cpi lights

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Jon A. Cyganiak, CLU
President

The desire for universal health care has been a long-discussed question that the federal government has been trying to solve for the last 12 years.

Recently our national professional organization, National Association of Health Underwriters (NAHU), presented testimony to a government subcommittee exploring the topic of the single-payer system. Many Americans receive their health insurance coverage from employer-sponsored plans, or the government funded Medicare program. To significantly change the current structure and offerings of these plans could be detrimental to the health insurance system. And while many people feel the federal government can do more, once they understand how a single-payer system would work support significantly decreases.

NAHU supports the use of premium tax credits and the ACA tool of the firewall that prevents employees with access to affordable coverage through the workplace from receiving premium tax credits. This helps stabilize the employer group market and keeps the marketplace from being flooded with individuals who could get coverage elsewhere. If there are too few employees in need of coverage businesses could drop the insurance benefits completely.

NAHU advocates expanding and building on the ACA in this way, instead of making sweeping changes to the Medicare program to create a single-payer plan. By understanding the full impact of these decisions hopefully lawmakers can make better informed decisions for the future.

Source: http://newsmanager.commpartners.com/nahuw/issues/2022-02-18/2.html

Thanks for continuing to read CPILights!

As always, if you would like to submit an idea or comment in writing you can reach me at **Jcyganiaksr@cyganiakplanning.com**

Regards,

Jon A. Cyganiak

Jon A. Cyganiak, CLU
President

Third Winter is over, Spring seems to be in full force and Summer is just around the corner. And that means our Summer Hours will resume.

Starting Monday, May 23rd and running through Friday, September 2nd our business hours will be:

Monday – Thursday 8:00am – 4:30pm

Friday 7:30am – 1:00pm

Our offices will also be closed on Monday July 4th in observance of the Fourth of July holiday.

If you or your employees need to reach us outside these revised business hours, you may leave a detailed message in our voicemail system. We will get back to you as soon as possible.

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LEGISLATIVE UPDATES

FEDERAL

There is a new Special Enrollment Period for people who are still interested in getting subsidized coverage through the Marketplace. Those with incomes less than 150% of the federal poverty level -- $19,320 for an individual and $39,750 for a family of four -- can select policies on healthcare.gov according to the Centers for Medicare and Medicaid Services (CMS). It is only available to consumers who lose, or aren't eligible, for Medicaid or CHIP in their home states.

Individuals who qualify for this new SEP can enroll in any metal level of coverage, but those who are already enrolled and want to switch plans during the year would be limited to switching to a silver plan (including a more generous silver plan).

The new SEP runs from March 18 through December 31.

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As part of the Families First Coronavirus Response Act (FFCRA), anyone enrolled in Medicaid could not lose coverage during the pandemic. Prior to the public health crisis, states regularly evaluated whether residents still qualified for the safety-net program. The pandemic suspended those routines for the past two years. When the continuous coverage requirement expires, states will have up to 12 months to return to normal eligibility and enrollment operations.

According to new CMS guidance, states will be required to share with the federal government how many renewals they plan to begin processing during each month of the year-long "unwinding period," which methods they will be taking and how they plan to limit coverage losses. States will be required to submit the form to CMS by the 45th day before the end of the month in which the public health emergency ends.

HHS extends the public health emergency in 90-day increments, and it is currently set to end July 15.

Source: NAHU Washington Update

THE Q & A CORNER

Aaron Bielawski
Agent
CYGANIAK PLANNING INC

The Cyganiak Planning Q & A Corner takes questions that our agents and sales/service associates were asked and provides detailed guidance to help you understand and resolve similar scenarios at your workplace, should they ever arise.

QUESTION: I have a company that has an HSA eligible plan, but they will be dropping it starting on June 1st. For the employees currently enrolled in that plan, can they continue to make contributions throughout the plan year as long as the contributions do not exceed 5/12ths of the contribution limit

ANSWER: Employees are eligible to contribute to their HSAs, and/or receive contributions made by their employer, only while all four of the following conditions are met:

- The employee has qualifying high deductible health plan (HDHP) coverage;
- The employee does not have any disqualifying non-HDHP health coverage;
- The employee is not enrolled in Medicare; and
- The employee cannot be claimed as a dependent on someone else's tax return.

Eligibility for HSA contributions is determined monthly, as of the first day of each month, so the IRS annual limit is prorated if the employee does not meet the four eligibility conditions for the entire year. The employee can confirm this by completing the limitation worksheet in the Form 8889 instructions.

An HSA account holder may make contributions to their HSA for the previous year through the date that they file their taxes (generally April 15th), but only for the months that they were eligible.

