MAPLE BROOKS Benefits & Consulting

THE RISK REPORT

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Regulatory Action

New Law Bans Surprise Medical Billing

PART OF the COVID-19 relief package that Congress passed in late December includes a provision that will reduce instances of surprise medical bills.

This "balance billing" occurs when an out-of-network provider is involved in a patient's care at a hospital that accepts their insurance. The services are then billed at out-of-network rates that can be in the tens of thousands of dollars.

The new law bars out-of-network providers and air ambulance firms from billing patients for more than they would be charged by in-network providers (ground ambulance services are not covered).

The law also bars health plans from requiring patients to pay more for care they unknowingly receive from out-of-network providers at in-network facilities.

According to the Kaiser Foundation, 18% of emergency visits lead to at least one out-of-network charge for people covered by large group plans, as do 16% of in-network inpatient admissions.

MAIN POINTS OF THE LAW

- The law requires that patients be billed on their plan's in-network rate for emergency medical care at an out-of-network facility, or if they are treated by an out-of-network clinician at an in-network hospital.
- It protects patients admitted to an in-network hospital for a planned procedure when an out-of-network doctor works on the patient. Most often this happens when a doctor is called to provide assistance in the operating room, or if the anesthesiologist is out of network.
- Doctors and health plans are allowed to bill for out-of-network treatment in the above situations if the patient is informed of the estimated costs at least 72 hours before they receive care.
- Whatever the patient pays for the above out-of-network services must be counted toward their in-network annual deductibles.

Billing disputes

For the health insurers and providers to agree on the cost of care, the new law sets up an arbitration process to settle payment disputes for out-of-network claims. The plan sponsor and the covered employee are not part of this dispute resolution process.

The law gives the insurer and provider 30 days to settle a dispute and if they can't come to an agreement, they can go to a binding arbitration process. This "Independent Dispute Resolution" (IDR) will be administered by independent entities.

During IDR, both the insurance company and the provider submit what they want to pay to the arbiter, who will decide a fair amount based on what other providers charge for similar services.

The arbiter will not be allowed to consider rates paid by Medicare and Medicaid, which tend to be lower than what commercial insurers pay for services and what hospitals normally charge.

See 'Gag Clauses' on page 2

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WISHES YOU A HAPPY NEW YEAR

CONTACT US

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Pandemic Fallout

Demand for Voluntary Group Benefits Grows

AS THE COVID-19 pandemic drags on and many Americans see unmet needs outside of their health insurance, more and more workers are increasingly signing up for the voluntary benefits their employers offer.

While many workers in the past had skipped on voluntary benefits, they have grown concerned that a good group health insurance plan may not be enough to provide all the coverage they need.

It's important for employers to react to this trend as the pandemic has put many people on edge about how they can continue to pay the bills if they are laid up with COVID-19, and especially if they have long-haul symptoms that have plagued some people for months after first getting sick.

Employers who fail to upgrade offerings could see higher turnover and more difficulty in retaining and attracting talent.

Extra peace of mind

There are a number of plans that can provide coverage that would be outside the scope of health insurance, including:

Hospital indemnity insurance – This is a supplemental plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. It will cover out-of-pocket expenses like medical copays, deductibles and regular expenses, such as food, rent and utilities.

Critical illness insurance – These plans pay out in the event of covered critical illnesses. This insurance can help alleviate financial worries during a serious illness by providing a lump-sum cash payment to the insured person when they're diagnosed with a specific critical illness. The benefit provides cash at a time when it may be needed most.

Life insurance – In case the unthinkable happens.

Disability insurance – These plans pay benefits when insureds are unable to work due to covered illnesses or injuries. If you have disability insurance and become injured or sick and lose your ability to work, you'll get paid monthly disability insurance benefits to cover your lost income.

Disability insurance can be bought individually, but many employers offer long-term and short-term disability coverage as part of an employee benefits package, like health insurance.

The key: Education

Education about voluntary benefits products is key, and if set up properly, they can provide a powerful level of protection for a variety of events.

If you're interested in expanding the voluntary benefits you offer your employees, now is the time. We can help you get the ball rolling and help educate your staff on their choices and why they are important. ❖

Continued from page 1

Gag Clauses Between Insurers and Providers Now Banned

The decisions are binding. after which the insurer has 90 days to pay the bill.

The new law took effect Jan. 1.

One more thing...

Besides banning surprise billing, the law also bars gag clauses. Many contracts between health insurers and providers include provisions that bar enrollees, plan sponsors or referring providers from seeing cost and quality data on providers. These provisions will now be prohibited.❖

New Law

COVID-19 Relief Bill Extends Unemployment Benefits, PPP

THE $900 billion COVID-19 relief bill, passed by Congress and signed into law on Dec. 27, includes a number of provisions that affect employers and their workers in terms of paid sick leave and Emergency Family and Medical Leave Act provisions.

The legislation also boosts unemployment benefits to out-of-work Americans, as well as reopening and expanding the Paycheck Protection Program that was introduced in March as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

Paid sick leave and family medical leave

The new law has not extended the obligation for employers to provide paid emergency paid sick leave and expanded family and medical leave beyond Dec. 31, 2020, instead making it voluntary after that date.

From Jan. 1, employers can continue receiving tax credits if they provide emergency paid sick leave (EPSL) and emergency family medical leave (EFML) to employees for COVID-19-related purposes through March 31. Here are the caveats:

- Tax credits will be available for leave granted to employees who did not already exhaust 80 hours of EPSL and 12 weeks of EFML. For example, if a worker who was entitled to 80 hours of EPSL last year used 50 of those hours, they'd have 30 hours left to use between Jan. 1 and March 31 this year.
- Employers must protect the jobs of any employee that is granted EPSL and EFML.

Other provisions

The law extends some CARES Act unemployment programs:

Unemployment benefits – The new law extends the Federal Pandemic Unemployment Compensation (FPUC) program supplement from December 26, 2020 to March 14. However, instead of receiving $600 a week under the original program, benefits will be $300 per week.

Gig worker unemployment benefits – The law also extends the Pandemic Unemployment Assistance (PUA) program, which covers independent contractors and gig workers who would usually not be eligible for unemployment insurance payments.

This program (originally created by the CARES Act) is also extended to March 14, and then a three-week phase-out period will run until April 5.

The law increases the number of weeks independent contractors are eligible for these benefits to 50 from the original 39.

Extra weeks for those whose benefits ran out – The Pandemic Emergency Unemployment Compensation (PEUC) program, which provides additional weeks of unemployment insurance benefits to individuals who use up all of their state unemployment benefits, will be extended until March 14.

The law also increases the number of benefit weeks to 24, from 13 under the original version of the program. After March 14, this program will be phased out over three weeks until April 5.

More money – Taxpayers with annual incomes below $75,000 will receive a $600 check, plus another $600 per dependent child. Payments are phased out for people with incomes in excess of $75,000.

Paycheck Protection Program (PPP) part II – The law also sets aside $284 billion for forgivable loans to struggling businesses as part of a second PPP. Companies that receive funds will have to use the money on payroll and other specific expenses if they want the loan to be forgiven.

Depending on the loan, employers will have either eight or 24 weeks after receiving the loan to spend it on approved expenses.

But PPP part 2 does have some additional prerequisites that differ from the original. It lowers the employee threshold for businesses to 300 employees or fewer (down from 500). Additionally, the maximum loan is now $2 million, compared to $10 million under the original PPP.

Qualifying expenses are also different in this version, which means any business thinking about applying needs to read all the fine print. ❖

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 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. ❖