August 2021 Benefits Newsletter

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Court Orders Payment For Residential Treatment Based On "Wildly Inconsistent" Rationales For Denial

An employee and child who were both covered under a self-insured group health plan, sued the plan's claims administrators (in Utah Federal District Court) for denying coverage for the child's long-term residential mental health treatment. See D.K. v. United Behavioral Health, 2021 WL 2554109 (D. Utah 2021). Following nearly three years of progressive treatment for anxiety, attention deficit disorder, and depression; multiple episodes of self-harm and attempted suicide; and repeated emergency room visits and hospitalizations, the child's physicians had concluded that long-term residential treatment was required. The administrators authorized coverage for an initial 90 days, to be followed by a review to determine whether continued residential treatment was necessary. However, near the end of the 90 days, the plan informed the employee that it would deny coverage going forward. The denial notice expressly acknowledged that clinical evidence showed that the child required long-term residential treatment but stated that such treatment was excluded under the plan. The administrators maintained this position through two levels of internal appeals but then changed course, admitting that the relevant exclusion was no longer in the plan but denying the claim because long-term residential treatment was not deemed medically necessary.

At trial, the employee and child argued that (1) the treatment was medically necessary under the plan's terms; (2) the claims administrators incorrectly disregarded the opinions of the child's treating physicians; and (3) the administrators did not articulate how they applied the plan's terms to the child's medical history or current condition. The court considered each argument but then added a fourth issue: the implications of the administrators' inconsistent rationale for denying the claim. The court concluded that even under ERISA's deferential "arbitrary and capricious" standard of review, the administrators' "wildly inconsistent" reasons for the decision were unacceptable. Rather than sending the claim back to the administrators for reevaluation (as is typical in such cases), the court ordered full payment for the child's residential treatment.

This case serves as a reminder that mental health parity compliance is not the only concern when considering claims for mental health or substance use disorder treatment. (This employee abandoned a mental health parity claim early on in favor of a claim for recovery of benefits under ERISA.) When processing claims, plans must carefully comply with ERISA's complex claims and appeals rules. Although courts generally give a great deal of deference to decisions made under compliant claims procedures, they will not afford such deference when the plan's actions are arbitrary or inconsistent.

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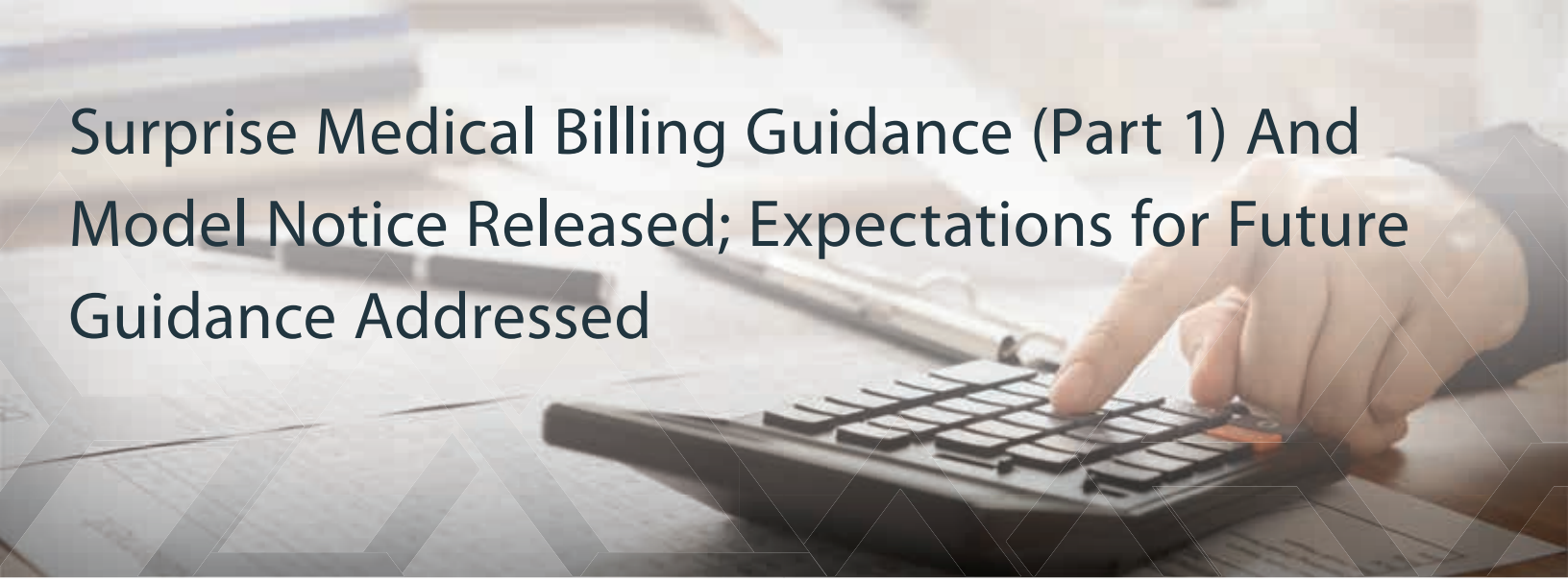

