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BARNARD INSURANCE GROUP

THE BARNARD BULLETIN

Employee Benefits

Lightening Your Employees' Premium Outlays

AS THE labor market tightens and businesses struggle to attract new talent, many companies are starting to boost their employee benefit offerings, particularly voluntary benefits.

But besides added benefit choices, what many employees want is relief from continually increasing health premiums as well as more options to choose from for their health insurance.

As we exit the ravages of the COVID-19 pandemic, more workers are looking to their employers to give them some relief from spiraling premiums and health care expenses. Here are a few things you can do.

Reduce the employee's share of premium

You could pay for a higher percentage of the premium, which would reduce their monthly contributions. If that's not feasible, one tactic that can end up saving you and your employees money is offering to either pay a certain portion of the premium if they choose a silver plan, or pay for the entire premium for those who choose bronze plans.

The trade-off for the workers who choose the latter option is having no premiums, but more out-of-pocket expenses when they use health care services.

But if you are thinking about taking this route, please discuss it with us first as it's best to crunch the numbers to see how cost-effective it would be for you.

The other option is to just offer to pay for a greater percentage of the premium across the board on the policies you do offer. Obviously, that comes with added expense. But it's not a strictly financial decision, as a more generous benefits package can have the added advantage of helping you keep key talent and generate employee loyalty.

Offer more choices

This can be a win-win for everyone. Younger, healthy employees that do not use health care services often can opt for a high deductible health plan, which features a lower up-front premium in return for the participant having to spend more out of pocket for services they access.

But if someone doesn't use medical services often, this type of plan may be the right and most cost-effective option.

See 'PPOs' 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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Annual Update

2022 HSA Contribution Limits, HDHP Minimums, Maximums Set

THE IRS has set the 2022 maximum amounts employees can funnel into their health savings accounts, as well as deductible minimums and out-of-pocket maximums for high-deductible health plans.

The IRS updates these amounts every year to adjust for inflation and other factors.

2022 HSA, HDHP limits, maximums

HSA annual contribution limit
Individual plan: $3,650, up from $3,600 in 2021
Family plan: $7,300, up from $7,200 in 2021

HDHP minimum annual deductible
Individual plan: $1,400, the same as in 2021
Family plan: $2,800, the same as in 2021

HDHP annual out-of-pocket maximum
Individual plan: $7,050, up from $7,000 in 2021
Family plan: $14,100, up from $14,000 in 2021

HSAs explained

Only available to workers enrolled in HDHPs, HSAs are savings vehicles in which employees can park earnings to save for future medical expenses.

An HSA is a special bank account for your employees' eligible health care costs. They can put money into their HSA through pre-tax payroll deduction, deposits or transfers. As the amount grows over time, they can continue to save it or spend it on eligible expenses.

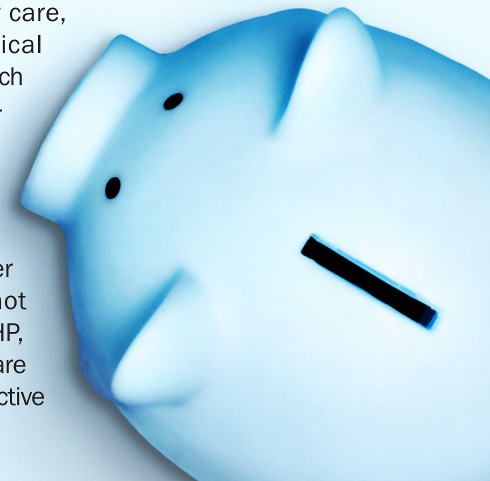
The money is typically put into the account before taxes are taken out. Employees are not taxed on withdrawals to pay for medical services or goods.

Employers can also contribute to the accounts, but the annual contribution maximum applies to all contributions in total (from the employee and the employer).

The money in the HSA belongs to the employee and is theirs to keep, even if they switch jobs. The funds roll over from year to year and can earn interest. Some plans also have investment options for the funds.

Here's how they work:

- Employees can make withdrawals with a debit card or check specific to the HSA.
- Employees can use the money in their HSA to pay for care, medicine and medical products until they reach their deductible, out-of-pocket expenses like copays and coinsurance.
- They can use the funds to pay for other eligible expenses not covered by their HDHP, like dental or vision care (eye exams and corrective lenses). ❖



Continued from page 1

PPOs Are Still the Most Common Type of Health Plan

On the other hand, for older workers or those who see the doctor more often or have health issues, they may be more inclined to go with a preferred provider organization (PPO) to pay more for a higher premium in exchange for lower out-of-pocket costs over the year.

For the fifth year in a row, the percentage of companies that offer high-deductible plans as the sole option will decline in 2021, according to a survey of large employers by the National Business Group on Health. That may be a continuation of a trend, but the pandemic has also put an emphasis on improved employee benefits.

Here's a breakdown of the kinds of small group plans across the country in 2020, according to Kaiser Family Foundation:

- PPOs covered 47% of workers.
- HDHPs covered 31%.
- Health maintenance organizations (HMOs) covered 13%.
- Point-of-sale plans covered 8%.
- Conventional (indemnity) plans covered 1%.

Hire more employees

The more people you have in your group health plan, the more the risk is spread around, which can yield lower premiums.

If you divide the risk amount of a small group of workers compared with a large pool, the law of averages dictates that the insurer will pay less in claims per worker in the larger pool.

In other words, the more staff you hire, the more risk is spread around, and the greater premium discount the insurer can offer.

Talk to us

An experienced benefits consultant can help you analyze your spending, and a good broker can help you get the best rates thanks to their network and know-how.

