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BARNARD INSURANCE GROUP

THE BARNARD BULLETIN

Regulatory Action

New Rules: Health Plans Must Cover COVID-19 Vaccines, More

THE TRUMP administration has issued interim final rules that set out coverage requirements for COVID-19 preventative services and covering out-of-network testing for the coronavirus.

There are two parts to the regulation:

- One requires that COVID-19 preventative services – including vaccines – be covered without any cost-sharing.
- The second creates a reimbursement formula for insurers to pay for COVID-19 testing conducted on their enrollees by out-of-network providers.

The new rules, which implement important parts of the CARES Act, were rolled out by the Treasury, Labor, and Health and Human Services departments.

If you are a plan sponsor, you need to know how this affects your group health plan so you can help your staff understand how testing and preventative COVID-19 services are covered.

COVID-19 preventative services

The CARES Act requires that COVID-19-related preventative services be covered within 15 business days after a doctor recommends them.

Preventative services must be covered without any out-of-pocket costs on behalf of health plan enrollees, whether they receive those services inside or outside their plan's provider network. The reason for this is that as vaccines roll out, not all providers may have access in the beginning.

Under the rules, insurers must pay out-of-network providers a "reasonable amount," which would be determined by the prevailing market rates that providers are charging health plans for the service.

Finally, if a preventative service, including a COVID-19 vaccine, is not billed separately from an office visit, and the primary purpose of the visit is to deliver a vaccine, the insurer cannot require any cost-sharing on the enrollee's part.

Out-of-network tests

The new rules also require that:

- Health care providers post on their websites the cash price or any lower negotiated price for COVID-19 testing.
- Health insurers pay out-of-network providers of COVID-19 diagnostic tests the price posted on their websites.

The takeaway

If you sponsor a group health plan, you should communicate the new rules to your participating employees so that they are aware of the no out-of-pocket rules for COVID-19 preventative services.

You should also keep up with the news about when vaccines will be rolled out in your area, so you can encourage your staff to get vaccinated.

The rules will sunset at the end of the public health emergency. Currently, that's slated for Jan. 21, 2021, but is bound to be extended as it is clear vaccines won't be rolled out en masse by that time. ❖

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WISHES YOU A HAPPY NEW YEAR

If you have questions regarding any of the articles in this newsletter or have a coverage question, please call us at:

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Coverage Trends

How COVID-19 Will Change Employee Benefits

THE COVID-19 pandemic has impacted businesses and other organizations in multiple ways. Lost revenue and the overnight change to remote workforces, among other things, have caused significant changes to operations and finances.

A new report shows that there will be long-term effects on employee benefit programs as well.

Health insurers are forecasting continued cost increases that dwarf general inflation rates, according to the report by Mercer Marsh Benefits. Most expect 2021 medical cost inflation to be 4.3%, slightly higher than in 2020. They expect the costs to continue rising next year and going forward.

The culprits? The high costs of diagnosing, caring for and treating COVID-19 patients. A survey of studies released in September showed that half of all COVID-19 patients who were admitted to an intensive care unit were there more than seven days. ICU patients who need ventilators also cost more to treat – 59% more per day, according to one report.

A new landscape for plan outlays

Like last year, 2021 will be a very different one for group health plan outlays, as a number of novel factors take center stage, including:

A rebound in elective diagnostics and treatments – Mercer Marsh predicts a rebound in some elective treatments when it is safe to resume these procedures in 2021. On the other hand, some elective procedures that were postponed will never be rescheduled as people end up taking a different non-surgical course and ideally recover from their ailment, or use lower cost-of-care virtual services.

Delays leading to greater need for care – Delays in treatment for serious conditions, such as cancer, and exacerbation of other chronic conditions, like diabetes, may require more invasive and expensive care. Many people have postponed these treatments during the pandemic and doing so may end up increasing the cost of the treatments if their conditions have deteriorated.

New claims linked to remote working – The report predicts a higher incidence of conditions relating to remote working and sedentary lifestyle, including musculoskeletal and mental health issues. According to the journal *The Lancet Psychiatry*, "A major adverse consequence of the COVID-19 pandemic is likely to be increased social isolation and loneliness … which are strongly associated with anxiety, depression, self-harm, and suicide attempts across the lifespan."

Coronavirus-specific claims – Sixty-eight percent of insurers expect to see higher outlays due to the cost of COVID-19-related diagnostics, care and treatment. There is also the issue of paying for a vaccine as they become more widely available. These costs cannot be predicted at this point.

Ongoing COVID-19 concerns – The long-term physical and mental health effects on survivors of COVID-19 are largely unknown. Some coronavirus "long-haulers," who have lingering symptoms and effects that can last for months, may require additional treatment and doctors' visits as they try to cope.

Increases to unit prices – Prices for a wide range of services are increasing as demand rises and/or to offset revenue lost due to COVID-19. Mercer Marsh found that 68% of insurers expect costs will rise in 2021 because of health providers charging more to offset revenue lost due to the cornavirus.

