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cpi lights

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Jon A. Cyganiak, CLU
President

CPI Lights has reached a milestone.... 30 years in production!

When we started our communication in 1992, we hoped it would be a vehicle to share important information to you, our trusted clients. In turn this information could be shared with your employees, friends, and family.

Over the years we looked to answer questions about insurance products, government actions, social norms, and many other topics related to insurance and employee benefits. We have covered the inception and implementation of HIPPA, PPACA, and Medicare Parts C and D.

There have been numerous OSHA, IRS and DOL guidance to interpret and explain. We have shared statistics and numbers related to insurance products, benefits employees are interested in, and benefits employers offer.

We hope you have found the issues interesting and will continue to enjoy reading them in the future.

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, CLU
President

MEDICARE 2021 CHANGES

Every year Medicare reviews the premiums, surcharges, and copayments it assesses beneficiaries. As is the usual case, the 2022 numbers are up from last year's charges.

The 2022 annual Part B deductible will again see a slight increase to $233 while the Part A Inpatient Hospital deductible increases a bit more than $70 to $1556. The daily copays for inpatient stays beyond the 60th day, skilled nursing home stays, and lifetime reserve days have also increased slightly.

Those with higher incomes have varying surcharges to their Part B and Part D premiums. The 2022 income thresholds increase from $3000 - $5000 as the income brackets increase. Incomes are based on 2020 tax returns.

Part B premiums, including IRMMA surcharges have again increased from 2021.

- $170.10/month: less than or equal to $91,000 (single)/ less than or equal to $182,000 (married)
- $238.10/month: $91,001-$114,000 (single)/ $182,001-$228,000 (married)
- $340.20/month: $114,001-$142,000 (single)/ $228,001-$284,000 (married)
- $442.30/month: $142,001-$170,000 (single)/ $284,001-$340,000 (married)
- $544.30/month: $170,001-$500,000 (single)/ $340,001-$750,000 (married)
- $578.30/month: more than $500,000 (single)/ more than $750,000 (married)

Part D fees are also slightly higher in 2022 compared to 2021.

- Plan premium: less than or equal to $91,000 (single)/ less than or equal to $182,000 (married)
- $12.40 + plan premium: $91,001-$114,000 (single)/ $182,001-$228,000 (married)
- $32.10 + plan premium: $114,001-$142,000 (single)/ $228,001-$284,000 (married)
- $51.70 + plan premium: $142,001-$170,000 (single)/ $284,001-$340,000 (married)
- $71.30 + plan premium: $170,001-$499,000 (single)/ $340,001-$749,999 (married)

$77.90 + plan premium: more than $500,000 (single)/ more than $750,000 (married)

Managing Editor: Laura Bagin

ACA EMPLOYER COVERAGE REPORTING UPDATES

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The ACA added two major employer coverage reporting provisions to the Internal Revenue Code (IRC).

IRC Section 6055 requires a health insurer to provide coverage statements that the insureds can use to show the IRS that they've met the individual shared responsibility requirements. Insurers meet the Section 6055 coverage reporting requirements with IRS Form 1095-B.

IRC Section 6056 requires an ALE (Applicable Large Employer) to provide coverage statements that show whether it's met the ACA employer shared responsibility standards. Employers meet the Section 6056 coverage reporting requirements with IRS Form 1095-C.

Self-insured employers usually meet the Section 6055 requirements along with the Section 6056 requirements by sending out 1095-C forms. A self-insured employer of less than 50 FTE's (Full Time Equivalents) that sends out 1095-B forms to the insureds is supposed to send copies of those forms, along with a 1094-B cover sheet form, to the IRS.

Similarly, an ALE that sends out 1095-C forms is supposed to send copies of those forms, along with a 1094-C cover sheet form, to the IRS.

On November 22, 2021, the Internal Revenue Service (IRS) published proposed regulations that introduce significant changes to the Affordable Care Act (ACA) reporting process for both large and small employers. These changes specifically impact the Form 1095-B & Form 1095-C distribution deadline and good faith transition relief.

Automatic Extension to the Distribution Deadline
Section 6055 and 6056 of the ACA reporting regulations require that employers furnish Forms 1095-B and/or Forms 1095-C to employees no later than January 31st of the year following the applicable calendar year. In other words, under the formal rules, forms for the 2021 calendar year need to be distributed by January 31, 2022. However, since 2015, the IRS has consistently extended this deadline, typically by 30 days. In 2020, the IRS requested comments about this extension while also indicating that they would not continue to offer such relief for future filings.

