Custom Design Benefits

Innovative Cost Containment Solutions for Employee Benefits

NEWSLETTER

Q2 | 2021

Executive Spotlight

Greetings,

For me, writing this letter is a very reflective exercise. I always think about where we've been and try to tie it to what's ahead. One year ago, like many of you our team was adjusting to COVID-19. At that time, my main goal was to let you know that we were here for you as a resource as we faced the uncertainty. In pausing to reflect on this past year, I am simply in awe of our customers and our team for the hurdles and pivots we successfully navigated, and relieved that much of the uncertainty is behind us.

With that as my frame of reference, I've never been more excited to invite you to our Customer Conference in September. Together we can celebrate that COVID-19 is looking farther in the rearview mirror and set a strong foundation for 2022. The healthcare benefits landscape has changed dramatically in the past year, and our team is pulling together the updates and expertise you need for the conference. We truly hope you can join us.

In this newsletter edition, you'll get important legislative updates on COBRA and HSA's and ABA Therapy, as well as when and where the Customer Conference will be held.

Best regards,

Julie D. Mueller
President & CEO

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DOL Issues New COBRA Notices for Employee Benefit Plans

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA) has revised Consolidated Omnibus Budget Reconciliation Act (COBRA) notices.

Plan administrators can use these model notices to notify plan participants and beneficiaries of their rights under COBRA and qualified beneficiaries of their rights to elect COBRA.

In general, COBRA allows employees (and their families) who would otherwise lose their group health coverage due to certain life events to continue their same group health coverage. These events include termination or reduction in hours, death of a covered employee, divorce or legal separation, Medicare entitlement and loss of dependent status. COBRA generally lasts for 18 months but, in some cases, can last up to 36 months.

Under COBRA, group health plans must also provide covered employees and their families with certain notices explaining their COBRA rights. The revised model notices provide additional information to address COBRA's interaction with Medicare. The model notices explain that there may be advantages to enrolling in Medicare before, or instead of, electing COBRA. It also highlights that if an individual is eligible for both COBRA and Medicare, electing COBRA coverage may impact enrollment into Medicare as well as certain out-of-pocket costs.

These documents will provide important information to COBRA-eligible individuals as they make healthcare choices for themselves and their families while assisting employers that must comply with the notice requirements under COBRA.

Custom Design Benefits has updated the COBRA notice with the additional model notice language. You can view the updated notice here.

For additional and ongoing American Rescue Plan Act and COBRA-related guidance, including new FAQs and model notices, click here.

IRS Releases Inflation-Adjusted Amounts for HSAs

The IRS recently released Rev. Proc. 2021-25, providing 2022 calendar year inflation-adjusted amounts for Health Savings Accounts.

The new revenue procedures include updates to the annual limitation on deductions for:

- An individual with self-only coverage under a high deductible plan is $3,650 – up $50 in 2021.
- An individual with family coverage under a high deductible plan is $7,300 – up $100 in 2021.

For calendar year 2022, a “high deductible health plan” is defined as a health plan:

- With an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage.
- For which the sum of the annual deductible plus annual out-of-pocket expenses – such as co-payments or other amounts, but not premiums – does not exceed $7,050 for self-only coverage (an increase from $7,000 for 2020) or $14,100 for family coverage (an increase from $14,000 for 2020).

Certification Validates Payer Compass' Commitment to Claim Data and Security

Payer Compass, a leading provider of healthcare reimbursement technology and price transparency solutions, recently received confirmation that it has been taking proactive steps to mitigate risk in third-party privacy security and compliance.

Payer Compass provides the technology needed to power TrueCost by CDB, our unique, copay-only plan that removes complexity from the payment process and eliminates coinsurance and deductibles.

In March, the company's core software platform, Visium™, earned CSF Certified status from the Health Information Trust Alliance (HITRUST), a leading data protection standards development and certification organization.

The certification demonstrates that the organization's cloud-based healthcare pricing, editing and contract management platform has met key regulations and industry-defined requirements, further emphasizing that it is appropriately managing risk and protecting sensitive information. The achievement places Payer Compass in an elite group of organizations worldwide that have earned this certification. By including federal and state regulations, standards, and frameworks, and incorporating a risk-based approach, the HITRUST CSF helps organizations address these challenges through a comprehensive and flexible framework of prescriptive and scalable security controls.

