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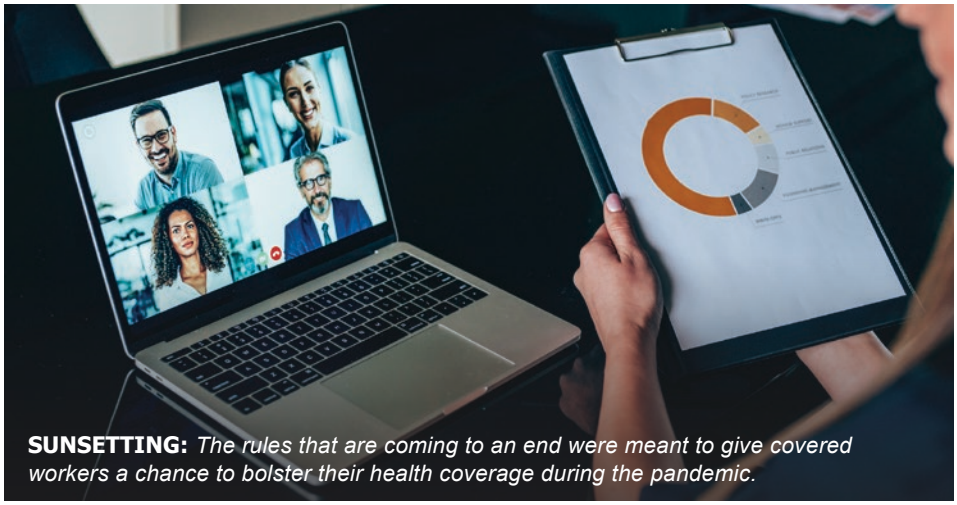
BARNARD INSURANCE GROUP

THE BARNARD BULLETIN

Employee Benefits

An Employer Guide to Open Enrollment



SUNSETTING: *The rules that are coming to an end were meant to give covered workers a chance to bolster their health coverage during the pandemic.*

AMIDST ANOTHER pandemic year, employers are gearing up for another unusual open enrollment season. No doubt your employees' health care priorities have changed, and some of them will be looking at making changes to their health insurance as well as voluntary benefits.

Against this backdrop, you'll need to inform your staff about benefits changes in health, such as making telemedicine more accessible. Also, you'll need to tell them about changes to the rules governing health savings accounts (HSAs) and similar plans.

Here's what to keep in mind in the lead-up to open enrollment.

Employees' new priorities

Here's what's become a priority for many workers today:

Mental health support – Many health plans are rolling out better access to mental health support, the demand for which has surged during the pandemic as many people struggled with sudden changes, isolation and personal loss.

Access to telehealth – Many people tried telemedicine services for the first time in 2020 or 2021.

Insurers see telehealth as a way to cut the cost of care, and they have invested in the infrastructure to enable enrollees to meet virtually with their doctors.

More health plans are also covering mental health video-conference sessions.

More interest in HSAs and similar plans – More workers are interested in HSAs and flexible spending accounts (FSAs), which are funded by the employee using pre-tax dollars. The funds can be used to reimburse for a wide variety of qualified medical expenses.

HSAs can only be offered to employees who are enrolled in a high-deductible health plan (HDHP). They can be kept for life even if the worker switches jobs.

FSAs are easier to set up, but they are not kept for life and cannot be transferred.

There are changes to these plans that you should inform your employees about.

The Coronavirus Aid, Response and Economic Security (CARES) Act of 2021 allowed HSA-qualified HDHPs to cover telehealth services before plan enrollees reached their deductible. This provision expires Dec. 31.

However, another change brought by the CARES Act is permanent: Employees with HSAs, health reimbursement arrangements or health FSAs are now allowed to use those accounts to reimburse for over-the-counter medications without a prescription, and for tampons and pads.

Communications and planning

If you make changes to your plan offerings or if your health plans have changed, you'll need to communicate those changes to your workforce during your open enrollment meetings and in your communications material.