New PPE costs – The unit cost of care is also being driven up by the cost of personal protective equipment, which is being added to many treatment bills.

The takeaway

In 2021 and the years ahead, employee benefits will change in terms of the services they provide, the treatments they cover, and the way they will be delivered.

More doctor's visits will be done via tablet computers. Coverage for preventative medicine will increase to drive better and less expensive health outcomes. But even with that, a vicious pandemic coupled with uninvited changes in lifestyles will likely drive up the cost of those benefits for years to come. ❖

New Rulemaking

Final Regulations Require Greater Health Plan Transparency

THE TRUMP administration has issued a new rule that will require greater price transparency on the part of health insurers, including rates charged by in-network physicians and copays and costs of drugs.

The final rule requires health plans and health insurers to disclose on a public website their in-network negotiated rates, billed charges and allowed amounts paid for out-of-network providers, and the negotiated rate and historical net price for prescription drugs.

The aim of the new rule is to give enrollees more information when seeking out and price-comparing care and choosing medications. With more information about health care costs, health plan enrollees can:

- Make cost-conscious decisions,
- Face fewer out-of-pocket surprise bills, and
- Potentially lower their overall health care costs.

It's important for health plan sponsors and employers to be aware of the rules as they will greatly affect how their employees access and shop for coverage and medications.

Transparency for enrollees

Insurers will be required to make available to health plan participants the following information:

- Personalized out-of-pocket cost information (for their particular plan) for all covered health care items and services, including prescription drugs.
- Negotiated rates for all covered health care items and services, including prescription drugs.

This information must be provided through an online tool on their website, and in paper form upon request. Items or services include encounters, procedures, medical tests, supplies, drugs, durable medical equipment, and fees (including facility fees).

Insurers will be required to make available an initial list of 500 shoppable services that will be determined by the Centers for Medicare and Medicaid, starting with the 2023 plan year. The remainder of all items and services will be required for these self-service tools for plan years that begin on or after Jan. 1, 2024.

Public transparency

Health insurers will be required to make available to the public the following information in "machine-readable" files:

- All in-network rates for services and equipment.
- Historical payments to out-of-network providers.
- In-network negotiated rates and historical prices for all covered prescription drugs at the pharmacy level.

The idea behind these changes is to provide opportunities for research studies, data analysis, and offer third party developers the ability to create private apps and websites to help consumers shop for health care services and prescription drugs.

These files are required to be made public starting in 2022.

The takeaway

Once the rules take effect, your covered employees should have a wealth of information at their fingertips when they are shopping and comparing health services and drug information. ❖

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Health Care Savings

Leveraging HSAs to Help Your Staff Manage Medical Costs

WITH THE COVID-19 pandemic weighing on employers and employees alike, businesses can help their staff by leveraging health savings accounts to pay for out-of-pocket expenses.

Congress in 2020 untethered HSAs and flexible spending accounts by changing the rules that prohibited account holders from using the funds in their accounts for over-the-counter medicines and other non-prescription health products and services.

HSAs are a great option to help employees save for health care expenses since all unused funds can be rolled over from year to year (there is no use-it-or-lose-it penalty). HSAs also provide the potential to build a health care savings nest egg, the funds in which can be invested so they can grow.

THE HSA TRIPLE TAX BENEFIT

- Contributions are not subject to federal income taxes;
- Earnings from interest and investments are tax-free; and
- Distributions to pay for qualified medical expenses are tax-free.

Here are some tips to help your employees access HSAs:

Design a strong plan

HSAs must be tied to a high-deductible health plan and there are certain steps you can take to make them more attractive to your workers.

The HDHP should have a lower premium than a traditional plan in order to give your employees affordability and leftover funds to funnel into the HSA.

You can instill confidence by:

- Providing your employer contribution on the first day of the plan year to alleviate concerns about covering the deductible.
- Utilizing a Section 125 cafeteria plan to allow employees to make pre-tax salary reduction contributions.
- Putting in place a matching contribution structure to employees making salary reductions. .

Educate and support your staff

Plan your HSA messaging early and way ahead of open enrollment to maximize interest.

This should be a year-round educational effort that engages your staff and helps instill confidence in HSAs.

Remember, the messaging should be different depending on the age of your workers. You may need to have different approaches to educating baby boomers compared to Gen Z staff.

Help them make good decisions

You should be able to show your employees at a glance which health plans will save them money.

There are tools available to do cost-benefit analyses of how much an employee spends on a health plan and if it was the most cost-effective choice.

The average employee leaves $1,500 per year on the table in money they could have saved on premiums had they chosen an HDHP, particularly if they don't use health care services often.

One way to illustrate how much money they may be wasting is to provide claims-based report cards, which show whether or not they made a good choice the previous year ahead of open enrollment.

The takeaway

The goal here is to educate your workers about the power of HSAs and how having one can help them amass a substantial war chest of funds for any future expensive health care needs. If entered into early, an employee can set aside hundreds of thousands of dollars for unanticipated health care expenses.

If you provide support and education, your staff will be more engaged, resulting in them making better health care choices. ❖