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THE RISK REPORT

April 2021 | **Volume 3** | Issue 4

Rescue Legislation

100% COBRA Subsidy in Effect Through Sept. 30

THE RECENTLY enacted American Rescue Plan Act of 2021 includes a 100% COBRA subsidy for up to six months through Sept. 30 for employees laid off during the COVID-19 pandemic.

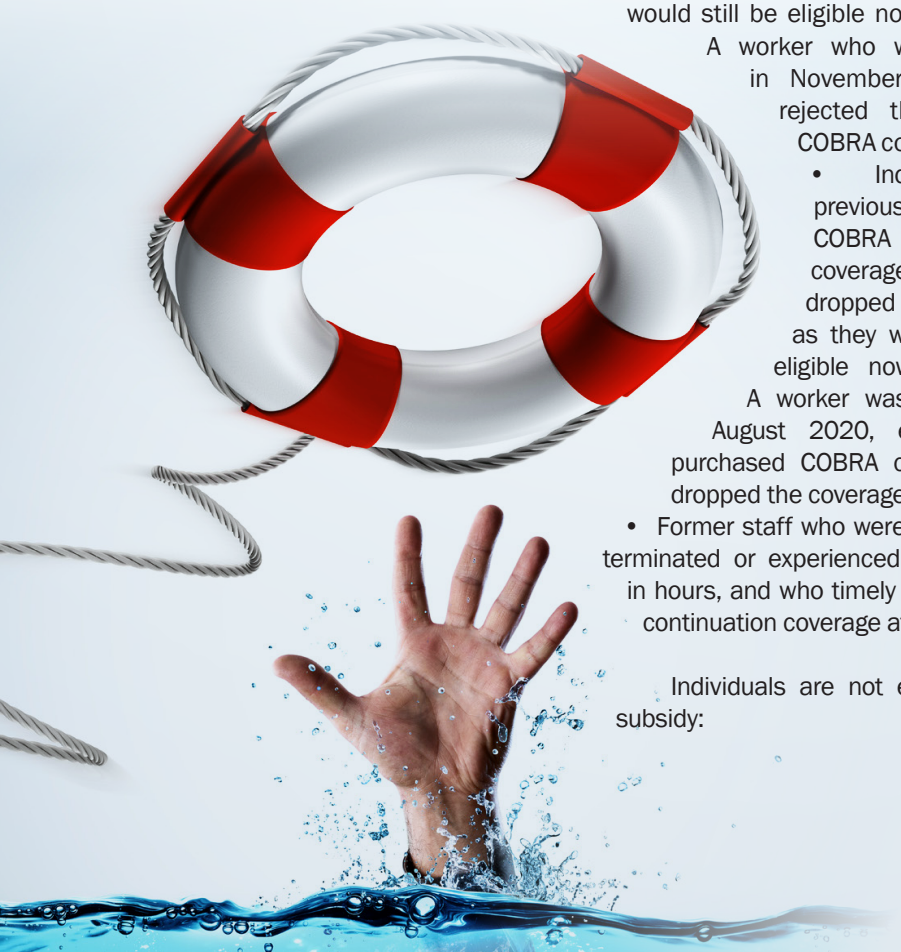
Due to the short ramping up period, it's imperative that employers who have laid off workers, or who plan to, start preparing to notify them.

The Consolidated Omnibus Budget Reconciliation Act requires health plans sponsored by employers with 20 or more workers to offer employees and their families the opportunity for an extension of health coverage (called continuation coverage) after they have quit or been laid off for up to 18 months. The workers are usually responsible for the entire premium.

Who is eligible?

Eligible individuals include:

- Workers who were previously laid off or lost their benefits and became eligible for COBRA continuation coverage but chose not to purchase it, as long as they would still be eligible now. **Example:** A worker who was laid off in November 2020 but rejected the offer of COBRA coverage then.
- Individuals who previously elected COBRA continuation coverage, but later dropped it, as long as they would still be eligible now. **Example:** A worker was laid off in August 2020, elected and purchased COBRA coverage but dropped the coverage in January.
- Former staff who were involuntarily terminated or experienced a reduction in hours, and who timely elect COBRA continuation coverage after April 1.



