MAPLE BROOKS
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THE RISK REPORT

Health Care Savings

2023 HSA, FSA Contribution Levels Set

THE IRS has released the 2023 maximum contribution amounts for health savings accounts and flexible spending accounts. You'll want to make note of the changes when discussing your employee benefits during annual open enrollment.

The changes, which the IRS releases in November each year, are designed to allow these savings vehicles to keep up with inflation.

Here's the rundown of the changes going into 2023:

HSAs and HDHPs

HSAs allow your staff to set aside a portion of their pre-tax earnings into an account they can tap later to reimburse for qualified medical expenses, including copays, coinsurance, deductibles and medications. The HSA must be attached to a high-deductible health plan.

2023 Levels

Maximum HSA contribution

- $3,850 for self-only coverage (up from $3,650 in 2022)
- $7,750 for family coverage (up from $7,300 in 2022)

HDHP minimum deductible

- $1,500 for self-only coverage (up from $1,400 in 2022)
- $3,000 for family coverage (up from $2,800 in 2022).

FSAs

FSAs are similar to HSAs in that they are funded with pre-tax dollars and can be used to reimburse for qualified medical expenses.

However, the funds in the account must be exhausted or the employee loses the rest, except if the employer allows them to carry over a set portion every year.

FSA Limits

- $3,050, up from $2,850 in 2022
- Carryover limit: $610 (2023 to 2024)

If the employer allows the partial carryover, the funds must be spent by March of the following year.

The maximum for the current year is $570, and your employees, if you allow it, would have until March 15, 2023 to spend those funds.

The takeaway

As we enter the final stretch of 2022, it's important that you inform your employees of these new limits so they can plan their salary deductions accordingly. ❖

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WISHES YOU AND YOUR
FAMILY A MERRY CHRISTMAS

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Group Health Plans

Narrow Networks, Tiered Plans May Reduce Costs

INFLATION, AN aging workforce and people catching up on care they skipped during the COVID-19 pandemic are some of the factors that will drive health benefit costs over the coming years.

Health spending dropped considerably in 2020 and 2021 as people stayed away from health care environments, but now they are back seeking care that was delayed. That's caused a sudden spike in claims for health plans across the board.

Also, more health plans have boosted their mental health offerings, which patients have been taking advantage of, leading to further outlays, according to a recent report by Marsh McLennan Agency.

Studies predict group health plan costs will rise an average of 6% in 2023, more in some markets.

Despite that, employers may be able to employ a combination of measures to defray cost increases.

Compare insurance plans and providers

If you've been offering the same plans every year, we can work with you to compare providers to see if there are better deals for you among their competitors.

Also, plans can vary among insurers plans and each insurer will have different deals to offer.

Even your current slate of insurers may have plans that you are not offering.

It is important to keep in mind that a lower premium does not mean it's the best deal. Some lower-cost plans may have very narrow networks, which could result in some employees losing access to their regular doctors.

That said, there's been a trend towards so-called "high-performance," narrow provider networks that aim to reduce costs while maintaining efficiencies and quality of care.

Other cost-saving measures

Insurance carriers have been trying out new approaches to controlling costs, while improving health outcomes for their plan enrollees.

Money spent up front on quality health services can yield future savings if the patient needs less treatment.

Some insurers and self-insured employers have been able to generate savings of 5 to 15% by employing:

Tiered networks – These health plans sort providers into tiers based on their cost and, often, quality relative to other similar providers who treat comparable patients.

Providers with higher quality and lower cost are typically given the most-preferred tier rankings.

Centers of excellence – Many self-insured employers and more health plans are also contracting with "centers of excellence." While there is no specific definition of a COE, these providers deliver positive patient outcomes, lower costs, raise member engagement and have high rates of patient satisfaction.

Often, an OEC may have a specialty, like a chronic disease or a specific service such as radiology. Working in tandem with a clinical analytics vendor, payers will connect members with health systems that demonstrate high performance in these areas.

Referral management – More health plans are also starting to use referral management software to improve efficiency and trust in care coordination.

These systems synchronize patient data transmission from one physician to another, and also to the patient.

A referral management system aims to facilitate good communication between the consultant, specialist, health care provider and the patient.

