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cpi lights

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Jon A. Cyganiak, CLU
President

Perhaps you've heard the suggestion of "Medicare for All." The government run healthcare program for individuals over 65 seems like it could be a solution to the health insurance problem.

But were you aware that according to the Congressional Budget office the trust fund which pays for most of Medicare Part A expenses is expected to be broke by 2026? The program's income will still be able to cover most of the hospital benefits paid by Medicare, but only to the extent that payroll taxes create enough revenue.

There are many ideas on how to infuse more money into the Hospital Insurance Trust Fund. Raise taxes overall, income-based benefits, benefits based on life-expectancy and a benefit stipend are just a few ideas that the pundits have discussed.

Ultimately the task will fall to our elected politicians. There is no doubt that a combination of ideas will be required to set things straight with the ailing Medicare system. Some may be more palatable than others, but a permanent fix is needed post haste.

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

Source: www.disabilitycanhappen.org

THANKSGIVING TIDINGS

What a difference a year can make. While all is not completely back to normal, we certainly have made great strides these past 12 months. Most of us are finding a way to resume our regular activities and travel.

The past two years have taught us many things. It is important to live in the moment, to remember our priorities, and to take nothing for granted. Be thankful for all that life has to offer and tell your loved ones you care as frequently as possible.

We at Cyganiak Planning can't say it enough… We remain honored to help you and your employees maneuver the benefits world to find the best and most appropriate coverage for health and dental benefits, for life and disability insurance, and your retirement planning.

It is our sincerest hope that you all have a happy and healthy Holiday Season.

Managing Editor: Laura Bagin

NO SURPRISE BILLING ACT

FINAL RULES EFFECTIVE JAN. 1, 2022 | PART 2 – CARRIER/PROVIDER RESPONSIBILITIES

Jon I. Cyganiak
Agent/Vice President
CYGANIAK PLANNING INC

In the last issue of CPI Lights we explained what specific medical services were covered under the No Surprise Billing Act that was passed as part of the Consolidated Appropriations Act 2021 (CAA). The other important component to discuss is how health plans will pay for these protected medical services.

What will health plans have to pay providers?
The new rules do not require health plans to pay providers based on billed charges. Instead, they introduce a complex set of rules for determining what the in-network rate "should be" for out-of-network services. The rules are similar but not identical for purposes of determining participant cost-sharing versus provider payments.

For participant cost sharing, the "in-network rate" is:

- The amount determined by an applicable All-Payer Model Agreement. These are agreements that certain states, most notably Maryland, have reached with the Centers for Medicare & Medicaid Services (CMS) that set specific pricing which all payers in the state abide by in paying for certain services; or
- If no All-Payer Model Agreement exists, the amount determined under a specified state law; or
- If neither of the above applies, the lesser of the actual billed charge or the "qualified payment amount," which is generally the plan's median contracted rate.

For purposes of paying providers and facilities:

- Plans have 30 days from the date they receive a bill from an out-of-network provider/facility to send a payment or deny the claim;
- If the provider/facility does not accept the plan's payment as payment in full, the parties have 30 days to resolve the matter privately.
- If the plan and provider/facility do not resolve the billing issue within 30 days, the plan must pay the provider/facility based on the "in-network rate" calculation described above for determining participant contributions.
- If the provider/facility does not accept this additional payment as payment in full, the final payment amount will be determined by an independent dispute resolution (IDR) entity.

These rules for determining in-network rates will add significant complexity to claims administration surrounding the protected services. There are many outstanding questions related to the IDR process that will be addressed in forthcoming regulations.

What are the notice and consent rules, and how do they work?
As noted above, post-stabilization services can revert to out-of-network rates if certain conditions are met, and the provider/facility gives notice that they are out-of-network and receive informed consent to continue treatment. Certain out-of-network providers at in-network facilities can also charge out-of-network rates if they follow these procedures.

For these purposes, the provider/facility notice must:

- State that the provider/facility is out-of-network;
- Include a good faith estimate of the amount that will be charged for the services;
- State that the estimated charges do not constitute a contract;
- Provide information about whether prior authorization or other care management requirements may apply; and
- State that the patient is not required to provide consent and that they may instead seek treatment from an in-network facility/provider.

To be valid, the notice must:

- Be provided separately from, and not attached to or incorporated into any other documents;
- Be written and provided on paper, or, as practicable, electronically as selected by the patient; and
- Be provided:
  - At least 72 hours before the appointment (if the appointment is made 72 hours or more in advance); or
  - On the day the appointment is made and at least 3 hours before services are rendered (if the appointment is made less than 72 hours before services are to be provided).
- The regulation does not include a model consent notice but specifies that the federal Department of Health and Human Services will release one shortly.