Individuals are not eligible for a subsidy:

- If they voluntarily resigned from their job.
- They become eligible for other employer coverage or Medicare.
- They are beyond their maximum COBRA coverage period (which under federal law is 18 months).

What's covered

The subsidy applies to all health coverage that COBRA usually covers: health insurance as well as dental and vision coverage. Generally, the coverage employers offer Assistance Eligible Individuals should be the same coverage in effect prior to their COBRA-qualifying events.

Individuals who qualify for the COBRA subsidy are not required to pay a premium.

The group health plan will cover the cost of the coverage, which will be reimbursed (including any administrative fee) by the U.S. government via a payroll tax credit.

Notice requirements

When notifying newly eligible individuals, the information can be included with the COBRA election notice or a separate notice that would come along with the election packet.

See 'Urgently' on page 2

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HDHPs Do Not Slow Down Health Care Spending Growth: Study

A NEW STUDY has found that high-deductible health plans have only a limited effect on the growth of health care spending for people who sign on for these plans.

The National Bureau of Economic Research examined HDHPs over a period of four years and found they failed to control health spending any more than traditional preferred provider organization plans (PPOs) and health maintenance organizations (HMOs). The only statistically significant impact on lower growth by HDHPs was on more expensive pharmaceuticals.

The news comes as HDHPs continue growing in use and popularity among employers and some of their workers. They are often paired with a health savings account that allows participants to set aside a portion of their wages before taxes in special accounts used to pay for health-related expenses, including deductibles.

When HDHPs first came on the scene they were touted as a potential cost-saver. The logic went that when the worker has more skin in the game and has to pay more for their medical care and medications, they will shop around for the lowest-cost service or drug.

Here are the main findings of the report:

- Covered workers who switched from low-deductible plans to high-deductible plans saw lower growth rates of spending, but for no more than a year.
- HDHPs seem to discourage the use of less cost-effective drugs. The report surmised that's because people with these plans will be more motivated to shop around for better prices, like from an online pharmacy.

Considerations

PPOs continue to be the most popular choice among employees and HDHPs continue growing as employers look to cut their and their employees' premium expenditures, according to a recent report by Benefitfocus, a benefits technology company. HDHPs currently account for about 30% of group health plans in play.

Also, some employees prefer having an HDHP as they can save money up front on the premium.

Over the past few years, employers have noticed that younger and healthier workers will gravitate towards HDHPs when offered them, as they will usually not need much health care and they are willing to trade a lower up-front premium for the small likelihood that they will need a significant amount of medical care, which they would have to pay for out of pocket.

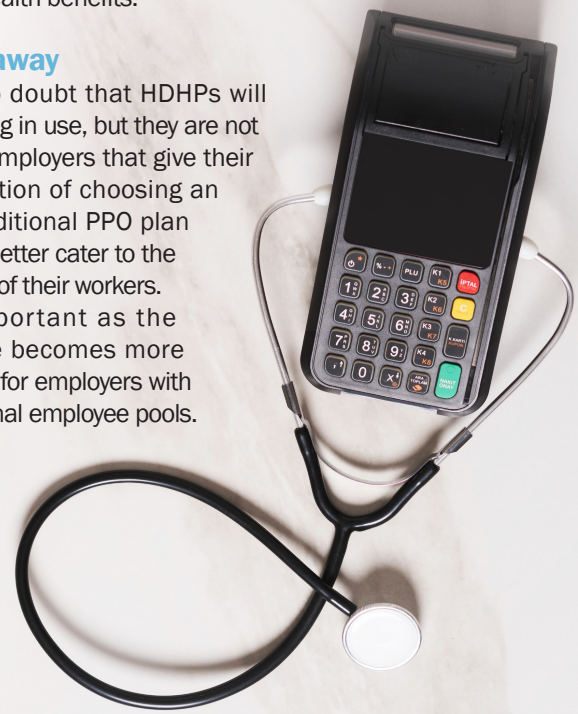
However, workers in their 40s and older are more apt to stick to their PPO or HMO plans, which have higher premiums but lower out-of-pocket maximums.

