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HEALTH & WELFARE PLAN LUNCH GROUP

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INDEX

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1

Agenda

- Reminders
- No Surprises Act Update
- Transparency Deadlines
- Premium Surcharge/Discount Based on Vaccination

2

Health & Welfare Benefits
MONTHLY UPDATE

REMINDERS

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3

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ARPA Subsidy Expiration Notice

- Subsidy expiration notices must be sent no more than 45 days and no less than 15 days before the date that the COBRA subsidy ends. For those whose subsidy extended through the entire subsidy period (until September 30, 2021), the deadline is September 15, 2021.

4

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4

Medicare Creditable Coverage Notice

- Medicare Part D notices (either creditable or non-creditable coverage) are due prior to October 15th (October 14th).

5

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No Surprises Act

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6

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Interim Final Regulations

- Effective for plan years beginning on or after January 1, 2022
  - Applies to both grandfathered and non-grandfathered plans
- Requirements related to Surprise Billing but not IDR
- Identification of “emergency services”, certain non-emergency services, and air ambulance services subject to protections
- Calculating participant cost share
- Calculating provider payment
- “Patient protection" regulations (basically restates them and then applies them to grandfathered plans)

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Interim Final Regulations

- Agencies forecast regulations on:
  - Federal independent dispute resolution ("IDR") process
  - Transparency and patient-provider dispute resolution process
  - Price comparison tools
  - Form and manner in which plans, issuers and providers of air ambulance services report required information
- Plans are expected to implement the CAA requirements using a "good faith reasonable interpretation" of the CAA until regulations are issued

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Surprise Medical Bills for Emergency Services

- If plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (IFED), plan must cover "emergency services".
- Must you cover Emergency Services?
- Must you cover emergency services in an IFED? If you cover emergency services in a hospital, it appears you do (i.e. it doesn't appear as though an exclusion for IFED would be effective if you are otherwise covering emergency services).
  - Could likely still exclude IFED for non-emergencies as urgent care.

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Surprise Medical Bills for Emergency Services

- What is an IFED?
  - Any entity licensed to provide emergency services
  - Does this include Urgent Care Clinics? Yes, if licensed by state to provide emergency services.
    - How does a TPA know if licensed to provide emergency services or not?

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Surprise Medical Bills for Emergency Services

- Emergency Services:
  - Appropriate medical screening (by reference to Section 1867 of the SSA)
    - Apply similarly to IFED even though SSA doesn't apply to IFED
  - Within the capability of the facility
    - Includes ancillary services routinely available to the facility to evaluate the emergency medical condition
  - Further medical examination within the capabilities of the staff/facility (see Section 1867 of SSA) to stabilize the patient *regardless of the department of hospital such examination/treatment is provided*
    - Stabilize defined by SSA 1867(e)(3)—no further deterioration will occur in transfer/delivery
    - Doesn't end necessarily when admitted
  - And "Additional Services"

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Surprise Medical Bills for Emergency Services

- What are "Additional Services"?
  - Services otherwise covered by the plan and
  - Furnished by *OON facility/provider* AFTER stabilization
    - Apparently not applicable to in-network
  - As part of outpatient observation OR in/outpatient stay with respect to the "visit" associated with the emergency services
    - Includes equipment and other services from a provider at the facility, even if provider is not at facility
  - NOTE: Not included as emergency services UNLESS all of the conditions of 45 CFR 149.410(b) are satisfied
    - Able to travel
    - Notice and consent rules satisfied
    - Notice from provider on bill to plan that consent was provided

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Surprise Medical Bills for Emergency Services

- Emergency Medical Condition
  - Medical/mental condition
  - Acute symptoms of sufficient severity
  - Prudent layperson with average knowledge of medicine could reasonably expect the absence of immediate medical attention to result in
    - Jeopardizing health of individual (or woman OR fetus if woman pregnant)
    - Serious impairment of bodily functions
    - Serious disfunction of any bodily organ/part
  - This will be based on the facts and circumstances, including presenting conditions and not solely on coding

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Surprise Medical Bills for Emergency Services

- Coverage terms and conditions for emergency services:
  - No prior authorization (in or out of network)
    - Even if service is provided out-of-network
  - Without regard to whether the provider is a participating provider or a participating emergency facility for that service
    - Must cover out of network emergency services even if no other out of network covered
  - Can't limit emergency medical condition solely on the basis of diagnosis codes
    - Must look at all documentation, facts and circumstances
    - Can't impose time limits between onset and emergency room visit

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Surprise Medical Bills for Emergency Services

- Without regard to any other plan term or condition, other than:
  - Exclusion or coordination of benefits
    - Can you exclude services for an "emergency medical condition" based on a general plan exclusion? NO.
  - An affiliation or waiting period
  - Applicable cost-sharing

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Surprise Medical Bills for Emergency Services

- Coverage terms/conditions (cont)
  - Not impose any administrative requirement or limitation that is more restrictive than the same requirements or limitations applied to emergency services from participating providers / emergency facility
  - Cost-sharing requirements can't be greater than the requirements that would apply if the services were provided by a participating provider or participating emergency facility
  - Calculate cost-sharing requirement as if total amount that would have been charged for services were equal to the **"recognized amount"**
  - Count any cost-sharing payments made by the enrollee with respect to emergency services toward any in-network deductible or in-network out-of-pocket maximum ("MOOP"), as if services were done in-network

