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THE RISK REPORT

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Employee Benefits

New Laws, Regs Affect Group Plan Open Enrollment

EMPLOYERS ARE entering the second year of open enrollment taking place during the COVID-19 pandemic, which is still having an outsized impact on the process and which has changed the face of health insurance.

There are a number of issues that will have an effect on health plans, including regulations and laws affecting coverage that were born out of the pandemic. Mercer LLC recently published a list of compliance-related priorities that health plan administrators and sponsors have to consider, including:

Legal and regulatory changes

Health plan transparency in coverage rules take effect on Jan. 1, 2022. Newly introduced regulations require hospitals to publish their standard prices, and for negotiated rates between health plans and providers to be made transparent too.

Employers will need to communicate these changes to their employees, particularly rules that require health plans to provide enrollees with out-of-pocket estimates for upcoming procedures.

Also, the No Surprises Act, which will prohibit surprise bills for certain out-of-network services, takes effect at the start of 2022 for providers and group health plans. Employers need to meet with their plan administrator to make sure that their plans are in compliance with these new regulations.

COVID-19 issues

Legislation passed last year requires health plans to cover additional services such as mental health and telehealth until the end of this year. Whether your plan offerings will keep providing those enhanced benefits or not, you'll need to communicate that to plan participants and include it in your plan documents.

You should also confirm that your group plans comply with COVID-19 testing and vaccine coverage requirements in the Family First Coronavirus Response Act, the CARES Act and any state laws.

Gender issues

Employers should review their benefit eligibility rules after the Supreme Court in 2020 ruled that Title VII of the 1965 Civil Rights Act protects LGBTW employees from discrimination in benefits.

You should ensure that benefits offered to opposite-sex spouses are the same as are offered to same-sex spouses.

Mental health parity

All health plans have to prepare a comparative analysis of their medical and surgical benefits and mental health and substance abuse treatment benefits to demonstrate that treatment limitations are applied comparably. This job does not fall on the employer, but you should make sure your plan has prepared the analysis or is working on it.

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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 (ALEs)" – that is, those with 50 or more full-time employees (FTEs) – 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.

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HSA, HRA, FSA Changes Sunset on Dec. 31, 2021

This is part of new laws that require health plans to offer similar benefit coverage for mental health and substance abuse treatment as they do for other medical and surgical procedures and services.

HSA, HRA and FSA revisions

The CARES Act temporarily authorized employers to allow employees with health savings accounts, health reimbursement arrangements and flexible spending accounts to make mid-year changes to how much they deposit in those accounts.

It also authorizes them to permit employees to roll over unused amounts in their health and dependent-care flexible spending arrangements from 2020 to 2021 and from 2021 to 2022. Employers that opted to allow their employees to make these changes and roll over funds, have to communicate to their employees that these changes come to an end on Dec. 31 this year.

The CARES Act also made permanent changes, including reinstating over-the-counter medical products as eligible expenses for HSAs, certain HRAs and FSAs without a prescription. These accounts may now allow certain menstrual care products, such as tampons, pads, liners and cups, as eligible medical expenses.

These are retroactive benefits to Jan. 1, 2020.

Make sure to notify your staff of these changes. You can tell them that if they have receipts for eligible expenses that date back to then, they can submit them for reimbursement. ❖

Vaccine Requirements

Compliance Issues for Firms Mulling Incentives, Penalties

EMPLOYERS THAT plan to or have already introduced incentives or penalties to coax their workers to get vaccinated against COVID-19, have to prepare for likely paperwork and compliance challenges.

The Biden administration has made it easier to require employees to get vaccinated after it ordered Fed-OSHA to write regulations mandating that all employers with 100 or more employees require their workers to get vaccinated or submit to weekly testing.

But for firms considering incentives or penalties in the form of higher premium contributions for workers who don't get vaccinated, there are three federal laws they will need to consider.

HIPAA portability rules

If you are planning to offer incentives for staff to get vaccinated or penalize those who don't, you have to consider HIPAA rules concerning wellness programs.

The rules bar wellness plans from discriminating against participants on the basis of a health factor, which experts say can include whether an employee has or has not received a vaccine.

That said, a program that conditions an incentive on a participant getting a vaccine would likely be classified as an "activity-only health-contingent program." To qualify as such, the program must meet five requirements:

- The maximum reward for all of the employer's wellness programs may not exceed 30%;
- The program must be reasonably designed to promote health or prevent disease (such as getting vaccinated);
- Individuals must have at least an annual opportunity to qualify for the reward;
- The reward must be available for all similarly situated individuals and must include a reasonable alternative standard for certain individuals who are not able to satisfy the standard; and
- All materials that describe the terms of the wellness program must include a disclosure of the availability of a reasonable alternative standard (or the possibility of a waiver).

