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BARNARD INSURANCE GROUP

THE BARNARD BULLETIN

Payer Outlays

The Top Five Health Conditions Driving Insurance Costs

A NEW STUDY has identified the top five health conditions that are driving the overall cost of group health plan expenditures to such an extent that without them overall payer outlays would actually be falling.

The report is enlightening, and employers can use the findings to offer programs aimed at education and prevention to help control their employees' health care costs. If that leads to smarter health and medical care choices by health plan participants, it could have a positive effect on premiums paid by both employers and workers.

Inspecting its study data for trends, the Health Action Council (HAC) determined that 63% of its covered lives had at least one of five conditions that were driving health care costs.

Most of these conditions are preventable or treatable with lifestyle modifications that employers can encourage.

Here's a look at the burden these conditions put on staff and employer based on the HAC study:

Asthma

Average costs paid per member of the HAC for asthma treatment are increasing on average 6.4% a year. This is one of the most prevalent health conditions in the country. Three important stats:

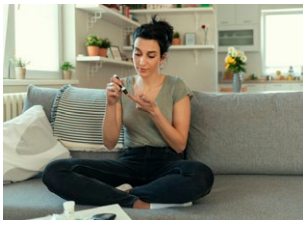
- The incidence of asthma was 31% higher among women than men.
- African American enrollees were 20% more likely to have asthma.
- The average age of HAC members with asthma was 31.9, two years younger than the overall membership average age.

Hypertension

Average costs paid per HAC member for hypertension treatment are increasing 6.3% a year. Three important stats:

- Hypertension was 23% more common in men than women.
- The average age among HAC enrollees with hypertension was 53.1.
- The risk of African Americans developing hypertension was 63% more than for other races.

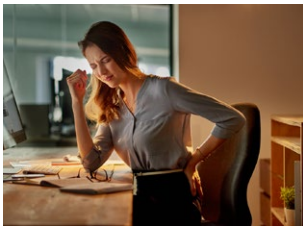
Diabetes



Average costs paid per HAC member for diabetic treatment are increasing 6.4% a year. Three important stats:

- Diabetes was 20% more common in men than women.
- The average age of HAC plan enrollees with diabetes was 52.
- Although Asian covered lives amounted to only 3% of the HAC enrollees, they had the highest incidence of diabetes of all racial groups.

Back disorders



Average costs paid per member of the HAC for back treatment are increasing 3.4% a year. Three important stats:

- Back disorders were 27% more common in women than men.
- The average age among HAC enrollees with back disorders was 43.3.
- Caucasian HAC members had 14% higher back disorder prevalence than other races.

See 'Create' on page 2

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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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Regulatory Change

Insurers No Longer Required to Send 1095-B Forms to Workers

HEALTH INSURERS will no longer be required to mail out the form 1095-B to employees who are covered under their employer's group health plan.

This means that the burden of producing and sending these forms out will lay solely with the employer going forward. The new policy applies to the 2020 tax year, so the time to ramp up and get these out is now.

Many health insurers have been sending out notices to their employer clients that they will no longer send these forms out to covered employees, unless they request them. While the new IRS guidance says the insurers do not have to send these forms to workers starting with the 2020 tax year, they will still be required to file the 1095-B forms with the IRS.