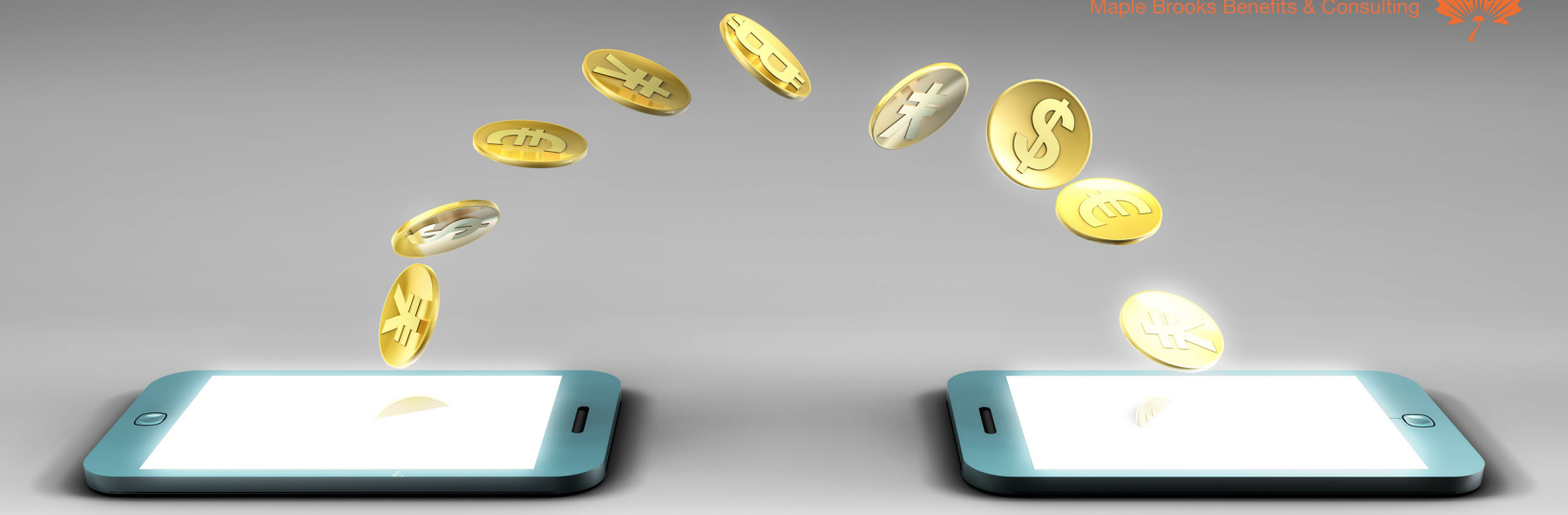
The system increases trustworthiness and transparency of treatment and diagnosis, and decreases inefficiency in care coordination and operational arrangements.

The takeaway

The above measures can be applied across the care continuum — hospitals, primary care, specialty groups, post-acute providers and ancillary care — while maintaining access and quality of care.

Getting the cost equation right will be a challenge in the coming years as premiums are expected to rise at a faster clip than they have been in the last five years.

Talk to us about finding health plans that are offering different structures for addressing costs while also improving care for your workers. ❖



Health Insurance Funding

Premium Reimbursement Plans Grow, Despite Drawbacks

MORE EMPLOYERS are opting to fund accounts that their employees can draw on to purchase their own health insurance, according to a new report.

Individual coverage health reimbursement arrangements (ICHRAs) offer employees a set budget for premiums, which they can use to purchase a health insurance plan either on an Affordable Care Act exchange or on the open individual market.

Some companies have been exploring these arrangements in lieu of providing their group health benefits in order to save money and reduce the administrative burden, according to the "2022 ICHRA Report" by PeopleKeep, a human resources software firm.

But these plans have their drawbacks and are not for all employers.

The ICHRA explained

ICHRAs allow employers subject to ACA coverage requirements to forgo purchasing insurance for employees and instead provide extra funds for them to purchase their own health insurance coverage. Here are some ICHRA basics:

- Regulations allow for employers to offer ICHRAs to some of their employees and group health benefits to others.
- Some accounts are restricted to reimbursing only for health insurance premiums, while others also reimburse for out-of-pocket medical expenses.
- Every pay period, the employer funds the account. The employee will pay for their premiums and get reimbursed by showing proof of payment.
- Employees don't pay taxes on health care spending reimbursements.
- Accounts are not portable when employment ends.
- For firms subject to the ACA employer mandate, the ICHRA funding must meet the law's coverage and affordability requirements and be enough to purchase the lowest-cost marketplace silver plan.