Since COVID-19 is still present and

See 'Consider' 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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Compliance Reminder

Large Employers Must File ACA Forms, Not the Insurers

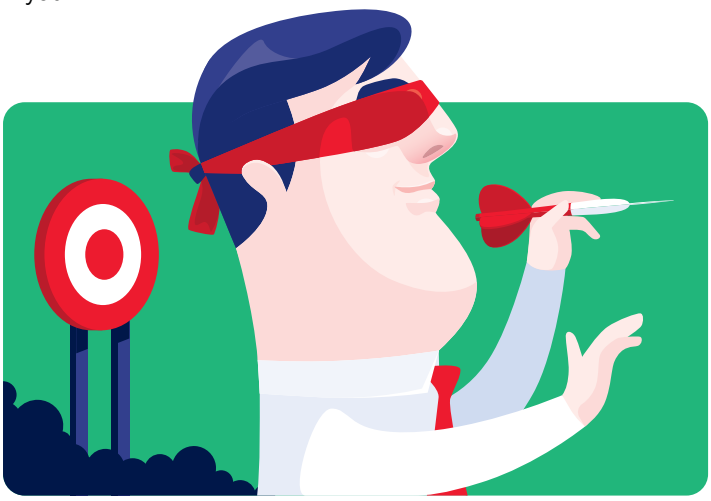
ONE MISTAKE more and more employers are making is failing to file required Affordable Care Act tax-related forms with the IRS.

If you are what's considered an "applicable large employer" (ALE) under the ACA, you are required to file with the IRS forms 1094 and 1095, often separately and before your annual tax returns are due.

Under the ACA, employers with 50 or more full-time and "full-time equivalent" workers are considered an ALE and are required to provide affordable health insurance to their staff that also covers 10 essential benefits as prescribed by the law. This is what's known as "the employer mandate."

Filing these documents is not the responsibility of your health insurer as it's you that's arranging the employer-sponsored health insurance for your staff. Be aware that you can face penalties if you:

- Don't file the forms in a timely manner,
- Make mistakes when filing the forms, or
- Fail to file the forms altogether.



SHOOTING BLIND: *Don't assume the insurance company will file Forms 1094-C and 1095-C for you. If you don't file them, you could be in line for substantial penalties.*

The IRS requires these forms to ensure that ALEs are providing health coverage to their employees and that the employer is complying with the employer mandate portion of the ACA.

The forms

Form 1095-C – This is basically the W-2 reporting form for Health Insurance. It tells the IRS which employers are providing coverage and which employees are covered through their employers.

Form 1094-C – This form provides information about health insurance coverage the employer provides.

THE DEADLINES

- **Jan. 31, 2022** – The deadline for furnishing individual statements (Form 1094 C) for 2021.
- **Feb. 28, 2022** – The deadline for filing paper returns of Forms 1094 C and 1095 C.
- **March 31, 2022** – The deadline for filing Forms 1094 C and 1095 C electronically.

Penalties

The general potential late/incorrect ACA reporting penalties are $280 for the late/incorrect Forms 1095-C furnished to employees, and $280 for the late/incorrect Forms 1094-C and copies of the Forms 1095-C filed with the IRS.

That comes to a total potential general ACA reporting penalty of $560 per employee when factoring in both the late/incorrect Form 1095-C furnished to the employee and the late/incorrect copy of that Form 1095-C filed with the IRS.

The maximum penalty for a calendar year will not exceed $3,392,000 for late/incorrect furnishing or filing. ❖

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Consider Teleconference Open Enrollment Meetings

cases are at an all-time high in some areas, you may want to consider:

Holding a "virtual benefits fair" – In these virtual fairs, employees can go online and learn about your plan offerings and provider networks.

Conducting virtual open enrollment meetings – Teleconference open enrollment meetings are a safe way to cover your employees' health plan choices, and the deductibles, copays, premium amounts and what the maximum out-of-pocket are for each choice.

Sending out more frequent, targeted communications – Targeted communications can be sent to various cohorts of your employees, such as information on plans that would be of most interest to people in their 20s and 30s.

Older workers would need different guidance.

Using technology for enrollment – Some health plans offer apps through which employees can choose and sign up for the plan of their choice. Talk to us about what's available to you.

What to do now

Now is the time to get the word out about the upcoming open enrollment. Consider:

- Distributing a pre-enrollment flier (printed and online) to all of your eligible staff.
- Holding a virtual benefits fair in mid-to-late September
- Distributing the enrollment packet (both printed and online). ❖

ACA Compliance

Group Plan Affordability Level Set for 2022

THE IRS has announced the new affordability requirement test percentage that group health plans must comply with to conform to the Affordable Care Act.