Surprise Medical Billing Regulation Under White House Review

HCAA NEWS UPDATE

The Value of Connection | HCAA.ORG |

The first rule implementing a 2020 law limiting medical bills in emergencies and in other situations beyond patients' control is under review by the White House's Office of Management and Budget.

How the Biden administration interprets the No Surprises Act, passed as part of appropriations legislation (H.R. 133) late in 2020, will likely be crucial to controlling costs of medical bills that can reach into the tens of thousands of dollars for both health insurers and employers who pay health-care bills for employees. The law takes effect in 2022.

The OMB must review the interim final rule before it can be issued by the Department of Health and Human Services, which sent it to OMB Tuesday. The regulations are due to be issued by July 1.

The No Surprises Act limits bills to patients for emergency treatment and for treatment by out-of-network doctors at facilities covered by health insurance networks, such as by anesthesiologists used during surgery. Bills in those situations can't exceed what patients would be billed for in-network care.

The law allows for billing disputes to be handled through arbitration, which under state surprise billing laws has led to high charges being passed on to insurers and employers.

Arbiters are prohibited from considering rates for government programs such as Medicare or Medicaid, which providers say are often below their costs. Nor can arbiters consider so-called "billed charges" by providers, which are typically well above what insurers pay for in-network treatment.

Allowing billed charges to be used by arbitrators under state laws, such as a surprise billing law enacted by New York state, has resulted in "very high out-of-network reimbursement," according to a 2019 report by the USC-Brookings Schaeffer Initiative for Health Policy. That in turn leads to higher premiums and costs borne by employers.

Arbiters can consider factors such as the median contracted rate, the provider's market share, provider training and qualifications, and the severity of the patient's condition in deciding between the competing offers submitted by the provider and insurance plan.

Payment Rate Calculations

The interim final rule is likely to define how to calculate the qualified payment rate that will be

used to help determine what providers should be paid, James Gelfand, senior vice president of the ERISA Industry Committee, said in an interview. The ERISA Industry Committee represents large employers that provide health and retirement benefits to employees.

The qualified payment amount generally is the median in-network rate, Gelfand said. The median in-network rate is one of the factors used to determine how much insurers and employers pay, and it also affects coinsurance payments that patients will have to pay. Coinsurance payments are a percentage of fees.

"How exactly is this going to be calculated? What is the methodology that is to be used?" are questions that need to addressed to determine the qualified payment amount, Gelfand said.

It will likely take longer to issue rules on how the independent dispute resolution, or arbitration process, will work and what entities can run that process, Gelfand said.

Various groups representing hospitals, doctors, insurers, employers, and consumers are lobbying the HHS to influence how billing disputes will be resolved.

The ERISA Industry Committee is part of a coalition of 49 organizations that sent the HHS a letter Tuesday calling for the agency to draft regulations "that make the qualifying payment amount (QPA), on which patient cost-sharing is based, the primary factor in resolving payment disputes."

The American Medical Association, in a May 21 letter to the department, said contracted rates used to calculate median rates should be limited by factors such as what is paid to providers in the same specialty. It also said the contracted rates "should be as specific as possible as to the type of item or service."

Twenty-two patient and consumer organizations representing millions of people with chronic conditions sent the HHS a letter Wednesday saying "the law must be implemented in a way that ensures the independent dispute resolution (IDR) process does not lead to higher costs for patients."

Balancing the Arbitration Process

At a House Ways and Means Committee hearing Tuesday, the panel's ranking Republican, Rep. Kevin Brady (R-Texas), told HHS Secretary Xavier Becerra that the department should carefully balance the arbitration process to avoid favoring health-care providers or insurers.

"The integrity of that arbitration process should be protected in as many ways as possible, including through robust transparency," Brady said.

Ways and Means Committee Chairman Richard Neal (D-Mass.) said lawmakers will be examining the coming regulations to ensure providers can't sidestep the rules. "Lawmakers did not design any intentional loopholes," he said.

Reminder: John Barlament of Quarles & Brady and Ashley Gillihan from Alston Bird will be discussing this regulation and other important pending regulations in their talks at TPA Summit.

Note: Our own Julie Mueller will be speaking as a panelist at this event.