The IRS issued an automatic 30-day extension to the January 31 filling deadline in the proposed regulations. This rule will apply to reporting for the 2021 calendar year and is likely to be made permanent thereafter when the regulations are finalized.

Under these rules, forms will be considered timely as long as employers furnish them to employees no later than 30 days after January 31st. In cases where the 30th day following the standard deadline falls on a weekend or legal holiday, employers must distribute forms to employees no later than the next business day. This automatic extension indicates that forms furnished after the 30-day grace period will be considered late (and subject to corresponding penalties), and that employers will not be able to request additional time past the 30 days to furnish forms to employees.

Good Faith Transition Relief Eliminated
Since 2015, the IRS has also provided good faith transition relief to ACA reporting. This relief has shielded employers from penalties for incorrect and/or incomplete ACA filings, provided that the employers have made a "good faith effort" (tried their best) to comply with the requirements.

The proposed regulations confirm the IRS's indication that they would not extend this transition relief past 2020: good faith transition relief will not be available for the 2021 ACA filing, nor for any subsequent filing year. This change will make it much harder in the future for employers to avoid ACA penalties based on incorrect filings.

How Do These Regulations Impact Employers?
It is more important now than ever that employers strive to ensure their initial submissions to the IRS are accurate and complete. This means employers not only need to file, they also need to "get it right" – from minute details such as employee name and SSN to critical information about employee eligibility and lowest-cost contributions.

Employers who submit erroneous filings now face a much higher risk related to inaccurate/incomplete information return penalties, up to $280 per form for 2021, which is typically doubled to account for the error that was both furnished to the employee and e-Filed with the IRS. These penalties are in addition to, not in lieu of, the ACA's employer mandate penalties that are often triggered by erroneous filings. The IRS does accept corrections filings that rectify ACA submissions; however, for any such filing submitted for 2021 or beyond, this could lead to an automatic information return penalty.

Source: IRS.gov
NAHU

LEGISLATIVE UPDATES

FEDERAL

There is a new Department of Labor FAQ that expands on the preventive care benefits for colorectal cancer screening and oral contraceptives.

The ACA requires all non-grandfathered health plans pay for any preventive care services on a first-dollar basis. This means no copays, coinsurance or deductibles can be charged.

Colorectal cancer screenings have historically been recommended for adults ages 50-75. In May, 2021 that age recommendation changed to ages 45-75. Plans effective on or after May 31, 2022 will include this expanded screening. In addition, if a participant receives a colonoscopy following a positive, non-invasive, stool-based screening test or a direct visualization test (e.g., sigmoidoscopy or CT colonography) the screening is still considered "preventive" care. This means these colonoscopies and the associated services must also be provided at no cost to the participant.

Oral contraceptives are also covered on a first-dollar basis, but prior guidance stated at least "one form of contraception in each method" be covered. The new guidance expands coverage requiring plans to develop a plan to allow providers easy and quick appeal process when a provider feels a particular form of birth control is medically necessary.

The new FAQs expressly provide that certain common plan practices violate these rules. These practices include:

- Denying coverage for all or particular brand name contraceptives, even after the individual's attending provider determines and communicates the brand is medically necessary;
- Requiring individuals to fail first using numerous other services within the same method of contraception before approving the contraceptive product that is medically appropriate for the individual, as determined by the individual's attending health care provider;
- Requiring individuals to fail first using other services in other contraceptive methods before the plan or will approve coverage for a service or contraceptive product in the contraceptive method that is medically appropriate for the individual, as determined by the individual's attending health care provider; and
- Failing to provide an easily accessible, transparent, and sufficiently expedient exception process for appeals.

COVID UPDATES

There have been a lot of legal decisions regarding COVID testing and vaccines in the news lately. The Supreme Court (SCOTUS) made rulings last month about vaccinations in the workplace. And the Department of Labor (DOL) has weighed in on payment for home test kits.

On January 13, 2022, SCOTUS overturned an OSHA interim final rule mandating private employers with 100 or more employees require all employees be vaccinated or be tested for COVID-19 weekly. OSHA also required employers to compensate employees' time to get vaccinated and pay sick leave for anyone who needed to recover from vaccine side-effects.