For a consent to be valid, it must:

- Be provided voluntarily;
- Follow the standard format provided by the Department of Health and Human Services;
- Be signed (including by electronic signature) by the patient or their authorized representative;
- Meet applicable language access requirements;
- Acknowledge that the patient has been notified that any payments made by them may not accrue towards their in-network deductible or out of pocket maximum;
- State that the patient agrees to be treated by an out-of-network provider/facility and understands they may be balance billed;
- Include the date notice was provided and the date and time at which the consent was signed; and
- Be provided to the patient in-person, or through mail or e-mail as selected by the patient.

No Surprise Billing Act - Part 2 continued on page 3

No Surprise Billing Act - Part 2 continued from page 2

Even if these complex notice and consent procedures are followed, surprise billing protections cannot be waived relative to:

- "Ancillary services," which include:
  - Items or services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or non-physician practitioner);
  - Items or services provided by assistant surgeons, hospitalists, and intensivists;
  - Diagnostic services, including radiology and laboratory services; and
  - Items or services provided by an out-of-network provider if no in-network provider can provide such item or service at the facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise during the course of treatment;
- Items or services by a provider/facility not listed in the notice; or
- Consent that is withdrawn in writing before an item or service has been provided.

Providers/facilities that do provide notice and receive consent must notify the patient's health plan so that claims can be administered appropriately and provide the plan with a signed copy of the written notice and consent documents.

What are the next steps for plan sponsors?
It is admittedly a hectic year for health plan sponsors and their service providers—and requests have been made to extend many of the forthcoming deadlines impacting plans. Note, however, that considering the issuance of the interim final rules described above, it is improbable that the implementation of the surprise billing prohibition will be delayed.

For fully insured plans, carriers will be responsible for ensuring compliance with these new rules, and no direct action is needed at this time. Self-funded plan sponsors, however, are legally responsible for ensuring compliance. To that end, plan sponsors should work closely with their claim's administrators in the coming months to ensure the plan is in a position to comply on a timely basis and that plan participants will get appropriate notifications.

Source: https://nahucompliancenow.com/2021/07/06/national-prohibition-on-surprise-billing-effective-starting-january-1/

DON'T FORGET…

Annual Enrollment – Medicare
October 15 – December 7:

Medicare beneficiaries may change PDP or MA/PD for 2022. Members may also change from Original Medicare to MA/PD or MA/PD to Original Medicare. All effective dates will be January 1, 2022.

Open Enrollment – Individual Plans/FFM
November 1 – December 15:

Individuals can enroll in or change their health insurance plan for January 1, 2022. If you have a current plan and make no changes you will be auto renewed for 2022 plan year.

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.

We are pleased to announce that **UFS LLC** received the Benefits Award for the Milwaukee Journal Sentinel Top Workplaces Program for 2021.

> *"Being considered a "Top Workplace" is a special recognition we graciously accept. We're proud to be considered a top workplace again, and to have an appealing benefit package also worthy of recognition. We have an incredible team and continue to add top talent to serve banks within the UFS Community."* –TEAM UFS

Congratulations on your commitment to your employees well-being!

Congratulations to Tammie Xiong, the Executive Director for the **Hmong American Women's Association** (HAWA), who was recently named as one of Wisconsin's most influential Asian American Leaders by Madison365. HAWA is a grassroots social justice organization, located in Milwaukee, that is led by Southeast Asian women and queer fem women. The organization is dedicated to ending gender-based violence against SE Asian women, girls, and LGBTQ folks. Xiong's current leadership rolls include serving on the WI Governor's Council on Domestic Abuse and as a Commissioner for the City of Milwaukee Commission for Domestic Violence and Sexual Assault.

LEGISLATIVE UPDATES

FEDERAL

The 2021 Retirement Plan contribution limits were recently released by the IRS. Among the highlights for next year:

- The 401(k) and 403(b) maximum annual elective deferral limits will increase $1,000 to $20,500. The higher-than-normal increase is due to higher inflation.
- The catch-up contribution limit for individuals aged 50 or over remains $6,500.
- The annual defined contribution limit has increased to $61,000. Up $3,000 from 2021
- The annual allowable compensation limit has increased to $305,000. Up $15,000 from 2021

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A bipartisan bill intended to provide relief to employers with regards to ACA reporting requirements was introduced in the House of Representatives in September. H.R. 5318 seeks to ease compliance under Section 6055 and 6056 by:

- Establish a new voluntary reporting system for employers to report to the IRS information about their health plans. Exchanges will use the federal data hub to access this data for individual verification for tax credits.
- Require that employers report to the IRS only those employees (and/or their dependents) who are not receiving healthcare from their employer, greatly simplifying the requirement that all employees be reported.
- Specify that information that would be reported would include name and employer identification, who has been extended an offer of minimum essential coverage, whether coverage meets minimum value and the affordability safe harbor, and months that coverage is available without waiting periods.
- Allow employers to deliver reports to employees electronically without another consent form.
- Instruct the Government Accountability Office to conduct a study on the notifications, HHS appeals process and the prospective reporting system.
- Require HHS to review the most recent tax filing for individuals automatically reenrolled in exchange-based coverage and adjust their tax credits accordingly.

INSURANCE AFFORDABILITY PERCENTAGE FOR 2022

With all the talk going on in Washington DC and lack of progress on ‘fixing’ healthcare, ALEs (Applicable Large Employers), any company or organization that has an average of at least 50 full-time employees or “full-time equivalents”) still should review their contributions strategy to avoid the ACA employer penalty.

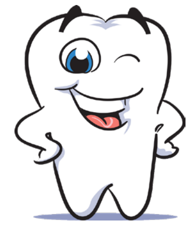
Employer sponsored coverage was originally defined as an employee contribution for self-only coverage of no more than 9.5% of the employee’s household income. This safe harbor was established by the IRS due to employers not knowing an employee’s exact household income.

The affordability percentage is indexed and has gradually increased reaching 9.78% in 2020 and 9.83% in 2021. Starting in 2022 the limit will decrease to 9.61%. This requirement applies to the lowest cost single coverage option that the applicable large employer offers. Originally the requirement was to compare premium contribution for such coverage to the employee’s household income. Below is an example for an employee with W-2 earnings of $45,000.

Year	Affordability %	Affordability-Year	Annual W-2	Monthly Max. Employee Contributions
2020	9.78%	$45,000	$4,401.00	$366.75
2021	9.83%	$45,000	$4,423.50	$368.62
2022	9.61%	$45,000	$4,324.50	$360.38

Large employers should take note that the affordability calculation will decrease in 2022. This change will affect all offers of coverage that begin on or after January 1, 2022. To review the IRS revenue procedure announcing the 2022 affordability measure, click here.

MAXIMIZE YOUR DENTAL BENEFITS



Eric Pierson
Sales Associate
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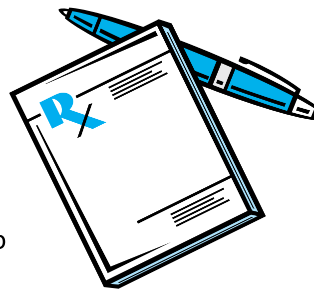
When most insurance experts talk about understanding your benefits, they are usually referring to your health insurance coverage. While it is important to know how your health coverage works it is also important to understand how your dental benefits work. There are similarities to how the medical insurance operates, but there is a major difference you should be aware of.

With medical insurance there is a maximum out-of-pocket, which resets annually. This is the maximum amount you will be responsible for during the calendar or plan year. With most dental insurance plans there is a maximum annual benefit. This is the most ***the plan*** will pay in that calendar year. This is usually between $1000 and $2000 and includes cleanings, exams, minor, and major services. However, orthodontia is almost always a lifetime maximum benefit, not annual.

At this time of year it's a good idea to try use up what's left of your annual dental benefit, because with most plans it resets on January 1. If you don't use it, there is a good chance you will lose it. Some plans will let you carryover a portion of the unused benefit, but if you need dental care, it's best to try to fit it in by the end of the year. Many people will try to schedule major services doing a portion before December 31st and the rest after the new year to maximize those annual benefits.

Always check your plan benefits to see exactly what your coverage is but using up your annual dental benefit is an overlooked strategy many people forget.

PRESCRIPTION COST SAVERS



Steve Flewellen
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Do you know if you are getting the best price for your prescription drugs? Do you know how to check?

There are three verified websites that are proven to help you get the best price on your prescription medications: GoodRX, RXSaver, and SingleCare. Each allows you to review drug costs before you go to the pharmacy, at the doctor's office or even while you are at your pharmacy. Once you have the best price, print the coupon or show it on your smart phone as you check out.

- Visit the site or download the app
- No enrollment or Registration is required
- Savings as much as 80% and helps you find FREE and $4 generics
- Most major pharmacies accept these programs
- None will combine with your insurance, so if the price under one of these programs is better it will not accrue to your out of pocket
- Each site or app can provide a different cost for the same medication, dosage and pharmacy
- GoodRx & Rx Saver have premium programs that may save even more

I personally have been recommending GoodRx for years and it works. However, I have seen that randomly these other two sites can beat GoodRx. So that means for anyone taking medications it may be worth taking a look at each site to find the best savings.