Surprise Medical Billing Guidance (Part 1) And Model Notice Released; Expectations for Future Guidance Addressed

The DOL, HHS, and IRS have released the first round of agency guidance on the surprise medical billing requirements of the No Surprises Act (NSA), enacted in December 2020 as part of the [1] Consolidated Appropriations Act, 2021. Building on patient protections for emergency services originally included in the Affordable Care Act (ACA), the comprehensively revised and expanded requirements protect individuals from surprise bills for emergency services, air ambulance services furnished by a non-participating provider (i.e., an out-of-network provider or other provider that does not have a contractual relationship with the plan), and non-emergency services furnished by a non-participating provider at an in-network facility in certain circumstances. Broadly, the surprise billing rules restrict cost-sharing for out-of-network services that fall within the surprise billing protections to in-network levels, require such cost-sharing to count toward in-network deductibles and out-of-pocket maximums, establish requirements for initial payments to nonparticipating providers, and prohibit surprise balance billing (i.e., seeking to collect from the patient more than the applicable cost-sharing amount). Here are highlights from the lengthy and detailed regulations, which are generally applicable to group health plans and insurers for plan and policy years beginning **on or after January 1, 2022:**

Applicability. The regulations clarify that the NSA applies to both grandfathered and non-grandfathered group health plans, as well as grandmothered plans and traditional indemnity plans without a network (although some rules may not be relevant). The rules do not apply to health reimbursement arrangements, excepted benefits, short-term, limited-duration insurance, and retiree-only plans. The agencies request comments on whether other plans should be exempt.

Cost-Sharing Amounts. The regulations explain that participants in group health plans will pay cost-sharing for items and services that fall within the NSA's scope based on the "recognized amount," which generally will be the lesser of the "qualifying payment amount" (QPA) (i.e., the plan's median in-network rate for an item or service) and the amount billed by the provider – unless an amount is prescribed by state law or an all-payer model agreement between CMS and a state. An in-depth description of the methodology for calculating the QPA is provided, including rules for determining the median contracted rates for items and services and the option for a self-insured plan to have its TPA calculate the QPA. By requiring the cost-sharing amount to be calculated using the recognized amount, rather than the amount ultimately paid to the nonparticipating provider, the regulations limit the effect of provider-payer payment disputes on participants.

The comprehensively revised and expanded requirements protect individuals from surprise bills for emergency services and more.

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Initial Provider Payments. The regulations establish rules for determining the amounts payable by a plan or insurer for items and services within the NSA's scope, referred to as the "out-of-network rate." The plan must pay an initial amount to the nonparticipating provider (or provide a notice of denial) within 30 days after receiving all information necessary to decide a claim for the services. The regulations clarify that this "initial payment" does not refer to a first installment, but rather the amount that the plan or insurer reasonably intends as payment in full. Although the regulations do not specify a minimum initial payment amount, comments are requested for consideration of future rulemaking on whether and how to set a minimum payment rate.

Plan's Notice to Provider. When a plan determines that the QPA is the recognized amount, additional information about the QPA must be furnished to the nonparticipating provider. The notice must identify the plan's contact person if the provider wishes to initiate a 30-day negotiation period with respect to the plan's total payment and explain the deadline to initiate independent dispute resolution (IDR) if an agreement cannot be reached. While these regulations mention the IDR process, the IDR requirements will be addressed in future rulemaking. The agencies highlight the distinction between the ERISA claims and appeals procedures (which are applicable to adverse benefit determinations when participants may be personally liable to a provider) and the IDR process (which is applicable to disputes between plans and providers when the provider has no recourse against a participant). The agencies note that the timeframes under the different processes "may not always align."