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Surprise Medical Bills for Emergency Services

- Recognized Amount:
  - In a state that has in effect "a specified State law", the amount determined under that law
  - If the state does not have in effect "a specified State law", the lesser of: the amount that is the "qualifying payment amount" (see later slides) or the amount billed by provider / facility
  - If the state has an "All-Payer Model Agreement" for the plan, facility and service, that amount

17

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Qualified Payment Amount

- For purposes of recognized charge (the amount used to determine cost share amounts) and the base for the IDR arbitrator:
  - All-Payer Model Agreement
  - If no applicable all-payer model agreement, then specified state law;
  - If no applicable specified state law, then the lesser of: (1) billed charged; or (2) qualified payment amount (QPA).

18

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QPA

- Relevant Questions:
  - What is the "contracted rate"?
  - What is the "median contracted rate"?
  - What is "underlying fee schedule"?
  - What is "derived amount"?
  - What is "sufficient information"
  - What is an "eligible database"?
  - What is a "same or similar item or service"?
  - What is "geographic region"?
  - What is a "service code"?

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19

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What is the QPA

- Identify the "median contracted rate"
  - Based generally on 2019 rates
  - Special rules if don't have "sufficient information", the plan is new, the service/item is newly covered, or there are new service codes

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20

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How to calculate Median Contracted Rate

- All plans of the employer
  - Does not include account-based plan/excepted benefits)
  - May use all plans administered by same TPA
    - What if an employer has multiple plans with one TPA?
      - Plan must come up with one rate for all the plans
    - What if an employer has multiple plans with multiple TPAs?
      - Plan can opt to determine median rate on a plan-by-plan basis
    - Can Employer rely on TPA's book of business?
- If there are an even number (e.g., 4 rates) then use average of middle two rates

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21

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How to calculate the Median Contracted Rate

- If plan has one contract with multiple providers in a group or facility, treated as one rate
- If plan has multiple contracts with multiple providers, and "separate negotiated rates" with each particular provider, each unique contracted rate is a single contracted rate
- If plan has separate contracts with individual providers, contracted rate under each contract is a single rate (even if same amount is paid to multiple providers)

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22

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How to calculate the Median Contracted Rate?

- Determine median rate based on service code except that:
  - Calculate separate median contracted rates for CPT code modifiers 26 (professional component) and TC (technical component)
  - For anesthesia services, use a conversion factor for codes
  - Where contracted rates vary based on applying a modifier code, calculate separate median contracted rate for each service-code modifier combination
- If plan's contracted rates vary based on provider specialty for a service code, median is calculated separate for each provider specialty
  - Same if rates vary based on facility code
- Use "underlying fee schedule" if not fee for service
- Use "derived amount" if no fee schedule

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How to calculate Median Contracted Rate

- What is the "contracted rate"? The total amount that a group health plan has contractually agreed to pay a participating provider, facility or provider of air ambulance services, whether directly or indirectly.
  - Does not include a single case agreement, letter of agreement or other agreement (for this purpose).
- What is the underlying fee schedule? The rate used to determine the participant's cost share when the rate is different from the contracted rate.
- What is the "derived amount"? The price that a group health plan or health insurance issuer assigns to an item or service for the purpose of internal accounting, reconciliation with providers, or submitting data in accordance with 45 CFR 153.710

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How to calculate QPA

- QPA for 2022 adjusted combined CPI-U increases 2019, 2020 and 2021
  - IRS will provide CPI-U increases
  - Through August of each year
- Anesthesia conversion factor based on certain factors:
  - "Base unit" for a service code under the American Society of Anesthesiologists Relative Value Guide
  - Physical status factor (value between 0 – 3) (level of complexity)
- Apply CPI-U increases in subsequent years

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Transparency Deadlines

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DOL FAQs Part 49

- Extends certain No Surprises Act (and existing regulation effective dates)

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27

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Machine Readable Disclosure of Rates (FAQs 1&2)

- Original 1/1/22 Deadline for providing machine readable IN rates extended to 7/1/22 for plan years starting 1/1/22 – 6/30/22
- Original 1/1/22 Deadline for providing machine readable OON allowed amounts and billed charges extended to 7/1/22 for plan years starting 1/1/22 – 6/30/22
- Original 1/1/22 Deadline for providing machine readable negotiated rated and historical net prices for prescription drugs extended indefinitely pending updated regulations

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28

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Price Comparison Tools (FAQ 3)

- Price comparison tool for 500 most common "shoppable" expenses originally due PY 1/1/23 (not extended but add phone number for questions)
- Price comparison tool for all covered expenses originally due PY 1/1/24 (not extended but add phone number for questions)
- Advance EOB originally due PY 1/1/22 enforcement delayed pending regulations pending regulatory price comparison tools

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Deductibles and OOP on ID Cards (FAQ 4)

- No extension to PY 1/1/22 deadline, but good faith compliance recognized

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Directory Cost Sharing and Continuity of Care

- Cost sharing based on provider listing in directory effective PY 1/1/22 (no delay) must use good faith reasonable interpretation of the CAA.
- Continuity of care for certain ongoing care impacted by termination of provider contract effective PY 1/1/22 (no delay) must use good faith reasonable interpretation of the CAA.