You can find more detail on each of their sites:

GoodRX: www.goodrx.com
RXSaver: www.rxsaver.com
SingleCare: www.singlecare.com

2022 HSA CONTRIBUTION LIMITS

Once again, the IRS has made some slight changes for Health Savings Accounts contribution limits. In 2022 the new amounts are:

	Single	Family
Maximum Contribution Limit	$3,650	$7,300
Minimum Deductible Requirement	$1,400	$2,800
Maximum Out-of-Pocket Expense	$7,050	$14,100
Catch-Up Contribution (For those 55 and older)	$1,000	$ 1,000

The annual deductible amounts remain the same as 2021, but the maximum contribution limits, and the maximum out of pocket expense, have gone up $50 for singles and $100 for families.

Employers with a Post-Deductible HRA should confirm that the employee front-end deductible responsibility is at least $1,400 for single coverage and $2,800 for family coverage to maintain participant's eligibility for HSAs in 2022. And if you also offer a Flexible Spending Account (FSA) no medical expense are eligible for reimbursement through it.

Remember that the limits for HSA plans do differ from out-of-pocket limits for health insurance plans subject to the Affordable Care Act. The ACA cost-share limits are actually higher than what the HSA regulations mandate.

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: Can an employer contribute money toward an employee's personal HSA account? This would be an HSA account the employee established with their own personal bank.

ANSWER: As we discussed, this is a case where the employer does offer an HSA-qualified high deductible health plan (HDHP) but does not require employees to establish an HSA with a specific bank/trustee. In that case, the answer is yes (assuming the employee is otherwise eligible to receive HSA contributions). The employer can choose to do this although they are not required to. Some employers prefer to establish a relationship with a single bank/trustee so that they don't have to be concerned about deposits to multiple banks but ultimately this is a business decision.

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.

COVID VAXX FAQs

The Department of Health and Human Services (HHS) and the Department of Labor (DOL) recently issued updated guidance regarding COVID-19 vaccinations.

The HHS guidance specifically speaks to the HIPAA Privacy Rule. Their new FAQs indicate that HIPAA does not prohibit businesses or individuals from asking customers or clients whether they have been vaccinated. HIPAA does not apply to businesses as covered entities, nor does it prohibit covered entities from asking about vaccination status.

There is also no issue with employers asking employees their vaccination status because Privacy Rules do not apply to employment records. Employers are compelled to keep vaccination status confidential and store the information separately from other employment records under the American with Disabilities Act.

The DOL clarified that health plans must pay for COVID-19 vaccinations in full, with no cost share requirements. This includes non-grandfathered plans and applies to booster doses, and doses for those who "age-in" to eligibility moving forward.

Health plan incentives for the vaccination are also permitted. The DOL FAQ considers this an activity-based health wellness program that would be subject to the nondiscrimination rules under HIPAA. These rules cap the reward/penalty for all wellness related activities at 30% of the total cost of coverage. An alternative method to qualify for the incentive must be offered if getting the vaccine would be "unreasonably difficult due to a medical condition or medically inadvisable."

Finally, the FAQs emphasize that any employer with different rates for vaccinated vs. non-vaccinated employees must use the rates for unvaccinated employees when determining if an offer of coverage is affordable for purposes of the ACA's employer mandate.

TIPS FOR BUYING ANNUITIES

This is the time of year when bonuses and required minimum distributions (RMDs) are handed out. If you are uncertain what to do with them, and you don't want to just spend the cash, consider an annuity.

Annuities are a safe investment option that can help round out your retirement portfolio or can be a vehicle to place lump sum dollars that need to be protected.

Before you purchase annuities keep these buying tips in mind:

- ✓ Do not buy the first contract you are offered. Take your time. Shop around.
- ✓ Compare contract summaries and policy benefits for similar contracts from several companies. Choose the one that best fits your needs at the most favorable premium rate.
- ✓ Ask questions. Your annuity contract might represent a considerable investment and might significantly affect your family's future.
- ✓ Be certain that you understand the effect of all charges and penalties that you might incur under the contract.
- ✓ If you are buying an annuity for an individual retirement account or another tax deferred retirement program, make sure that you are eligible. Also make sure that you understand any restrictions connected wit the program.
- ✓ Ask your accountant about any potential tax consequences.

Source: Wisconsin Commissioner of Insurance