We can provide the insights you need to make the best decision on which types of plans to offer your workers and the best plans for your and your employees' money – and we can negotiate the best rates possible on your behalf. ❖

Patient Protections

CMS Issues New Regulations Barring Surprise Billing

THE CENTERS for Medicare and Medicaid Services in late June released a series of new regulations targeted at banning surprise billing in most instances, taking aim at a scourge that ends up costing many covered individuals thousands of dollars even when they are treated in-network.

The goal of the rule, slated to take effect Jan. 1, 2022, is to ensure that health plan enrollees are not gouged for out-of-network billing and balance billing for most services unless divulged to the beneficiary and approved by them in advance.

Balance billing – when a medical provider bills a covered individual for the difference between the charge and the amount the insurer will pay – is already prohibited by Medicare and Medicaid.

The interim rule will cover people who are insured by employer-sponsored health plans and plans purchased through publicly operated marketplaces. The new regulations are being implemented as required by the No Surprises Act of 2021, which passed through Congress with bipartisan support.

The effects of surprise billing

Surprise billing happens when people unknowingly get care from providers that are outside of their health plan's network, which can happen for both emergency and non-emergency care. Examples of surprise billing include:

- Someone breaks their leg in a fall and has to go to the nearest emergency room, which is not part of their insurer's network. They are billed at market rates as their insurer doesn't cover the service.
- Someone has an operation in a network hospital but one of the providers treating them (an anesthesiologist or radiologist, for example) is not in the network, so the covered individual is billed at market rates.

Two-thirds of bankruptcies are caused by outstanding medical debt, and out-of-network billing is partly to blame for that.

Studies have shown that more than 39% of emergency department visits to in-network hospitals resulted in an out-of-network bill in 2010, increasing to 42.8% in 2016.

During the same period, the average amount of a surprise medical bill also increased, from $220 to $628.

WHAT THE REGULATIONS DO

- Ban surprise billing for emergency services, regardless of where they are provided. That means if a person has no choice but to go to an emergency room that is out of network, they can only be billed at the same rate they would be charged for services at an in-network hospital.
- Bar health insurers from requiring prior authorization for emergency services, and they can't charge their higher out-of-pocket costs for emergency services delivered by an out-of-network provider. They would also be required to count enrollees' cost-sharing for those emergency services toward their deductible and out-of-pocket maximums.
- Ban out-of-network charges for ancillary care at an in-network facility in all circumstances. This happens when there is an out-of-network provider working at an in-network hospital.
- Ban other out-of-network charges without advance notice.
- Require providers and hospitals to give patients a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

What's next

This is an interim final rule that is still out for public comment. It may be changed after the CMS receives comments.

More than likely it will take effect at the start of 2022, mostly intact. ❖

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Price-Shopping Breakthrough

Few Plan Enrollees Seem Aware of Price Transparency Rules

DESPITE A new law requiring hospitals to post detailed pricing information for their treatments and procedures online, fewer than 10% of U.S. adults are aware of the requirement.

That's a problem considering that a growing number of Americans have high-deductible health plans, which come with up-front lower premiums but with higher out-of-pocket expenses.

One of the driving forces behind HDHPs is that they give the enrollee more "skin in the game," by incentivizing them to shop around for care since they will have to pay for it themselves up to their deductible.

But if people are not aware they can find pricing for medical services on providers' websites, they may not know how to begin comparing prices.

A new study by the Kaiser Family Foundation found that only 9% of those surveyed were aware that hospitals are required to publish the prices for their services online, in line with new price transparency regulations that took effect Jan. 1, 2021.

The price transparency rule requires hospitals to post on their websites costs of services and medical items.

What hospitals must post online

- A clear description of each shoppable service and item.
- A description of charges including:
  - » Payer-specific negotiated charge, or the price a third party payer such as a health insurance company would pay.
  - » Discounted cash price, or the price a patient would pay without insurance.
  - » Gross charge, or the charge absent any discounts.
  - » De-identified maximum and minimum negotiated charges for each.
- Any primary code used by the hospital for purposes of accounting or billing

Here's what the survey found:

- 69% said they were unsure whether hospitals are required to disclose the prices of treatments and procedures.
- 22% said hospitals aren't required to disclose this information.
- 9% are aware hospitals are required to disclose the prices of treatments and procedures on their websites.
- 14% said that they or a family member had gone online in the past six months to research the price of hospital treatment.

Educating your staff

Employers should inform their staff about the price transparency rule so that they can research pricing ahead of any procedures they may have. Most health system websites should be posting their pricing by now, but it may take some digging to find them.

If they have been ordered to get a certain procedure, they can start by going to each provider available to them through their health insurance and researching the pricing on their website. If they can't find the information, they should call the provider to get it. They will need the negotiated price between their health plan and the provider.

Prices can vary dramatically between providers, and your staff need to make sure they are making accurate comparisons.

They should also consider calling the providers and inquiring about the cash price for the services. In some instances, the cash price can be less than their deductible or copay.

One problem: Some hospitals have not published their rates and there has been a lack of consistency between providers in terms of how they are providing the information.

This has prompted the Centers for Medicare and Medicaid Services to audit hospitals' websites, and it has sent out notices to hospitals that are not complying with the transparency regulations.

Finally, many insurance carriers offer searchable online databases for their enrollees where they can research the approximate cost of certain procedures among all the providers available to them.❖

CHEAPER SCAN: *Your workers can shop around for medical services like an MRI by going to network hospitals' websites, potentially saving them thousands in out-of-pocket expenses.*