The key aspect that employers need to keep in mind is that they will have to offer a "reasonable alternative" to employees whose doctors say that the vaccine is not medically appropriate for the employee.

In those cases, the plan has to offer an alternative option that meets the doctor's recommendations, or waive the requirement for that employee and provide the incentive.

Employer shared responsibility rules

Another way an incentive program could run into an issue is if the premium surcharge for employees that don't get vaccinated requires them to pay more for their share of the health insurance premium than is permitted by the Affordable Care Act.

The ACA's employer shared responsibility mandate requires applicable large employers (those with 50 or more full-time workers) to offer coverage that is affordable.

For 2022, that means the employee's share of health insurance premium cannot exceed 9.61% of their household income for the taxable year.

If you surcharge employees, it may affect affordability and subject your firm to employer shared responsibility penalties. This issue would likely arise more with your lowest-paid employees.

ERISA implications

If you have a vaccine incentive or penalty that's tied to your health plan, it could create a conflict with your ERISA-compliant plan and you would need to make changes to plan documents to reflect those changes.

Once you've updated your ERISA plan documents, you would also be required to notify your staff of those changes, such as providing them with a summary of material modification or reduction.

Also, because the change could result in some employees paying more for their coverage, you would need to make sure your plan's wording allows for plan election changes, if at all. In either case, you may need to amend your plan documents.

A final note

You should talk to your counsel before implementing an incentive program. You'll want their input so that your program complies with the law and doesn't create an affordability issue for any employees under the ACA, thus saving you from being hit with an employer shared responsibility mandate penalty.

You'll also need to communicate changes to your covered employees and prepare to respond to requests for a reasonable alternative standard. ❖

Coverage for Virtual Substance Abuse Treatment Grows

THOUSANDS OF American families have been affected by the tragedy of someone with a substance abuse problem. For many, especially during the COVID-19 pandemic, finding available and affordable treatment has been difficult or impossible. Recently, however, virtual treatment options have become available, and some insurance companies are beginning to pay for them.

This is an important development for both the group health insurance arena as well as the individual health insurance market. For employers, this is another lifeline that they can highlight for their staff as so many people have been affected by the stresses of the pandemic. For individual policyholders, they could have access to convenient and timely treatment.

Start-up companies across the country are offering virtual substance abuse treatment, including:

- Boulder Care, which provides digital opioid-addiction treatment.
- Pear Therapeutics, which provides software-based disease treatments; its lead product is a treatment for substance abuse disorders approved by the U.S. Food and Drug Administration.
- Ria Health, which employs 45 clinicians who can prescribe treatments online for alcohol-addicted patients.

These start-ups have attracted the attention of group health insurance companies, some of which are starting to cover their treatments for people insured under their health plans. For example:

- Ria Health has contracts with at least four insurers covering millions of people.
- Boulder Care has a partnership with Anthem.
- Pear Therapeutics has contracts with regional health plans in three states.
- An opioid-addiction treatment provider in Massachusetts has partnerships with UnitedHealth Group and Kaiser Permanente.

High demand

Demand for substance abuse treatment has grown during the pandemic.

Studies show that a quarter of American adults reported drinking more alcohol during the health emergency. As a result, space has been at a premium at in-patient rehabilitation facilities. Some have had lengthy waiting lists.

Virtual treatment gives new options to patients who cannot get admitted to rehab centers.

In addition, demand for counseling services skyrocketed as well as more people battled mental health issues brought on by the pandemic, particularly feelings of isolation and disconnection.

New Rules Rise from the Pandemic

- Some states made new rules for prescribing medicine via telehealth visits less restrictive.
- The federal government started requiring payment parity for mental health and substance-abuse visits done via video.

The benefits

These solutions are attractive to insurers because they reduce costs. Substance abuse patients who cannot get into rehab centers may overdose and end up in emergency rooms.

Employers see these new plan features as an additional way to retain valuable employees. In any large group of employees, there will be some who are suffering from addiction or have family members who are, and they will value this benefit.

If you are an employer who offers these plans, check with your health insurers to see if they've changed coverage terms for this type of treatment. If so, you may want to consider spreading the word among your staff.

For some of your employees or their family members, life-saving help may be just a video chat away. ❖