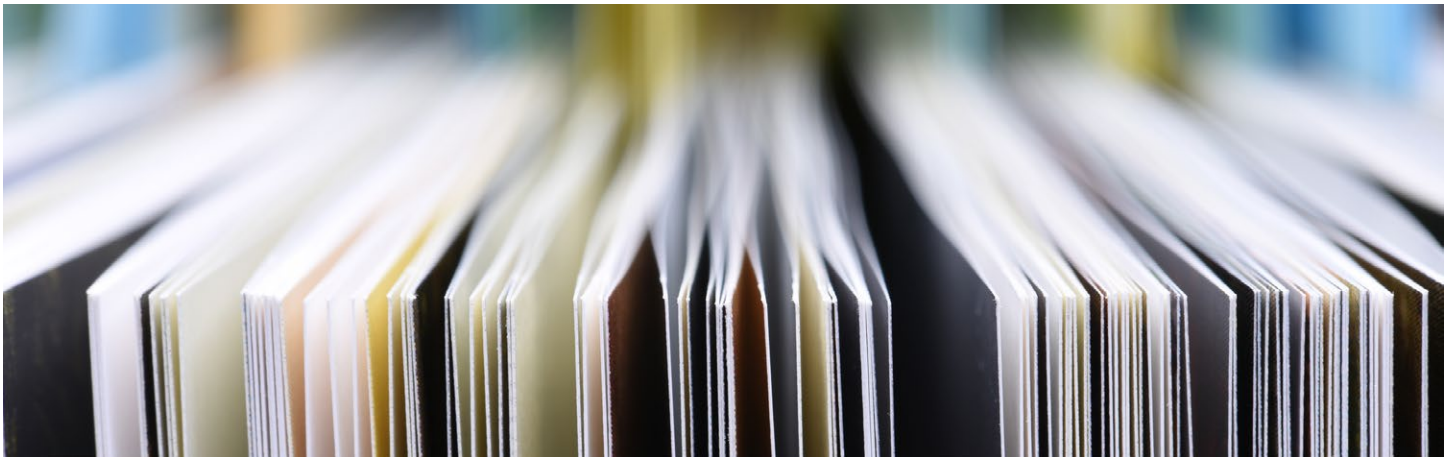
However, there may be some state laws that still require that health insurers send these out to insured group members.

This is a big change from prior rules as many employers have relied on their health insurers to send these forms to their workers.

Form 1095-B documents that a worker is receiving minimum essential coverage through their workplace health plan.

It should also be noted that the IRS announced it would extend the deadline for employers to provide employees with a copy of their 1095-C or 1095-B reporting form, as required by the Affordable Care Act, from Jan. 31 to March 2.

In addition, the IRS again extended "good-faith effort" transition relief to employers for plan year 2020 reporting. ❖



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Create Education and Targeted Wellness Programs

Mental health, substance abuse

Average costs paid per member of the HAC for mental health and substance abuse treatment are increasing 2.7% a year. Three important stats:

- Mental health and substance abuse problems were 39% more common in women than men.
- The average age among HAC enrollees with mental health and substance abuse issues was 32.8.
- Caucasian HAC members had 20% higher mental health and substance abuse issues than other races.❖

WHAT EMPLOYERS CAN DO

To help workers with these conditions, the report recommends:

- Creating and implementing simple education and targeted wellness programs to address common conditions among your employees.
- Instituting an exercise, stretch or meditation program at the beginning of a work shift to improve safety and decrease injuries. These types of practices are preventative and may decrease the severity of an injury if one occurs.
- Evaluating benefit plan design for opportunities to implement continuum-of-care protocols. For example, employers can make chiropractic care or physical therapy mandatory for back disorders before moving to more aggressive treatments.
- Covering medications for specific common chronic conditions as preventative care. Another option is to promote the use of patient assistance programs for medicines that may be excluded in your plan's drug formulary.
- Promoting virtual care for specific conditions; for example, mental health support if you have staff in rural areas.
- Working with your health insurer or medical expert(s) to identify opportunities for provider outreach and education to your workers.

Consolidated Appropriations Act

Take Note of How New Law Affects Group Health Plans

THE NEWLY enacted Consolidated Appropriations Act, 2021 contains a number of provisions that will affect group health plans, with most changes aimed at helping insured workers with flexible spending accounts (FSAs), cost transparency and surprise billing.

Some of the provisions are permanent while others are slated to run through the anticipated end of the COVID-19 pandemic. Here's a look at the highlights that will affect employer-sponsored health benefits.

FSA carryover rules loosened

The law authorizes employers to amend their cafeteria plans and FSAs to either:

- Allow participating staff to carry over unused amounts from the 2020 plan year to the 2021 plan year (and from 2021 to 2022 as well), or
- Provide a 12-month period at the end of the 2020 and 2021 plan years.

Under existing law, employers can only allow employees to carry over $550 from one plan year to the next.

