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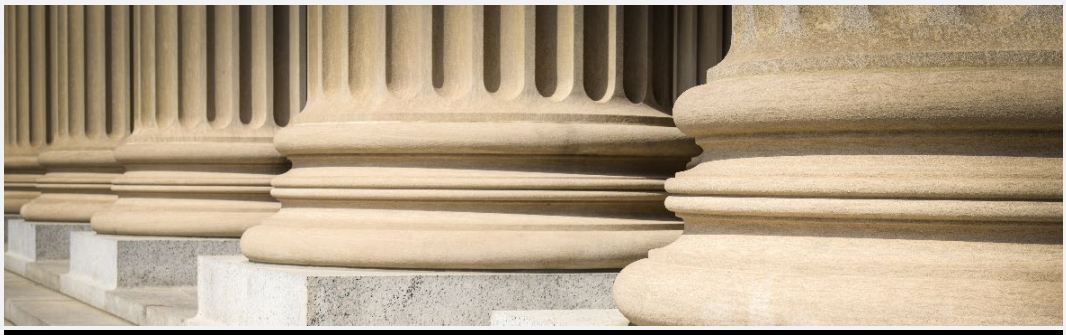

Rewards Policy Insider
2021-13

In this Issue:

IRS Extends Relief from Physical Presence Requirement for At Least One More Year

Due to the unique circumstances of the COVID-19 pandemic, in 2020, the IRS provided temporary relief from the requirement that a participant making certain retirement plan elections sign in the physical presence of a notary or plan representative. On June 24, 2021, the IRS issued Notice 2021-40, which provides a 12-month extension, through June 30, 2022, of the temporary relief provided in Notices 2020-42 and 2021-03. This relief was due to expire on June 30, 2021.

In certain cases, qualified retirement plan participants who are married are prohibited from designating a non-spouse beneficiary or receiving a distribution in any form other than a qualified joint and survivor annuity (QJSA) unless: (1) the participant's spouse provides consent; and (2) such consent is witnessed by a plan representative or a notary public. Under existing IRS regulations, a spouse may provide this type of consent electronically and a notary may provide electronic notarization. Generally, when electronic media is used for these purposes, IRS regulations require any spousal consent to be "witnessed in the physical presence of a plan representative or a notary." The COVID-19 pandemic made this "physical presence" requirement difficult, if not impossible, to satisfy.

Notice 2020-42 provided relief from the "physical presence" requirement, as described in Treasury Regulation section 1.401(a)-21(d)(6) if certain requirements are satisfied.

- Remote notarization. In the case of an election witnessed by a notary public, the physical presence requirement is deemed satisfied for an electronic system that uses remote notarization if executed via live audio-video technology that: (1) otherwise satisfies the IRS's rules for electronic participant elections; and (2) is consistent with the state law requirements that apply to the notary public.
- Plan representative. In the case of an election witnessed by a plan representative, the physical presence requirement is deemed satisfied if an electronic system using live audio-video technology satisfies the following requirements:
    - The individual signing the election (i.e., the spouse) presents a valid photo ID to the plan representative during the live audio-video conference;
    - The live audio-video conference must allow for direct interaction between the individual and the plan representative (for example, a pre-recorded video of the person signing is not sufficient);
    - The individual must transmit by fax or electronic means a legible copy of the signed document directly to the plan representative on the same date it was signed; and
    - After receiving the signed document, the plan representative must acknowledge that the signature has been witnessed by the plan representative in accordance with the requirements of Notice 2020-42 and transmit the signed document, including the acknowledgement, back to the individual in accordance with certain other IRS rules regarding electronic delivery of documents.

Notice 2021-03 extended the guidance until June 30, 2021, and IRS has now extended it an additional year to June 30, 2022.

The latest Notice seeks additional comments on whether guidance modifying the physical presence requirement should be issued. Comments on Notice 2021-40, the full text of which is available here, are due September 30, 2021.

Agencies Issue Part 1 of "Surprise Billing" Rules

The Consolidated Appropriations Act (CAA), 2021, features new restrictions on "surprise billing" for certain emergency services provided by out-of-network providers and/or at out-of-network facilities, certain non-emergency services provided by out-of-network providers at participating facilities, and out-of-network air ambulance services. These new requirements, which will apply to plan years beginning on or after January 1, 2022, will affect group health plans and participants, as well as health insurers and health care providers. Because of the breadth of the new requirements and the short timeline from enactment to implementation, the Departments of Health and Human Services, Labor, and Treasury (the "Agencies") are providing guidance in two sets of interim final rules. Part 1 was issued recently, and is the subject of this article. Part 2 is expected by October of this year.

Broadly speaking, the CAA's "surprise billing" provisions are targeted at situations where group health plan participants and others with insurance end up with unexpected medical bills because they received care from an out-of-network provider in an emergency situation, for example. Because the provider's bill exceeds the amount the plan or health insurance issuer is willing to pay for an out-of-network provider, the provider may "balance bill" the participant or insured for the difference.