Firms most suited for ICHRAs

These plans often work best for operations that have:

- High staff turnover,
- A large number of lower-paid workers,
- A mix of salaried and hourly workers, and/or
- A mix of employees at the company site and remote workers in other regions.

Not a good fit for all firms

There are many restrictions to ICHRAs as well as drawbacks which employers need to consider:

- The employee loses the employer-sponsored coverage they're accustomed to and has to fend for themselves to find coverage that fits within the budget their employer provides. This could cause employee resentment.
- Offering group health plans to salaried employees and higher-wage staff and ICHRAs to lower-wage workers, who may view it as a two-tier system, can also lead to resentment.
- Having an ICHRA could affect recruitment efforts and retention, as most workers have grown accustomed to their group health benefits.
- Employees may choose plans that leave them with either higher premiums than they'd pay for a group plan or higher out-of-pocket expenses on the back end.
- Employees must use the funds to purchase health insurance, and they may not be enrolled in their spouse's health plan.
- If your ICHRA is considered affordable according to ACA rules, employees lose the premium tax credit if they opt out of the ICHRA. If your ICHRA is considered unaffordable under ACA rules, they can claim the premium tax credit and waive their right to the ICHRA.

The takeaway

Sticking with a traditional group health plan can help you with recruitment and retention, but for some employers who look to attract workers who do not put a priority on employee benefits, these types of plans could be a good fit.

However, making a move to an ICHRA takes careful consideration and planning. We can help you sort through the facts and fiction about these accounts. ❖

No Surprises Act

New Law Prevents 9 Million Surprise Medical Bills

AS MANY AS 9 million surprise medical bills have been prevented since January due to the impact of the No Surprises Act, according to a new report.

This is the first data that indicates the law, aimed at eliminating surprise medical billing for patients getting emergency treatment, is working. The number of claims subject to protections of the law have far exceeded expectations, the report by AHIP Health Policy & Markets Forum and the Blue Cross Blue Shield Association found.

If you have not made your employees aware of this groundbreaking law, you should, as Americans are tagged with billions of dollars a year in surprise bills when they go out of network, even if they don't know it.

The act

Beginning Jan. 1, the No Surprises Act banned surprise medical billing in most instances. Often these bills come after going to an in-network hospital but either the doctor, the lab or the anesthesiologist was out of network.

Surprise billing is also common in medical emergencies, when an ambulance takes a patient to the closest ER – and frequently at a hospital that's not in their network.

The purpose of the law was to reduce surprise medical billing for insured patients getting emergency treatment.

However, the law provides patients additional rights in some non-emergency situations, as well.

Emergency services

To help control your employees' medical costs, it's a good idea to make sure workers and their families understand how the law works, so they can assert their rights under the act.

The act prohibits in-network hospitals and other providers from billing patients any out-of-network charges for emergency services. The most the in-network provider can bill the patient for is their plan's maximum in-network cost-sharing amounts.

Patients must still pay their deductible, copays, and coinsurance amounts. Providers cannot bill patients with insurance for anything beyond that.

Waiving rights

Some providers may ask your employees to sign a document that waives their rights under the law. However, the law prohibits waivers for any of these services:

- Emergency care
- Unforeseen urgent medical needs during non-emergency care
- Ancillary services
- Hospitalist charges
- Assistant surgeon charges
- Out-of-network provider services when no in-network alternative is available
- Diagnostic services. ❖

Tips for covered employees

- You are not required to waive your rights under the No Surprises Act.
- You are not required to use out-of-network providers. You can seek non-emergency care in-network.
- Your plan must cover emergency services without requiring preauthorization.
- Your plan must cover emergency services by out-of-network providers.
- Your plan must apply any amounts you pay for emergency or out-of-network services towards your deductible and out-of-pocket limits.
- If you think you've been wrongly sent a surprise medical bill, visit: *www.cms.gov/nosurprises*.