The majority ruling stated that these requirements are a "significant encroachment into the lives – and health- of a vast number of employees. ….Although COVID-19 is a risk that occurs in many workplaces, it is not an occupational hazard in most. It can and does spread at home, in schools, during sporting events, and everywhere else that people gather." OSHA overstepped their authority.

Despite their ruling regarding large employers, SCOTUS upheld the CMS vaccination requirement for healthcare workers.

"Congress has authorized the secretary [of Health and Human Services] to impose conditions on the receipt of Medicaid and Medicare funds that 'the secretary finds necessary in the interest of the health and safety of individuals who are furnished services,'" the majority opinion reads. According to the judges, the secretary's conclusion that a vaccine mandate would "substantially reduce the likelihood that healthcare workers will contract the virus and transmit it to their patients" thus "fits neatly within the language of the statute."

The Department of Labor's new guidelines on home test kits went into effect on January 15, 2022. Over-the-counter test kits are subject to coverage by health plans. Both fully insured and self-funded health plans must comply. No cost-sharing, prior authorization or other medical management is required.

OTC test kits must be purchased by, and reimbursement made to the individual. Pharmacies, or other sellers, may not be reimbursed. OTC kits may be limited to eight per month (or 30-day period), but physician ordered tests cannot be limited.

Source: NAHU Washington UPDATE, Jan 14, 2022
NAHU Compliance NOW, Jan 11, 2022

DISABILITY BASICS

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COVID-19 has made us reevaluate a lot of aspects of our lives. One of those has been what we do if we become sick or injured for an extended period and are not able to work. As a result, more people are purchasing disability insurance. This coverage is used to protect against loss of income due to injury, illness or condition that causes physical impairment or the inability to work.

There are two main types of disability insurance, short-term disability (STD) and long-term disability (LTD). Their names basically describe what they are used for. Short-term disability insurance provides coverage for a shorter period, usually 26 weeks or less, and is often offered as group coverage. Group STD usually has an elimination period (length of time before coverage begins) that is between 0 and 14 days. Long-term disability insurance covers for much longer periods of time and for more serious situations. LTD policies usually have a 90-to-180-day elimination period and can provide coverage for various amounts of time, usually at least 2 years on group contracts. Individual policies are a combination of short- and long-term coverage with benefits often beginning after 30 days of disability and lasting up to age 65.

Group plans can be employer sponsored or voluntary and vary for income covered, elimination periods, and length of time covered. The best way to set up group disability plans is to use post-tax salary, so benefits are received tax-free. Taxes may need to be paid for benefits received from an individual plan if the insurance company does not take them out before sending benefit checks.

When purchasing DI here are some points to check:

- What is the definition of disability? Does it cover both injury and sickness? Is it for partial or total disability? Is it defined as inability to perform your current occupation or as inability to perform any occupation of which you are capable?
- When does coverage begin? Is it different for injury and sickness?
- How long will benefits be paid? What is the weekly or monthly benefit?
- How much of your income will be replaced?
- What does it cost?
- Is it guaranteed renewable?

**Sources: Wikipedia, WI OCI*

THE MARK CUBAN COST PLUS DRUG COMPANY
An Alternative RX Plan

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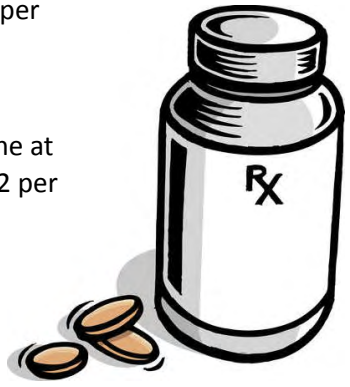
There is a new online pharmacy company funded by Mark Cuban, owner of the Dallas Mavericks and star of the TV show Shark Tank. The goal of "The Mark Cuban Cost Plus Drug Company" (MCCPDC) is to offer 100 generic medications at a reduced price. Those purchasing prescription medication from the site can expect to pay 15% above manufacturing costs plus a $3 fee for pharmacists and another $5 for shipping. A doctor's prescription is also required.