The CAA amended ERISA, the Internal Revenue Code, and Public Health Service Act (PHSA) to prevent "surprise billing" in certain circumstances in which it is most likely to occur. Generally speaking, the new rules address three separate (but related) issues:

1. What prior authorization and cost-sharing requirements can the plan impose on participants?
2. What amount can providers and facilities recover from plans for their services?
3. What, if any, responsibility does the participant/patient have to pay the provider for amounts the plan doesn't pay?

Before getting too deep into what the new rules are, it is important to understand when they do (and do not) apply.

When do Surprise Billing Rules Apply?

In general, the surprise billing rules apply to any group health plan that provides or covers any benefits with respect to services in a hospital emergency department or in an independent freestanding emergency department. The rules do not require group health plans to cover emergency services, but instead simply establish standards for plans that choose to cover such services.

Specifically, the rules will come into play if the emergency services are being provided in an out-of-network facility, and/or by an out-of-network provider. The term "emergency services" includes the initial screening as well as further medical examination and treatment as may be required to stabilize the patient, even if not furnished in the emergency room. In other words, "emergency services" may include services provided after the individual has been admitted to the hospital. The term includes "post-stabilization" services as well, although the surprise billing protections may end at this point if certain requirements are satisfied.

The surprise billing rules also come into play when a participant receives non-emergency services in a network facility from a nonparticipating provider. However, if certain notice and consent requirements are satisfied, the surprise billing protections will not apply in these circumstances. The rules do not apply if a participant obtains non-emergency services at an out-of-network facility, regardless of whether the provider is in- or out-of-network.

Finally, the surprise billing rules apply if a plan provides or covers any benefits for air ambulance services and a participant uses a nonparticipating provider of air ambulance services. This is true even if the plan does not have any air ambulance service providers in its network.

The rules do not apply in cases where a participant receives emergency or non-emergency services at a network facility from a network provider, or from a network air ambulance service provider. In those cases, the agreement between the plan and provider or facility will govern the participant's cost-sharing obligation as well as the total amount the provider or facility will be paid the services provided.

The rest of this article focuses on applying the surprise billing rules to emergency services provided by a non-network provider or facility. Future editions of the Rewards Policy Insider will provide more details, including information about how these rules will apply to non-emergency services delivered by a non-network provider in a network facility, as well as to air ambulance services.

Plan Coverage and Cost-Sharing Requirements

Pursuant to the new rules and the Interim Final Regulations (IFR), group health plans and issuers of group coverage that provide coverage for emergency services must do so regardless of whether they are provided by an in-network provider or facility. Additionally, plans may not impose any prior authorization requirement for such services whether provided in- or out-of-network.

If the plan has a provider network it may not impose any administrative requirement or limitation on coverage for emergency services received from nonparticipating providers or nonparticipating emergency facilities that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers or facilities.

The IFRs clarify that plans that cover emergency services may not limit what constitutes emergency services solely on the basis of diagnosis codes. Whether something is or is not an emergency service is to be determined by a prudent layperson standard based on presenting symptoms, and not by the ultimate medical diagnosis. Additionally, plans may not restrict coverage of emergency services by imposing a time limit between the onset of symptoms and the participant's arrival at emergency department.

If a participant receives emergency services from a nonparticipating provider or facility, the plan must impose at least as favorable cost-sharing requirements on the participant as would have been applied if they had used a network provider or facility. Also, any cost sharing the participant is required to pay must be applied towards the plan's in-network deductible and out-of-pocket maximums.

How is the Participant's Cost-Sharing Determined?

To the extent the plan's cost-sharing is based on the amount a network provider or facility would charge it, the cost-sharing amount will generally be calculated as if the total amount that would have been charged for the services by a participating emergency facility were equal to the "recognized amount" for such services. The "recognized amount" is:

1. An amount determined by an applicable State All-Payer Model Agreement;
2. If there is no applicable State All-Payer Model Agreement, an amount determined by a specified state law; or
3. If no applicable State All-Payer Model Agreement or specified state law, the recognized amount is the lesser of the amount billed by the provider or facility and the Qualifying Payment Amount (QPA).

Currently, Maryland is the only state with an All-Payer Model Agreement for hospital services.

At least 33 states and the District of Columbia have implemented some form of balance billing protections for consumers. Some of these protections include requirements for how much group health insurance issuers must pay out-of-network providers and facilities for certain services in certain circumstances. These state laws generally do not apply to self-insured group health plans, although in some cases a plan may have opted-in to a state's rules.

In situations where there is no State All-Payer Model agreement or specified state law, the plan will have to set the QPA in order to determine the recognized amount. However, the IFR establishes a process for out-of-network providers and facilities to challenge a plan's QPA.

According to the IFR, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019 for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased annually for inflation.

The median contracted rate is determined with respect to all group health plans of the plan sponsor or all group or individual health insurance coverage offered by the issuer that are offered in the same insurance market.

If there is insufficient information to calculate a median contracted rate for an item or service, alternative methodologies – such as an independent third-party database – can be used to determine the QPA. But these alternative methodologies are meant to be used only in limited circumstances.

