for providers and insurance companies to implement data and paperwork changes.

State Laws May Change

Thirty-two states already enacted some type of surprise billing protections. Of those, the Commonwealth Fund rates only 17 as comprehensive and many apply only to certain types of insurance.

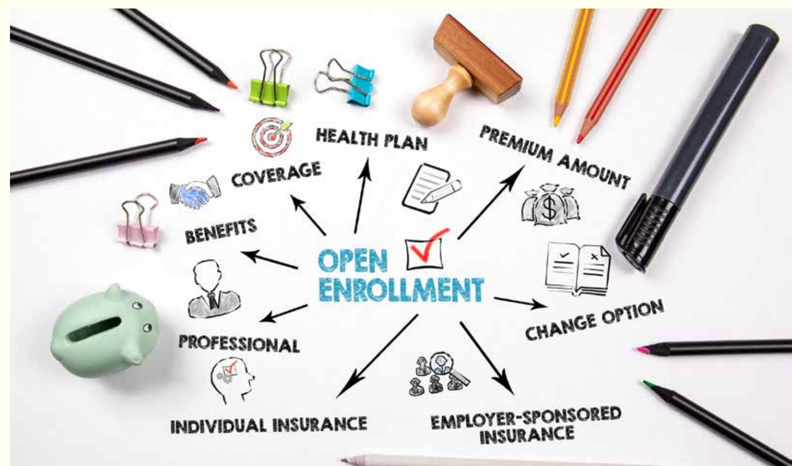
The new federal rules will cover most types of insurance plans, including those offered by self-insured employers. In addition, some provisions in state law, such as how to determine a payment, differ from the federal law. In these cases, the federal law defers to states.

Observers expect that state lawmakers may eventually alter their legislation or adopt new proposals to avoid confusion. ■

Pros and Cons of Having Two Health Insurance Policies

If having one health insurance policy is good, is having two even better?

There are advantages to having double or multiple policies, but it's not a guarantee that all your expenses will be covered. So, before paying for more than one policy, it's important to understand how dual coverage works.



First, it is legal to have more than one plan, and there are a variety of reasons why you might have more than one. For instance, if you're:

- Under age 26 and have coverage through your parents and your employer.
- Married and have coverage through your and your spouse's employers.
- Under 26 years old with married parents who have you covered under both their plans.
- Under 26 and you're married and covered by your spouse's plan and one of your parents' plans.
- Covered under a health insurance plan and receive Medicaid coverage.

How it Works

If you have more than one plan, first make sure that the doctors you are seeing are covered by both plans.

Your primary insurance will pay first, up to your coverage limits. Determining which of your policies is primary insurance depends on the situation. For example, if you're:

- Covered under insurance by both your parents, primary coverage will come from the parent whose birthday comes first in the calendar year (age has nothing to do with it).
- Under 26 and covered by your school/employer's plan and your parents' health plan, then your school or employer-sponsored coverage is primary.

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- Married and both you and your spouse have coverage through your employers, your employer's coverage is primary.
- Under 26 with divorced parents who both cover you under their separate policies, the parent who has custody is the primary coverage. If both parents have joint custody, the birthday rule applies.
- Under 26, married and covered by both your spouse's plan and your parents' plan, then your spouse's plan is primary.
- Covered under a health plan and receive Medicaid, your health plan pays first.
- Covered under Medicare and a private health plan, then Medicare pays first if your employer has fewer than 20 employees

After your primary insurance pays its portion, you will still need to cover any deductibles, cost sharing or out-of-pocket expenses, such as copayments or coinsurance. But your secondary insurance kicks in once your primary insurance has paid its share. Your secondary insurance may cover part or all of the remaining cost if the procedures or services are deemed covered and necessary.

It's important to remember that both the primary and secondary insurance will only cover up to plan limits. You may be responsible for any remaining amount that wasn't covered.

In addition, if your primary insurance is a HMO (Health Maintenance Organization) plan, and you see a provider who is out-of-network, your primary insurance won't cover the costs AND your secondary insurance won't cover the costs either because you didn't follow the primary plan's rules.

Pro

If you're prone to illness, then dual or multiple coverage can help reduce your health care costs. Plus, if you have two plans, you don't need to worry about being uninsured if you lose your job and employer-sponsored health insurance.

Before deciding to take this route, it's important to estimate whether the cost of paying premiums under two plans and incurring two sets of deductibles would outweigh the extra coverage of having two plans.

Cons

Having dual coverage may require more paperwork if a health plan denies a claim or pays less than you expected.

Plus, you'll have to deal with two insurance companies. Each company's plan could have a different design, such as a preferred provider organization (PPO) and health maintenance organization (HMO) plan. Or one plan may agree to pay for a test or prescription, while the other may deny it.