This site will concentrate on sales for the lower-volume demand generic medications. MCCPDC plans to cut out the middleman by only charging customers their out-of-pocket costs. No insurance carriers need be involved. The company also created its own pharmacy business manager firm in October, allowing it to negotiate prices with drugmakers in-house.

Here are some of the anticipated generic drugs and their pricing:

- Leukemia therapy imatinib for $47 per month compared to $120 or more with a common voucher and a retail price of $9,657 per month.
- Ulcerative colitis treatment mesalamine, for $32.40 per month, vs. $940 per month retail.
- Gout treatment colchicine at $8.70, compared to $182 per month retail.



Like all pharmacy plans this is not a one-size-fits-all program. It may benefit some and not others. Your insurance plan may offer you the best pricing for your medications. But it is important to look at all options when purchasing prescriptions. You never know when they may change, and you need to re-evaluate your situation.

Source: https://costplusdrugs.com/medications/
https://www.webmd.com/drug-medication/news/20220128/mark-cuban-online-pharmacy-generics

THE Q & A CORNER

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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 group that would like to incentivize employees not to take the medical insurance plan. They are offering 50 dollars a month to do so, but are there any parameters to that, or is it against compliance to do so?

ANSWER: Per our phone conversation, here is information on a cash in lieu plan. Additional related topics are concerning an applicable large employer, the cash in lieu amount and ACA affordability. Also included is information on our POP plan document creator.

Cash-In-Lieu of Enrolling in the Employer Group Health Plan
The employer can offer an incentive for employees who have outside medical coverage. We refer to this type of policy as a cash in lieu of health coverage policy or "cash in lieu". The only way that an employer may offer employees compensation for waiving coverage is through a "cash in lieu" provision which is part of the employer's Section 125 cafeteria plan. These types of payments are also often known as waiver credits or opt out credits. When offered compliantly through a Section 125 plan, these payments must be taxed.

Example: Employee has a choice of electing Medical Plan A or receiving $100/month cash (in addition to wages). If employee elects the cash, it is subject to all ordinary income taxes and employment taxes.

An established cafeteria plan must be created in accordance with IRS regulations (e.g., written plan; elections made prior to start of coverage period; no mid-year changes other than certain change-in-status events; nondiscrimination rules). For a cash in lieu provision, the employer cannot restrict the use of cash, i.e. they cannot say it must be used for benefits, etc. Additionally, to be valid, the option must be offered to all benefit eligible employees equally.

Applicable Large Employers subject to ACA Employer Shared Responsibility Provision:
Part of the ACA Employer Shared Responsibility Provision on providing affordable coverage (to not be possibly subject to a penalty) requires that a cash-in-lieu benefit (i.e., cash option under a cafeteria plan for employees that waive or opt out of health coverage) is counted as an additional employee cost for purposes of determining "affordability." E.g., if self-only contribution is $100 and cash-in-lieu benefit is $50, the employee's contribution is deemed to be $150.

There was additional IRS guidance concerning the ACA affordability rules and opt-out (cash in lieu) credits that took effect January 1, 2017. The opt-out credit amount does not have to be added to the employee only premium amount for the affordability calculation if the employee provides reasonable evidence that they have other minimum essential coverage (must be a group plan, not individual plan).

The IRS said when an employee waives medical coverage and receives an opt out credit if the employee provides reasonable evidence that they have other minimum essential coverage under a group plan (not individual coverage), this will eliminate the need to add the opt-out credit amount to the cost of employee self-only coverage to determine if the plan is affordable. If the plan does not follow the requirements to be a "eligible opt-out arrangement", then the cash in lieu amounts are added to the employee only premium to determine affordability.

Conditions on Who Can Receive:
Most plans don't include any additional conditions to qualify for the credit. However, some cafeteria plans place limits; the most common one is limiting the payment to employees that have group health coverage through another source (such as the spouse's employer plan). To our knowledge, the IRS rules governing cafeteria plans do not prohibit designing the plan to limit cash-in-lieu to employees that coverage under another group health plan. However, keep in mind that you should be offering the payment to all "similarly situated" employees; this means all employees in a specific, non-discriminatory benefit class. If you only have one benefits class, such as all employees working 30 or more hours a week, then you would offer the payment to everyone meeting that condition.

IRS regulations: https://www.govinfo.gov/content/pkg/FR-2016-07-08/pdf/2016-15940.pdf

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