Plan Responsibilities to Out-of-Network Providers and Facilities

When the out-of-network provider or facility bills the plan or issuer for the relevant services, the plan or issuer has 30 calendar days to either make an initial payment or provide a notice of denial of payment. This 30-calendar day period does not begin to run until the plan receives all the information it needs to make a determination on the claim.

Ultimately, the plan or issuer's responsibility will be to pay the provider the "out-of-network rate" less the participant's cost-sharing obligations. In general, the "out-of-network rate" for this purpose is the rate negotiated by and between the plan and provider or facility, or, if they can't agree, the amount determined by an independent dispute resolution process (IDR) specified in the statute. However, similar to the "recognized amount" rules discussed above, if there is an applicable State law or an All-Payer Model Agreement, then that will be used to determine the "out-of-network rate."

The plan's initial payment to the provider or facility should be an amount the plan reasonably intends to be payment in full based on all the facts and circumstances and as required by the plan's terms, prior to any open negotiations or initiation of the IDR process. The IFR does not establish a minimum payment amount, but the agencies indicated they may do so in future rulemaking if they find evidence of plans and issuers taking advantage of this flexibility to systematically under-pay providers and facilities.

Can the Provider "Balance Bill" the Participant/Patient?

The end-goal of these reforms is to prevent the provider in these situations from looking to the participant for any difference between the provider's bill and the amount the plan pays – i.e., the "balance billing" amount. When the new rules apply, they will prohibit out-of-network facilities and providers from balance billing, or otherwise holding the group health plan participant responsible, for any amount more than the cost-sharing amounts the plan is permitted to impose in these circumstances under these requirements.

A future edition of Rewards Policy Insider will discuss the "balance billing" rules for providers in more detail.

Surprise Billing Rules Apply to Grandfathered Health Plans Too

Significantly, the CAA amended the Affordable Care Act (ACA) to specifically apply these surprise billing requirements to all group health plans, including grandfathered group health plans, for plan years beginning on or after January 1, 2022. The CAA also makes ACA provisions relating to direct access to OB/GYN services and designating a pediatrician or OB/GYN as a primary care provider applicable to grandfathered plans as well. The original ACA requirements relating to coverage for emergency services, direct access to OB/GYN services, and designating a pediatrician or OB/GYN as a primary care provider did not apply to grandfathered plans.

The full text of the IFR is available here.

PBGC Implements Special Financial Assistance Program for Troubled Multiemployer Plans

The American Rescue Plan Act (ARPA) created a Special Financial Assistance (SFA) Program for "severely underfunded" multiemployer plans. On June 9, the Pension Benefit Guaranty Corporation (PBGC) released interim final regulations to implement the SFA Program. The interim final regulation is effective as of July 12, the date it was published in the Federal Register.

The SFA Program will provide approximately $94 billion in assistance to more than 200 eligible multiemployer plans. The additional funds will be used to reinstate previously suspended benefits and to ensure eligible plans can pay all benefits due through 2051. The ARPA also addresses the solvency of PBGC's Multiemployer Insurance Program, which was projected to become insolvent in 2026.

The interim final rule sets forth what information a multiemployer plan is required to file to demonstrate eligibility for the SFA Program. It also provides the formula to determine the amount of special financial assistance that PBGC will pay to an eligible plan.

Additionally, the ARPA authorizes PBGC to prioritize SFA applications of plans in specified groups, and the interim final rule identifies the priority order in which such plans are permitted to apply. The priority order established by the IFR is summarized in the following table.

Priority Group	Description of Priority Group	Date Plans May Apply for SFA Program
1	Plans already insolvent or projected to become insolvent before March 11, 2022	Beginning on July 9, 2021
2	Plans that implemented a benefit suspension under ERISA section 305(e)(9) as of March 11, 2021 Plans expected to be insolvent within 1 year of the date an application for SFA is filed.	Beginning on January 1, 2022, or earlier date specified on PBGC's website
3	Plans in critical and declining status that had 350,000 or more participants	Beginning on April 1, 2022, or earlier date specified on PBGC's website
4	Plans projected to become insolvent before March 11, 2023	Beginning on July 1, 2022, or earlier date specified on PBGC's website
5	Plans projected to become insolvent before March 11, 2026	Date to be specified on PBGC's website at least 21 days in advance of such date, but no later than February 11, 2023
6	Plans for which PBGC computes the present value of financial assistance under	Date to be specified on PBGC's website at least 21 days in

	ERISA section 4261 to be in excess of $1 billion (in the absence of SFA)	advance of such date, but no later than February 11, 2023
7	Additional plans that may be added by PBGC based on other circumstances similar to those described for priority groups 1-6	Date to be specified on PBGC's website no later than March 11, 2023

The interim final rule also outlines a processing system, which is designed to accommodate the filing and review of many applications in a limited amount of time. In addition, it specifies permissible investments for SFA funds and establishes certain restrictions and conditions on plans that receive SFA.

The full text of the IFR is available here.