Disclaimer: Guidance provided above is opinion gathered from Cyganiak Planning Inc.'s Human Resources Advocacy Firm based on their research of specified topics and cannot be considered as legal opinion or legal fact. Please consult with your legal counsel for any specific and final guidance in any situation pertaining to your own company.

TELEHEALTH AND HSAS

Jon I. Cyganiak
Agent/Vice President
CYGANIAK PLANNING INC

In early March, Congress passed the Consolidated Appropriations Act (CAA) of 2022, a $1.5 trillion governmental funding package. Among its many provisions, the bill extends access to telehealth services for individuals who are covered under a health savings account (HSA)-qualified high deductible health plan (HDHP).

Typically, HSA-qualified HDHPs cannot pay for covered services, except for specified preventative care, until the participant meets the plan's deductible. This legislation permits sponsors of HDHPs to offer telemedicine services at no cost to participants, regardless of the plan's annual deductible, without impacting participant HSA eligibility. This relief was initially established as a component of emergency COVID-19 legislation, and it expired on December 31, 2021. The 2022 CAA reinstates these telemedicine protections for the period of April 1, 2022 through December 31, 2022.

There is a three-month gap in this relief between January 1, 2022 and March 31, 2022, which means that participant deductibles should be applied to any non-preventative telehealth claims incurred during this time. If the IRS chooses to take enforcement action against HDHP plan participants who accessed telemedicine services without cost-sharing at the beginning of this year, those individuals could lose eligibility to contribute to their HSAs from January-March 2022. It is unclear if the IRS will pursue enforcement for the period when this relief lapsed or not.

In addition to the extension of telemedicine protections for HDHPs, the 2022 CAA expands the scope of telehealth services that Medicare will cover. The legislation also allows both Medicare and Medicaid to continue covering select telehealth services for 151 days after the COVID-19 public health emergency ends.

Source: NAHU

HEALTH SAVINGS ACCOUNTS
PROS AND CONS

Health Savings Accounts can be an important tool for saving money related to medical expenses. But for them to be effective they need to be funded properly.

HSAs are not for everyone.
Health Savings Accounts are a great option for individuals and families that want to lower their insurance premiums and are willing to take on some of the monetary risk with higher deductibles and out-of-pocket costs. But for those who are risk adverse, or who may have higher medical expenses, a plan with a higher premium and lower out-of-pocket costs may be more realistic.

HSAs can be a great retirement tool.
One of the benefits in having an HSA is its savings power. Money that is deposited can be used as additional retirement savings if it isn't used for medical expenses. But, like any retirement vehicle, it can't be withdrawn until age 59 ½.

HSAs could be more harm than good.
To be eligible for a health savings account you must have a high deductible health plan (HDHP) which have lower premiums. But you must also make sure to put money into the HSA to pay any medical expenses. If you don't, or can't afford to, then you, or your employees, may find yourself in a bind when it's time to go to the doctor or get a prescription.

Make sure you evaluate all the circumstances when deciding if the HSA and the related HDHP are a good fit. Healthcare is one of the most expensive costs everyone will incur as some point in time. There is no use having a savings tool if you can't afford to fund it.

Source: https://www.benefitnews.com/advisers/list/pros-and-cons-of-an-hsa-compatible-healthcare-plan

NO SURPRISES ACT
WHAT IS THE POINT?

Steve Flewellen
Agent
CYGANIAK PLANNING INC

The new federal prohibition on surprise billing went into effect on January 1, 2022 (and applies to plan years beginning on or after that date) via the No Surprises Act. The new rules prohibit providers from charging "out-of-network" rates for emergency care, air ambulance services, and all care by an "out-of-network" provider in an "in-network" facility. Any differences between what a provider charges in these circumstances and what a plan is willing to pay must be resolved between the provider and the health plan. If payment details cannot be settled within 30 days of billing, either party may start the independent dispute resolution (IDR) process that utilizes a web-based portal maintained by the federal government. A new FAQ published by the Department of Health and Human Services, Labor, and Treasury details how that process will work.

Some highlights in the **FAQ** include the document-based review of the federal Independent Dispute Resolution (IDR). Both parties will submit all required information and supporting documents to their IDR entity, and the arbitrator will make their determination based on those materials alone. The information that must be submitted includes the final offer of payment expressed as both a dollar amount and a percentage of the qualifying payment amount (QPA). Certified IDR entities have 30 business days after selection to settle the dispute. The external review process for coverage disputes between individuals and plans or issuers remains in place. The federal IDR process involves disputes regarding payment amounts between providers, facilities, or providers of air ambulance services and plans or issuers. No coverage determinations are made by IDR entities.