But the authors of the National Bureau of Economic Research report said that for some people with health problems, HDHPs "may have high adverse health consequences when patients delay, reduce, or forgo care to curb costs, even when costs are moderate compared to health benefits."

The takeaway

There is no doubt that HDHPs will continue growing in use, but they are not for everyone. Employers that give their workers an option of choosing an HDHP or a traditional PPO plan will be able to better cater to the different needs of their workers.

This is important as the U.S. workforce becomes more diversified, and for employers with multi-generational employee pools. ❖



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Urgently Identify Individuals Who May Be Eligible for Subsidy

THE NOTICES MUST INCLUDE:

- Notification of the availability of subsidies.
- A description of their right to the subsidy and conditions.
- The forms necessary to establish eligibility.
- A description of the special election period.
- A description of the qualified beneficiary's obligation to notify the plan when they are no longer eligible for coverage.
- Contact information of the plan administrator or contact.

Important: The Department of Labor is expected to provide model language for these notices by April 10.

What you should do

There are a number of steps employers need to take as the ramping up period is quite short. If your firm is large enough to be covered by COBRA, you should:

- Coordinate with your administrator to ensure that you agree about who should identify eligible individuals and who will be sending out notifications.
- If that is you, identify those individuals who may be eligible for the COBRA subsidy and who may be eligible to make a new election.
- Prepare notification documents.
- Notify all eligible individuals. ❖

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 come in at 4.3%, slightly higher than in 2020. They anticipate the trend of escalating costs to continue 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 this 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 once they become 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 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. ❖

Pandemic Relief

IRS Lets Employers Give Workers a Break on FSA Contributions

NEW GUIDANCE from the Internal Revenue Service allows employers to temporarily give their employees extra benefits leeway in making changes to their flexible spending accounts (FSAs) and health savings accounts (HSAs).

The guidance, in response to the COVID-19 pandemic, also allows employees to make changes to their health plans outside of the traditional open enrollment period.

The COVID-19 relief bill signed into law at the end of 2020 changed the tax law.

The law ordinarily requires employees to make irrevocable plan choices before the first day of the plan year; later changes are normally permitted only under certain circumstances, such as a change in employee status.

However, 2020 was an abnormal year. For example, stay-at-home orders left employees with unused money in their dependent care FSAs because they unexpectedly did not have to pay for child daycare.

The temporary changes

Recognizing the current extraordinary situation, the new guidance makes several temporary changes:

- Employers can permit employees to carry over unused funds from their 2020 FSAs to 2021, and from 2021 to 2022. Ordinarily, these accounts have a "use it or lose it" rule under which the employee forfeits unused funds at the end of the year.
- If an employee contributed $5,000 to a dependent care FSA in 2020 but used only $3,000 because he or she worked from home, they can now carry the remaining $2,000 forward for use in 2021.
- Alternatively, employers can extend the grace period for employees to spend unused FSA funds. Normally, employees have two and a half months from the end of the plan year to spend the money on qualifying expenses. The temporary rules permit employers to give them up to 12 months to do it.
- Employers can allow certain employees to use dependent care FSA funds for care of children up to age 14. The normal cut-off age is 13.
- Employers may allow employees to change their future contributions to 2021 FSAs mid-year, something that is ordinarily prohibited.
- Employers may also permit employees to make mid-year health plan changes. Employees who did not enroll in the employer's health plan during open enrollment will be able to do so.
- Employees can change available plans, or they can drop coverage entirely if they can show that they have replacement coverage such as through a spouse's employer.
- If an employee changes from a high-deductible health plan to one with copayments or lower deductibles (or vice versa), employers can also permit them to switch mid-year between contributing to an HSA or an FSA. By law, an HSA must be coupled with an HDHP.
- Lastly, they can allow employees who stop contributing to a health care FSA mid-year to receive reimbursements through the end of the plan year.

It is important to know that:

- The law does not require employers to make these changes.
- The changes expire for plan years starting in 2022 and later.

The pandemic has been difficult for employers and employees alike. These temporary changes will make it a little easier for both to cope. ❖