Article by HCAA

Updated PCORI Fee Amount

The PCORI fee, originally mandated by the ACA, is collected annually to help fund the Patient-Centered Outcomes Research Institute. On November 24, 2020 the IRS released the updated PCORI fee amount as part of Notice 2020-84. For plan years that end on or after October 1, 2020, and before October 1, 2021, the applicable fee amount is **$2.66** multiplied by the average number of covered lives. The fee is due by July 31st along with IRS Form 720.

To calculate the average number of covered lives for the purposes of determining the appropriate PCORI fee, one of the following three methods may be used (as specified in *Treas. Reg. § 46.4376- 1(c)(2)(i))*:

- The actual count method
- The snapshot method
- The Form 5500 method

Custom Design Benefits supports your compliance reporting needs. If you are a medical self-funded group, your PCORI information is on your Monthly Summary in Executive Analytics. If CDB administers your HRA, contact your Account Manager to request a PCORI report.

Join Us At Our Customer Conference!

When: Thursday, September 23

Where: Hard Rock Casino
1000 Broadway Street
Cincinnati, Ohio

RSVP By: September 1

The first step in taking charge of your benefits in 2022 is spending time with us on September 23. The CDB Team and our partners will share the insights and updates you need to know before you make important decisions for next year. And that's no bull.

To learn more about the event and RSVP, visit:

CustomDesignBenefits.com/ConferenceRSVP

Compliance Corner:

New MHPAEA Comparative Analysis Requirement

Under the Mental Health Parity and Addiction Equity Act (MHPAEA) plans cannot impose Non-Quantitative Treatment Limitations (NQTLs) on Mental Health or Substance Use Disorder (MH/SUD) benefits in excess of those applied to medical or surgical (med/surg) benefits. For example, a plan could not require prior authorization for a mental health inpatient stay, when a similar requirement is not in place for a standard inpatient stay.

NQTL's include the following items:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review)
- Formulary design for prescription drugs
- Network tier design
- Standards for provider admission to participate in a network, including reimbursement rates
- Plan methods for determining usual, customary, and reasonable charges
- Fail-first policies or step therapy protocols
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage

The Consolidated Appropriations Act, 2021 added the requirement that plans offering coverage for both MH/SUD and med/surg benefits and that impose NQTLs on MH/SUD benefits must complete and document a comparative analysis of the application of NQTLs. The analysis documentation must be made available to the Departments of Labor, Health and Human Services, and the Treasury (the Departments) within 30 days of a request, and the Departments are required to collect at least 20 NQTL analyses per year. This requirement went into effect on February 10, 2021.

In addition to the previously available MHPAEA Self-Compliance Tool maintained by the Department of Labor, the Departments provided an FAQ on April 2, 2021 to assist in the preparation of the analysis. In an acknowledgement of the broad scope of the analysis, the FAQ lists four specific NQTLs the DOL expects to focus its enforcement efforts on initially.

Ultimately, the requirements for plans have not changed in terms of how NQTLs can be applied; plans are just now required to "show their work."

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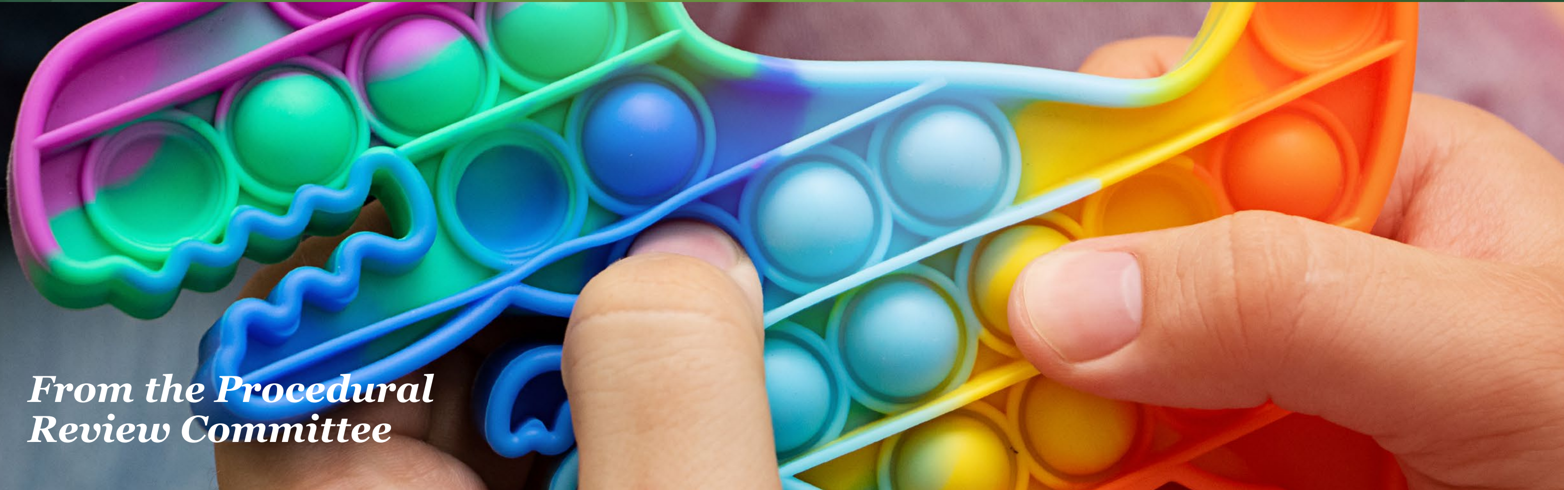
[1] *Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance; DOL & HHS.*