Notice and Consent Exception. Non-emergency services furnished by a nonparticipating provider at a participating health care facility are generally exempt from the NSA's balance-billing and cost-sharing protections when the provider satisfies certain advance notice requirements and obtains the patient's consent. To enable a plan or insurer to apply cost-sharing correctly, a provider (or facility, as applicable) relying on the notice and consent exception must timely notify the plan or insurer and provide the plan or insurer a signed copy of any binding notice and consent documents.

Model Notice. A model notice is provided for plans and insurers to post and includes in all explanations of benefits to which the NSA applies. The regulations lay out the process for providing the notice, which is intended to serve as good faith compliance with the NSA requirement that, beginning in 2022, a plan or insurer disclose the prohibition on surprise billing and the entities to contact in the event of a violation.

These regulations represent an opening salvo in the process of implementing the extensive surprise billing requirements in the NSA. The agencies intend to issue guidance later this year on the IDR process and some of the surprise billing disclosure requirements (including rules for price comparison tools); however, they caution that regulations on many of the NSA transparency requirements might not be provided in 2021 (but will include a prospective applicability date and an expectation of good faith compliance before then). This first round of regulations will give plans, insurers, and providers plenty to do in the meantime.

[1] https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf

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IRS Information Letters Address Substantiation Rules for Health FSA Debit Card Programs

The IRS has released two information letters that address the substantiation rules for health FSA debit card programs. One letter responds to an inquiry on behalf of an individual whose card was deactivated for failure to provide requested documentation to substantiate expenses paid with a health FSA debit card. The other letter responds to a request for information about the substantiation rules for health FSA debit card transactions.

The letters explain that medical expenses must be substantiated with information describing the service or product, the date of service or sale, and the amount of the expense, but some debit card transactions do not provide all of the required information. If the information from the card transaction does not satisfy the substantiation requirements–e.g., the item or service was not specified–then the plan administrator must request additional information and must deactivate the card if the expense is not timely substantiated. The review of additional information can be avoided if an independent third party provides information at the time and point of sale to verify that the charge is for a medical expense (real-time substantiation). Also, a health FSA may coordinate with an individual's health insurer to use information from an explanation of benefits to fully substantiate a debit card charge. Payment of recurring expenses incurred at certain providers that match the amount, provider, and time period of previously approved expenses can be approved without additional substantiation. The letters note that health FSAs may be designed to impose stricter standards and suggest contacting the employer or plan administrator about options for submitting claims directly to the plan with the required documentation.

These IRS information letters do not break new ground or include any surprises. But like other recent IRS information letters, they may be helpful to those on the "front lines" of cafeteria plan administration, who are sometimes asked to explain the reasons for plan operating rules and decisions. While not mentioned in the letters, the debit card program rules also allow automatic substantiation of card transactions at medical providers and 90% pharmacies (locations at which 90% of prior year gross receipts consisted of eligible medical expenses) where the dollar amount of the transaction equals an exact multiple of not more than five times the dollar amount of the copayment imposed for the service or product under the participant's health plan. Automatic substantiation is also allowed at merchants that have an inventory information approval system (IIAS) in place to ensure that cards are used only for eligible medical care expenses.

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EEOC Gives Green Light to Employers' COVID Vaccine Incentives, With Important Caveats

The EEOC has updated its guidance on COVID-19-related compliance issues under the [1]ADA, GINA, and other employment laws. In addition to modifying and expanding earlier guidance on employer vaccination programs, the updated guidance adds six Q&As addressing ADA and GINA considerations for employer-provided COVID-19 vaccination incentives for employees and their family members. Employers had requested clarification from the EEOC on the rules applicable to vaccination incentives in light of the withdrawal of proposed EEOC regulations earlier this year that would have limited incentives under many employer-sponsored wellness programs to de minimis amounts.

The updated guidance permits employers to offer COVID-19 vaccination incentives to employees and their family members, but the rules for these incentives differ depending on whether the employee or family member receives the vaccination independently in the community (e.g., at a pharmacy, public health department, or health care provider) or through an employer-administered program. The EEOC indicates that an employer does not make a disability-related inquiry for ADA purposes when requesting that employees voluntarily confirm that they received a COVID-19 vaccination in the community. Similarly, an employer does not request genetic information about employees or family members when requesting proof of community vaccination. According to the EEOC, neither the ADA nor GINA limits incentives in these situations.