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Provider Provision of Good Faith Estimate

- Required starting 1/1/22. Regulations expected 2021
- Provider work with plans to provide information for advance EOB. Enforcement deferred indefinitely pending regulations.

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Additional Requirements

- Gag order prohibition (contracts/renewals on/after 12/27/20) not delayed, but attestation delayed until 12/27/22
- Prescription drug information and cost data originally due 12/27/21 delayed until 12/27/22

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Vaccine Incentives – More Risk Than Reward?

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Areas of Legal Concern

- Primary concern is the HIPAA Nondiscrimination Rules
  - Potential excise taxes of $100 per day per impacted individual under IRC §4980D and/or specific enforcement under ERISA
- Other areas –
  - Americans With Disabilities Act (ADA) and Genetic Information Nondiscrimination Act (GINA)
  - ACA Employer Shared Responsibility Affordability Penalty ("ESRP")
  - Title VII
    - Reasonable accommodation for those that have sincerely held religious beliefs
  - Costly litigation even if employer prevailed

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HIPAA Nondiscrimination Rules for Wellness Programs

- Is the wellness program participatory or health contingent?
- Participatory programs are available to all employees regardless of health status
- If participatory then no limit on the "Reward" (includes *both* an incentive or absence of a surcharge) if the program is available to similarly situated individuals.
- If health contingent, then there are limits on the Reward and other requirements.
- Two types of health contingent wellness programs.
  - Activity Only
  - Outcome Based

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HIPAA Nondiscrimination Rules for Health-Contingent Wellness Programs

Rules apply if the following conditions present:

- Provide a "Reward"
- To individuals covered by a group health plan
- In exchange for achieving a specific health outcome or completing a health-related activity
  - "Activity based" requires an individual to perform or complete an activity related to a health factor in order to obtain a Reward such as a walking program
  - "Outcome-based" requires an individual to attain a specific health outcome such as not smoking or attaining specific BMI or cholesterol level.

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HIPAA Nondiscrimination Rules

- Requirements for a non-discriminatory program:
  - Total Reward cannot exceed 30% of the total costs of single coverage (or family coverage if dependents are allowed to participate)
    - Total Reward includes all other non-smoking related rewards
    - Cost of coverage is COBRA premium w/o 2% fee
  - Qualify for the Reward at least once per year
  - Must be available to all similarly situated individuals
  - Notice that a reasonable alternative will be provided
  - Must be reasonably designed to promote health or prevent disease

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Issues: Reasonable Alternative

- What is a reasonable alternative differs based on type of program:
  - If activity based, then reasonable alternative must only be provided to those with an underlying health condition that makes the vaccine medically inadvisable.
    - Does collecting information on underlying condition trigger ADA and GINA?
  - If outcome based, all individuals who do not receive a vaccine must be given an alternative w/o regard to underlying medical condition
- Is a vaccine incentive program activity based or health outcome based?
- From a practical standpoint what is a reasonable alternative? Requiring masks and social distancing? In many jurisdictions these requirements apply to both vaccinated and non-vaccinated individuals

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Promote Health or Prevent Disease?

- Program satisfies this standard if
  - Has a reasonable change of improving health or preventing disease
    - What about individuals who already had the virus and may have antibodies?
  - Not overly burdensome
    - How does the emergency use authorization and lack of clinical trial data impact this analysis?
  - Not a subterfuge for discriminating based on a health factor
  - Not highly suspect in the method chosen to promote health or prevent disease

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ADA and GINA

- Title I of the ADA prohibits disability-related medical examinations and inquiries with two exceptions:
  - Medical examinations or inquiries if they are "job-related and consistent with business necessity"
  - Voluntary medical examinations, including medical histories and disability-related inquiries, that are part of an employee health program
- Informal EEOC guidance says that requesting proof of vaccination from community providers (*e.g.,* pharmacy, health department) is not a disability-related inquiry for ADA purposes
- If employer or its agent provides the vaccinations, information obtained in the screening process would likely be a disability-related inquiry
  - Would likely impact GINA as well if offered to employees' spouses or other family members
  - Any incentive cannot be "so substantial as to constitute coercion"

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ACA Affordability

- If offer the vaccine incentive, then all full-time employees must be treated as if they failed to obtain the Reward for affordability calculations
- Implementing incentive mid-year may raise some issues under ESRP rules and require employers to allow employees to drop coverage if unaffordable
- ESRP excise taxes are non-deductible for full-time employees who decline unaffordable employer coverage and receive a subsidy on a governmental exchange
- Also note that a mid-year increase raises some issues under the IRC §125 plan rules with regard to permitted election changes for significant plan increases
  - Waiting to annual enrollment to implement a vaccine incentive might be simpler if an employer wants to move forward

Thanks!

- Questions?