[2] *Pub. L. 116-260 (Dec. 27, 2020).*

[3] *FAQS About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45; DOL, HHS, & Treasury.*

Inside Insights:

Applied behavioral analysis (ABA Therapy)



From the Procedural Review Committee

Custom Design Benefits' Procedural Review Committee has completed a literature review of Applied behavioral analysis (ABA Therapy) with the intent of providing medically necessary therapy according to plan and ERISA compliance. ABA Therapy is available to children, after a review for medical necessity, upon evaluation and diagnosis of autism spectrum disorder (ASD) with developmental delays or persistent deficits in social communication and social interaction across multiple contexts and is performed by the appropriate certified/licensed health care professionals. Targeted symptoms, behaviors, and functional impairments related to underlying behavioral health disorder have been identified as appropriate for applied behavioral analysis. The treatment plan addresses comorbidities and includes coordination of care with other providers and community-based resources. The plan includes explicit and measurable recovery goals that will define patient improvement, with regular assessment that progress toward goals is occurring or that condition would deteriorate in absence of continued applied behavioral analysis and engages family and caregivers. Intensity and duration is individualized and is focused on patients with ASD who are 1 to 12 years of age and require program designed to address multiple areas of behavioral and functional impairment in coordinated manner. Evidence reviews suggest at least 15 hours per week, and up to a maximum of 25 hours per week, over 1 to 4 years, depending on the scope of the intervention and the child's response to treatment. Patient is expected to be able to adequately participate in and respond as planned to proposed treatment and this is evaluated by a medical review every 6 months.

Custom Design Benefits' Procedural Review Committee, led by the Medical Management team, is a multi-disciplinary group that meets monthly to review trends in authorization requests with the purpose of taking care of our clients. This group makes recommendations and develops policy based on compliance with federal regulation, industry trends and review of evidence-based medicine.

Custom Design Benefits in the News

[Women Presidents' Organization Announces Julie D. Mueller as Newest Member of Prestigious Women's Business Organization]

April 2021 – Chief Data Officer

The Women Presidents' Organization (WPO), a peer advisory group for million dollar plus women-led companies, has announced Julie D. Mueller, President & CEO at Custom Design Benefits as the newest member of the Greater Cincinnati II Chapter of the WPO...Read Full Article

The 5 levers of health plan cost control for 2021

May 2021 – BenefitsPRO

Benefits advisors can help employers offer great, and even improved, health plan benefits to their employees, often at reduced costs, by breaking out of the box defined by traditional health plans. The trick is finding solutions that provide flexibility...Read Full Article

Custom Design Benefits hosts Food Drive for GO Pantry

May 2021 – CDB Event

Our recent food drive collection helped GO Pantry tackle childhood hunger in NKY. GO Pantry uses donations like these to provide food to local children outside of school hours. Today, GO Pantry helps more than 750 children through the efforts of more than 2,000 volunteers. We are thankful to be a part of such an amazing cause...Read Full Article

Contact Your Broker, or the **CDB Team** for more information!

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