COMPLIANCE
Friday Fast Facts

Proposed Legislation To Address "Surprise" Billing

"Surprise" medical bills are unexpected bills patients receive after getting care from an out-of-network provider or facility. Surprise billing is a hot topic in Washington, and there appears to be bipartisan support for legislation addressing the issue. The following is a summary of current contenders, but we could see additional proposals from House Education and Labor Committee, and/or the Ways and Means Health Subcommittee. We'll be tracking the progress of the various bills and will be sure to keep you posted on developments.

- The Senate has introduced a bill that would provide protections for patients who receive emergency care from out-of-network providers or facilities; elective care from an out-of-network doctor at a facility that is in-network; or additional post-emergency services at an out-of-network facility because the patient is unable to travel without medical transport. Similar protections would apply for lab and imaging services and for non-physician providers. Under the Senate proposal, doctors would be paid a "median in-network rate," a predetermined amount based on what other health plans in the area pay for similar services. Providers would be able to challenge the pay rate and would have 30 days to initiate a dispute resolution process between the health plan and the provider. Patients would be exempt from this process and would not be billed for any amounts not covered by insurance.
- The House is working on its own bill, which includes provisions that are similar to the Senate proposal. The House bill would require healthcare facilities to provide 24-hours' notice to patients seeking elective treatment that they are about to see an out-of-network provider. It would prohibit the facility or provider from billing patients for amounts that are not covered by insurance, and would set provider payment rates based on the market in that specific area.
- Another broad proposal from the Senate Health, Education, Labor and Pensions committee is underway. Their proposal would address not only surprise billing, but also limits on drug pricing and price transparency. Some stakeholders view the breadth of the proposal as an obstacle to passing the legislation.

Inflation Adjustments for HSAs

Late last week, the Internal Revenue Service released the 2020 inflation-adjusted figures for contributions to HSAs. The 2020 annual contribution limit is $3,550 (up from $3,500) for individuals with self-only high deductible health plan (HDHP) coverage and $7,100 (up from $7,000) for individuals with family HDHP coverage. "High deductible health plan" is defined as a plan with an annual deductible of not less than $1,400 for self-only coverage or not less than $2,800 for family coverage, and where annual out-of-pocket expenses don't exceed $6,900 (self-only) or $13,800 (family coverage). Also remember that ACA out-of-pocket limits continue to apply. Those out-of-pocket limits are $8,200 for individuals with self-only coverage and $16,400 for individuals with family coverage. Importantly, the ACA's self-only out-of-pocket limit must be embedded for each individual coverage at the family coverage tier. For assistance on how to calculate HSA contribution limits when an individual changes coverage tiers mid-year or has a mid-year change to HSA eligibility, check out our HSA FAQ. For a robust discussion of issues with implementing an HSA/HDHP offering see our Alliant Insight, Implementing an HDHP HSA Benefit Option.

FAQ of the Week

Q. Can COBRA coverage be paid on a pre-tax basis through a cafeteria plan?

A. Yes in some cases, but this is rarely done. A cafeteria plan *can* be drafted to allow COBRA premiums to be paid on a pre-tax basis. For example, an employee could pay their own COBRA premiums on a pre-tax basis if they went from a full-time position to a part-time position and lost health plan eligibility. An employee could also pay COBRA premiums pre-tax for a child who "ceases to be a dependent" (e.g., ages out), as long as the child is under age 27 at the end of the tax year or otherwise qualifies as a tax dependent. However, cafeteria plans are rarely drafted to allow this, likely because the lack of regulatory guidance makes administration a challenge. For example, the regulations do not address the 60-day COBRA election period and how that is reconciled with election change concepts that generally require changes to be prospective. Additionally, individuals who elect to pay COBRA premiums pre-tax will be locked into that coverage unless there's a permitted election change event.

Happy Friday!!

Compliance team
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