Starting in 2022, the cost of self-only group plans offered to workers by employers that are required to comply with the ACA, must not exceed 9.61% of each employee's household income.

Under the ACA, "applicable large employers" – that is, those with 50 or more full-time employees – are required to provide health insurance that covers 10 essential benefits and that must be considered "affordable," meaning that the employee's share of premiums may not exceed a certain level (currently set at 9.83%). The affordability threshold must apply to the least expensive plan that an employer offers its workers.

The threshold has been reduced from the 2021 level because premiums for employer-sponsored health coverage increased at a lower rate than usual this year as many people stayed away from hospitals for routine procedures due to the pandemic.

Affordability example

The lowest-paid worker at Company A earns $25,987 per year. To meet the affordability requirement, the worker would have to pay no more than $2,497 a year in premium (or $208 a month).

Penalty alert

Failing to offer a plan that meets the affordability requirement to 95% of full-time employees will trigger penalties of $4,060 per worker receiving subsidized coverage through an exchange. That's the full-year penalty, but it's typically charged monthly.

Out-of-pocket maximums

The IRS also sets out-of-pocket maximum cost-sharing levels for every year. This covers plan deductibles, copayments and percentage-of-cost co-sharing payments. It does not cover premiums. ❖

Out-of-pocket limits for 2022

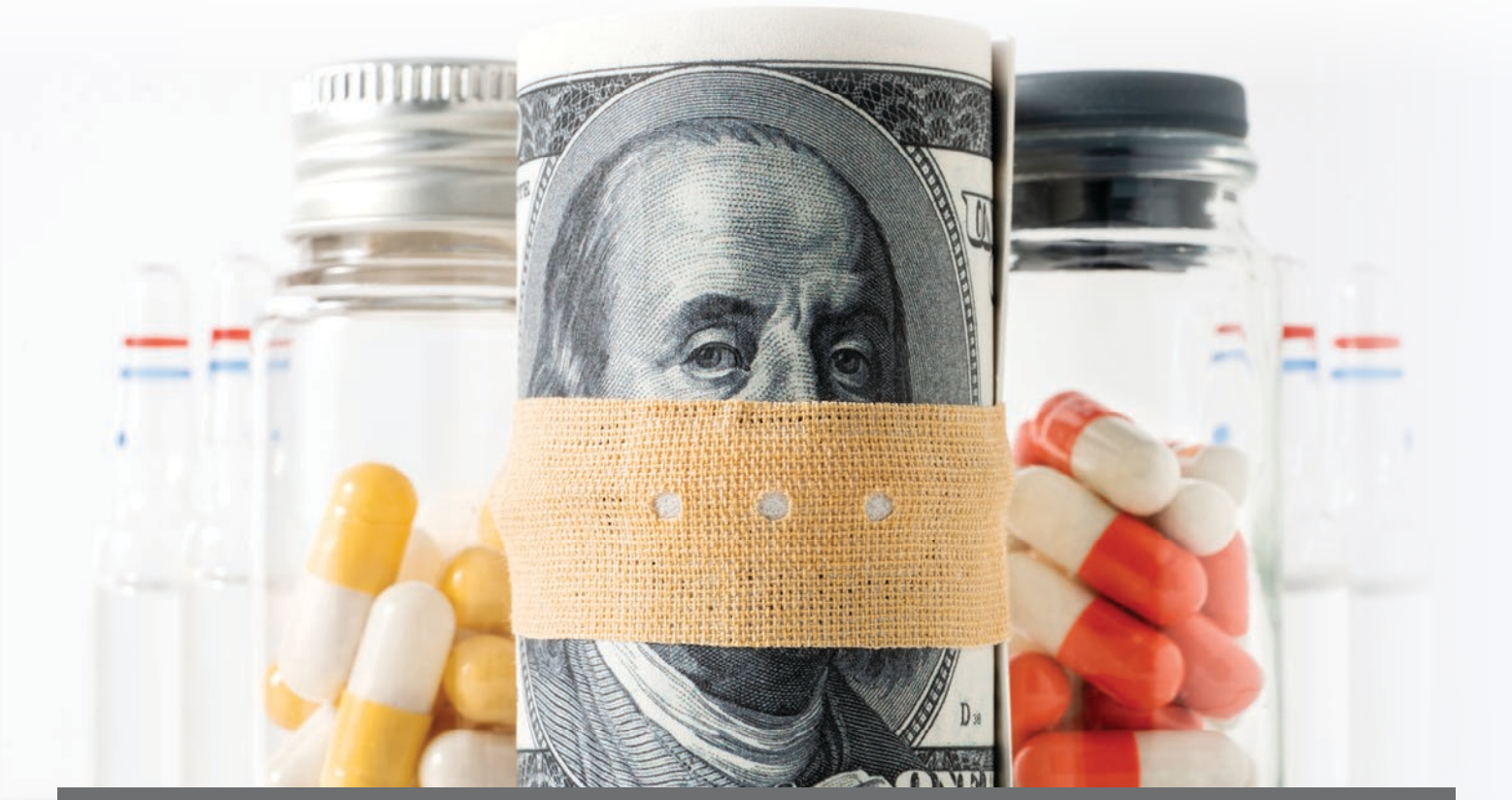
The new out-of-pocket limits for 2022 are as follows:

Self-only plans – $8,700, up from $8,550 in 2021.

Family plans – $17,400, up from $17,100 in 2021.

Self-only HSA-qualified HDHPs – $7,050, up from $7,000 in 2021.

Family HSA-qualified HDHPs – $14,100, up from $14,000 in 2021.



Out-of-Pocket Costs

New Health Plan Transparency Rules Explained

REGULATIONS ARE slated to take effect over the next few years that will greatly increase the transparency requirements for group health plans.

The regulations issued in 2020 will require health insurers in the individual and group health markets to disclose cost-sharing information upon request, make cost-sharing information available on their websites and disclose negotiated rates with in-network providers.

The rules are designed to help health plan enrollees choose the plan that is best for them and their family, as well as to give them a full picture of what they can expect to pay for services as part of their deductibles, copays and coinsurance.

There are two parts to the rules: one focuses on personalized cost-sharing information and the other focuses on other pricing and information that insurers are required to post on their websites.

Personalized cost-sharing information

The new rules require health plans to provide personalized estimates for enrollees upon request, so they can calculate their potential out-of-pocket expenses prior to receiving medical treatment.

The following must be provided to a plan enrollee upon inquiry ahead of receiving care:

Estimated cost-sharing liability – This covers how much the enrollee would have to pay out of pocket under their plan for deductibles, coinsurance and copays for a specific medical service. These estimates must be specific to the individual that's inquiring and not a general estimate.

Accumulated out-of-pocket payments – Enrollees can inquire to their health plans about how much they've paid out towards their deductibles and their plan's out-of-pocket maximums as of the date requested.

In-network rates – Upon request, the plan must divulge how much the enrollee will have to pay out of pocket in relation to the rates it has negotiated for a specific procedure by an in-network provider.

The plan or insurer must disclose the negotiated rate, expressed as a dollar amount, even if it is not the rate the plan or insurer uses to calculate cost-sharing liability. The plans must also disclose out-of-pocket liability for an individual as well as the negotiated rates for prescription drugs. The health insurer does not have to disclose drug discounts or rebates as part of the inquiry.

Out-of-network allowed amount – The insurer must disclose the maximum amount its plan will pay for an "item or service" from an out-of-network provider.

Notice of prerequisites to coverage – If the service the enrollee is inquiring is about prior authorization, concurrent review or step-therapy, the insurer must include this information in the answer to the request.

All of the above will take effect in two phases:

- Jan. 1, 2023: Insurers will be required to provide personalized cost-sharing information on 500 specific services.
- Jan. 1, 2024: Insurers will be required to provide personalized cost-sharing information on all specific services.

Publicly available cost-sharing information

The new regulations also require health plans (not including grandfathered ones) and health insurers to post on their websites machine-readable files with detailed pricing information. They must post this information starting Jan. 1, 2022.

The website must include the following information, which has to be updated on a monthly basis:

- Rates for all covered items and services that the plan has negotiated with its in-network providers.
- Historical payments the insurer has made to out-of-network providers, as well as the billed charges.
- The plan's in-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy location level. ❖