Fully insured groups will generally rely on their health insurance carrier to handle surprise billing issues. Self-funded group plans should develop parameters with their third-party administrators regarding the negotiation process, a strategy for proposed fee payments, and how an IDR claim is to be handled. Groups with January 1 plan years are beginning to see affected claims. These details should be resolved soon and likely need to be reflected in an amendment to the group's administrative services agreement.

The ultimate point of this is that the No Surprises Act bans providers in your in-network facility emergency departments from balance billing. Those providers are typically sub-contracted out to ER specialty provider groups that do not contract with insurance company's networks. This has created an opportunity in the past, for those non contracted providers to balance bill people using emergency services, above and beyond the structure of insurance plans. Providers and facilities in these situations are required to provide an easy-to-understand notice explaining the billing protections, who to contact with concerns about violations and that consent is required to waive billing protections. Hopefully, this will do as intended and end the balance billing issue that has come about in the last few years.

Sources: https://nahucompliancenow.com/2022/02/14/new-guidance-on-the-federal-surprise-billing-process/
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-FAQs-Federal-Independent-Dispute-Reolution-Process.pdf
https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list

In the SPOTLIGHT

A WHO'S WHO IN SUCCESSFUL BUSINESS

Cyganiak Planning, Inc. would like to recognize the physical growth, as well as the accomplishments of our clients. If you are expanding your human resources or your facility, please let us know. If you are participating in some community outreach or volunteer effort or have recently been recognized with an award, please contact your agent (262-783-6161) and we will share your achievements with our readers.

The James Beard Foundation recently honored Milwaukee's own **Solly's Grille** with one of six America's Classics Awards for 2022 for their legendary butter burger. Kenneth "Solly" Salmon created his version of the delectable treat in 1936, the same year the restaurant opened. It has been bringing customers to their doors ever since.

The Beard Foundation Awards Committee was established in 1998 to recognize restaurants for their "timeless appeal" and quality food that reflects the character of their communities. More than 100 restaurants have been honored since its inception.

PCORI FEES EXTENDED

Eric Pierson
Sales Associate
CYGANIAK PLANNING INC

A law signed at the end of 2019 extends the Patient-Centered Outcomes Research Trust Fund fee, part of the Affordable Care Act that helps fund the Patient-Centered Outcomes Research Institute (PCORI). The extension imposes the fee through 2029.

The PCORI fee is due by July 31st from issuers of specified health insurance policies and the plan sponsors of applicable self-insured health plans. For most fully insured insurance programs the fee is collected and paid directly by the insurance carrier. With level-Funded, partially self-funded, and self-funded insurance programs this fee is usually paid by the employer and is paid annually using tax Form 720 (Quarterly Federal Excise Tax Return).

The PCORI fee is calculated on the average number of lives covered under an applicable self-insured health plan. Generally, plan sponsors of applicable self-insured health plans must use one of the following three alternative methods to determine the average number of lives covered under a plan for the plan year:

- Actual Count Method
- Snapshot Method
- Form 5500 Method

The fee applies to health plans for the preceding calendar year. According to **Notice 2021-04**, the current annual fee adjustments are:

- For plan years that ended on or after Oct. 1, 2021, and before Oct. 1, 2022, the fee is **$2.79** per person covered by the plan
- For plan years that ended on or after Oct. 1, 2020, and before Oct. 1, 2021, the fee is **$2.66** per person

Forms and more information can be found on the IRS website:
https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

**Sources IRS.gov, shrm.org*

ACTIVE OR EXERCISE

Our society has a varying range of health consciousness. It is a fact that the more you move the healthier your body will be, and the longer it will last.

But there is a difference between being an active person and one who exercises. Research shows that people who exercise regularly can extend their life span up to 10 years and the incident of becoming disabled in your "senior" years can be reduced or even avoided.

So, what is the difference between being an active person and one who exercises? Generally speaking, when you are active you are simply doing things that require some type of movement such as gardening, yard work, or cleaning your house. It can even be doing light exercise, but on an inconsistent basis.

Exercising is an activity that has physical or mental exertion to maintain or improve the function of your body, is structured, goal oriented and done on a consistent basis. Exercise is what allows you to remain active now, and as you age. It helps rejuvenate your body and your mind.

Cardiovascular exercise, such as running or swimming, strengthens our heart, lungs, and vascular system. Strength training, such as lifting weights or doing bodyweight exercises, helps our bones and muscles. And flexibility training, such as yoga helps keep joints and muscles healthy.

What you do isn't as important as actually doing it and doing it consistently. We all want to live a healthy productive life. To do that to our fullest potential we need to keep our bodies in good working order. Exercise is the best way to do that.

Source: https://www.eptrail.com/2021/10/03/high-altitude-health-active-vs-exercise/