Conversely, limits apply to incentives that are provided for vaccinations administered by the employer or its agent. Under the ADA, the incentive to the employee for an employer-administered vaccination cannot be "so substantial as to be coercive." However, the guidance does not elaborate on the meanings of "substantial" or "coercive." GINA does not limit incentives for an employee's own employer-administered vaccination, so long as the pre-vaccination screening questions do not seek genetic information. However, the employer may not offer any incentives to employees in exchange for a family member's vaccination because the family member's answers to the screening questions would disclose medical information about the family member, which is considered genetic information (family medical history) of the employee. Under certain conditions, an employee's family members may be offered employer-administered vaccinations, so long as the employee does not receive an incentive if family members receive vaccinations or suffer a penalty if they decline. The guidance emphasizes the importance of keeping vaccination information confidential.

While employers will welcome the clarifications and opportunities afforded by this guidance, they should not lose sight of some core limiting principles. For example, although the ADA does not limit employer incentives for vaccinations received in the community, employers should consider their obligations to employees who cannot receive a vaccination. Employers may need to provide reasonable accommodations so that employees whose disabilities or religious beliefs prevent them from being vaccinated can earn the same incentives as vaccinated employees. And, if the incentive is offered through or as part of a group health plan, then HIPAA's nondiscrimination rules (including those for health-contingent wellness programs) may come into play.

The EEOC has updated its guidance on COVID-19-related compliance issues under the ADA, GINA, and other employment laws. Visit the link below for more information.

[1] https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

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U.S. Supreme Court Rejects Attempt To Invalidate ACA Based On Elimination Of Individual Shared Responsibility

The U.S. Supreme Court has rejected an attempt to invalidate the Affordable Care Act (ACA). The challengers (two individuals and several states) contended that, after the Tax Cuts and Jobs Act reduced the individual shared responsibility penalty to zero beginning in 2019, the requirement for individuals to maintain minimum essential coverage (referred to as the "individual mandate") was unconstitutional because it no longer was defensible under Congress's taxing power–the Court's basis for upholding the individual mandate in an earlier ACA legal challenge. They asserted that, because the individual mandate was essential to the operation of the ACA, its removal invalidated the entire law. A trial court in Texas agreed and ruled that the individual mandate was unconstitutional, the remaining ACA provisions could not be severed, and the entire ACA must fall. An appellate court agreed that the individual mandate was unconstitutional but sent the case back to the trial court to determine whether other provisions of the ACA could be severed from the individual mandate and remain in effect.

The Court dismissed the case, holding that the challengers lacked standing to pursue their case because they failed to show that they suffered an injury attributable to the challenged provision. Addressing the individuals' claims, the Court noted that, because the individual shared responsibility penalty had been "zeroed out," neither the IRS nor any other federal agency could seek a penalty against those who fail to purchase minimum essential coverage. Therefore, the individuals' alleged injury (the cost of purchasing health insurance) could not be fairly traced to the now-unenforceable individual mandate. Regarding the states' claims, the Court identified two types of injuries allegedly caused by the individual mandate: (1) increased use and costs of state-operated medical insurance programs (such as Medicaid) and (2) increased administrative expenses. The Court concluded that the substantial benefits associated with the state-operated programs were reason enough for residents to enroll, and that the states had failed to demonstrate that the now-unenforceable mandate would cause their residents to enroll in valuable programs that they would otherwise ignore. In discussing the increased administrative expenses identified by the states, the Court focused on the expense of reporting minimum essential coverage under Code § 6055 and offers of coverage by applicable large employers under Code § 6056. Because these reporting requirements are not imposed by, and operate independently of, the individual mandate, the Court held that the associated expenses were not fairly traceable to the mandate.

Many observers initially dismissed this challenge to the ACA as farfetched, but the lower court victories raised the case's profile and created uncertainty about the law's future. By deciding the challenge on procedural grounds, the Court avoided having to tackle (again) the ACA's constitutionality or untie its complex and intertwined provisions. For group health plans, the decision maintains the status quo. More than ten years after its enactment, the ACA has proved its staying power.

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