You'll need to make sure all of your providers accept both plans and that you follow the in-network guidelines, if applicable.

Because of deductibles and other plan features in the dual policies, you may still not be able to have all your costs covered.

The Increased Importance of Life Insurance During the Pandemic

The popularity of life insurance has grown during the pandemic. Here's why it's a wise purchase.

Interest in purchasing life insurance has soared during the pandemic. Experts say that now may be the best time to buy it, before prices rise to cover the cost of COVID-19 related illnesses.

According to the MIB Life Index, the life insurance industry's timeliest measure of application activity across the United States, life insurance applications during the first half of 2020 increased 1.5 percent from the previous year. Applications for those younger than 44 rose about 3.4 percent, while activity for ages 45 to 59 was up 0.5 percent.

As states implemented shelter-in-place orders and several states had massive outbreaks, more people began to worry about their mortality and whether buying life insurance might be a good addition to the family's financial strategy.

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Why Now?

Anytime is a good time to purchase life insurance if you're in a situation where you want to provide for your dependents' financial future. However, experts point out that shelter-in-place rules and increased demand have made it an optimal time to purchase life insurance because medical exams often are being suspended.

In addition, three primary providers of life insurance medical exams have stopped operating. But insurance companies have not stopped writing life insurance policies. Without in-home visits and medical exams, the result is a considerable shortening of the normally lengthy application process that includes labs, doctors' visits, documentation and in-person meetings.

Instead, some insurers have been using data from electronic health records and prescription databases as a substitute for medical exams. However, insurers may still ask for a medical exam if the individual is looking for $1 million or more of coverage.

It's expected that companies will eventually re-introduce exams in exchange for lower rates.

But prices will go up soon. Experts say your chances of getting a good rate are better now. The COVID-19 mortality risk is too high for many companies to keep offering policies at current prices. Life insurance rates are expected to eventually increase 5 to 10 percent over the next year, or carriers will reinstate requirements for medical exams.

What to Expect Now

Insurers usually ask questions about an applicant's health, prescriptions, family health history, driving record and dangerous activities such as sky-diving.

Since the insurer is assessing risk, COVID-19 questions are becoming a standard part of applications. Answering questions positively about COVID-19 could lead to the postponement of getting coverage. Plus, there's uncertainty about how the virus will affect a person's long-term health and life expectancy.

While some insurers may rely on reviews of your medical records, others are using previous doctor's visits or in some cases, still sending medical professionals to the applicant's home.

Two Basic Types of Policies

There are two basic types of life insurance policies — term and permanent.

Term life insurance covers a person for a specific period, usually 10, 20 or 30 years. If the policy holder dies while the policy is in place, their beneficiaries will receive the death benefit.

Permanent life insurance — which includes universal life, variable life and whole life — covers the policy holder as long as they are paying the premiums. Not only does the policy pay a death benefit, but it creates a savings account where the policy holder can earn a minimum guaranteed interest or dividend.

Need more information? Contact us to learn about your options and what policy and application process might be best for your situation.

Social Security Adjustments for 2021

The Social Security Administration (SSA) made two decisions regarding earning limits and cost of living increases that positively affect monthly benefits.

Earnings Limits Adjusted

Individuals who work part or full time and are receiving Social Security benefits before reaching their full retirement age (FRA), are subject to the retirement earnings test. If they make more than the annual limit, they will receive less in monthly benefits.

In 2020, the limit was $18,240 per year and $48,600 per year for those nearing and reaching their FRA. The SSA increased the minimum for 2021, so if a worker doesn't reach FRA any time this year, they may now earn up to $18,960 without having their benefits reduced. If they earn more than that amount, their payments will be reduced by $1 for every $2 they earn over the annual limit.

If the worker reaches their FRA in 2021, their earnings have a different limit — $50,520. For every $3 they earn over that, their benefits will be reduced by $1.

The reduction is not permanent. The SSA will recalculate each retiree's benefit amount once they reach their FRA, and then they'll start receiving larger checks to compensate for the amount withheld. After they reach their FRA, benefits will not be reduced, regardless of income.

Cost of Living Increase

The SSA's cost of living adjustment for 2021 is 1.3 percent for Social Security and Supplemental Security Income benefits, which assist low-income individuals who are disabled but who haven't worked enough to qualify for Social Security Disability Insurance.

The Social Security Act ties the annual cost-of-living adjustment to the increase in the Consumer Price Index as determined by the Department of Labor's Bureau of Labor Statistics.

The SSA also increased the maximum amount of earnings subject to the Social Security tax from $137,700 to $142,800.

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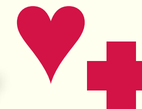

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