Finally, under the CAA, employees can change how much they set aside into their FSA mid-year (usually they can only change their contribution levels ahead of a new plan year).

In all of the above cases, employers must approve these changes and update them in their plan documents.

Health plan transparency

The CAA also bars "gag clauses," which bar health insurers from entering into contracts that restrict a plan from accessing and sharing certain information. This is effective as of Dec. 27, 2020.

The goal of these new rules is to increase transparency in pricing and quality information for health care consumers and plan sponsors.

Also, there are new requirements for what health plan ID cards will need to include, starting with the 2022 plan year.

REQUIRED ID CARD INFO*

- Deductibles that are applicable to their coverage
- Out-of-pocket maximum limits
- Phone number and website address that enrollees can access for assistance.

**Starting with 2022 plan year.*

The CAA also created the No Surprises Act, which will, starting with the 2022 plan year, cap a plan enrollee's cost-sharing obligations for out-of-network services to the plan's applicable in-network cost-sharing level for the following three categories of services:

- Emergency services performed by an out-of-network provider or facility, and post-stabilization care if the patient cannot be moved to an in-network facility;
- Non-emergency services performed by out-of-network providers at in-network facilities, including hospitals, surgical centers, labs, radiology facilities and imaging centers; and
- Air ambulance services provided by out-of-network providers.

The takeaway

What to do now: If you offer FSAs to your staff and want them to be able to carry over funds from 2020 to 2021, and next year as well, you will need to make those changes to your plan documents.

Employers that sponsor group health plans should review their agreements with their health insurers and ensure that their plan contractors include language indicating that the contract complies with the prohibition on gag clauses.

What to prepare for: Starting with the 2022 plan year, employers should check with us or their insurer to make sure that the transparency changes are reflected in their plan documents and that their employees' health plan cards also include the changes required by the new law.

Plans should also reflect the new rules created by the No Surprises Act. ❖

FSA FREEDOM: *The law allows employers leeway to free their FSA users to carry over any unused portion of their account from one year to the next.*

Compliance

Changes for 2021 Summary of Benefits and Coverage

THERE ARE new Summary of Benefits and Coverage notice requirements for health plans starting with the 2021 coverage year.

The requirements, released by the Department of Labor, have new model templates, new instructions and new information that affects the coverage examples which are required to be in SBC documents that employers with group health plans must distribute to their employees.

Under the Affordable Care Act, all non-grandfathered health plans are required to provide enrollees and prospective applicants an SBC, which is essentially a synopsis of the plan's coverage and benefits. It must be produced in a specific format, contain specific information, and be written in a way that is easily understood.

Here are the changes that were made to the SBC template for plans that started on or after Jan. 1:

Coverage examples

The coverage examples that appear on the last page of the document have been modified to reflect changes in the cost of medical services that occur over time due to inflation and other factors:

"Managing Joe's Type 2 diabetes" (diabetes example): The total amount of expenses incurred for "Joe" has decreased.

"Mia's simple fracture" (fracture example): The total amount of expenses incurred by "Mia," who visited the emergency room for a simple fracture, has increased.

"Peg is having a baby" (maternity example): The costs incurred during "Peg's" hospital stay have been changed to remove separate newborn charges. The deductible line of the example should now match "your deductible amount" (if applicable).

Minimum essential coverage

Under the entry for minimum essential coverage, the template has been revised to reflect the elimination of the individual mandate penalty, which was repealed effective Jan. 1, 2019.

The entry now indicates that individuals eligible for certain types of minimum essential coverage may not be eligible for a premium tax credit under the ACA marketplace.

Uniform glossary

The uniform glossary has been updated to remove references to the individual mandate penalty.

What to do

If you offer group health plans to your employees, you are a plan sponsor and thus required to distribute SBCs to staff who are eligible for coverage during open enrollment. The SBC must also be given to new hires within 90 days of hiring for mid-year enrollment.

If you don't have your latest SBC, you can contact us or your health insurer. The insurer is obligated to provide all covered employers with updated SBCs after the Department of Labor and the Department of Health and Human Services release changes to templates. ❖