IslerDare PC

*Employee Benefits Update* March 2, 2022

# Dispute Resolution Procedures and Other Developments Impacting Costly Air Ambulance Claims Under Group Health Plans

## EXECUTIVE SUMMARY

To protect patients from significant, unexpected air ambulance bills, the No Surprises Act (part of the Consolidated Appropriations Act, 2021) bars out-of-network providers from billing patients for more than in-network cost-sharing amounts for air ambulance services, effective as of January 1, 2022. While several of our newsletters from 2021 provide a general overview of the No Surprises Act (which can be found here), this Employee Benefits Update goes into more detail about the patient billing protections for air ambulance services, including the controversial arbitration process for determining the appropriate payments for air ambulance claims and data reporting requirements that apply to such services.

## *Payment Determinations and Arbitration for Air Ambulance Claims*

Historically, air ambulance claims under group health plans, whether for emergency or non-emergency services, have been among the most costly claims that a plan can experience. While the No Surprises Act provides that group health plans must make an initial payment to the provider (or send a notice of denial) within 30 days of the date the service is delivered, the new law does not mandate a payment amount.

Consequently, if an out-of-network provider for air ambulance services is not satisfied with the group health plan's initial payment, interim regulations issued by the Departments of Labor, Treasury and Health and Human Services (the "Departments") stated that the provider could trigger a 30-day negotiation process, after which, if no resolution was reached, the provider could initiate binding, "final offer" arbitration. During the final offer arbitration, both sides would make a final payment offer, and the arbitrator would then choose one of those two payment amounts after considering numerous factors, including the "qualifying payment amount" (QPA), which is generally the median in-network rate for similar services in that geographic region, within the same insurance market, adjusted for inflation. Moreover, the interim regulations established a presumption that the arbitrator must select the payment offer closest to the QPA, unless the arbitrator determined that credible information clearly demonstrated that the QPA was materially different from the out-of-network rate.

The arbitration features of the interim rules implementing the No Surprises Act—and in particular the determination of the QPA—have been extremely controversial and the focal point of litigation. Since they were announced, six different lawsuits have been filed around the country, one of which was filed by the Association of Air Medical Services, challenging the rules requiring arbitration and, in particular, the use of median in-network rates to determine the QPA. Most of these lawsuits are still pending, but on February 23, 2022, a Federal court in Texas ruled in favor of the Texas Medical Association, striking down a portion of the interim regulations focusing on the determination of the QPA in the arbitration process and the presumption that the QPA is the appropriate rate for out-of-network services unless there is credible evidence that clearly demonstrates that the QPA is materially different from the appropriate out-of-network rate. In the court's judgment, having a presumption in favor of the offer closest to the QPA would systematically reduce out-of-network reimbursements, and ultimately give group health plans and over payers significant influence and an unfair advantage in establishing reimbursement rates, compared to an arbitration process without such a presumption. The court also ruled that the government's implementation of the interim regulations was improper under the Administrative Procedure Act and failed to follow the text of the No Surprises Act statute itself.

In response, on February 28, 2022, the Departments announced that they would be withdrawing their guidance relating to the portions of the No Surprises Act that were struck down, and would be updating their guidance to conform with the court's order. While good-faith arbitration of disputed air ambulance claims is still permitted, it

remains to be seen how the arbitration rules and determination of the appropriate pricing for such claims will be impacted by these recent developments.

## *Air Ambulance Data Reporting Requirements*

In addition to understanding the new payment and dispute resolution process described above, group health plan sponsors should work with their insurance carriers and third-party administrators to ensure compliance with new reporting requirements for air ambulance services and payments made under the plan for the 2022 and 2023 calendar years.

Specifically, group health plan sponsors must report specific data to the Department of Health and Human Services and the Department of Transportation for each ambulance claim during the 2022 and 2023 calendar years, including the name of the plan; the plan's market type; service dates; CPT billing codes; billing national provider identifiers; specific information related to the transport (origin and destination zip codes, aircraft type, whether the transport was emergent or non-emergent, etc.); whether the provider had a contract with the group health plan to provide air ambulance services; claim adjudication information including whether the claim was paid, denied or appealed, the denial reason, and the appeal outcome; and claim payment information. Group health plans must provide the information by March 31, 2023 for the 2022 calendar year, and by March 31, 2024 for the 2023 calendar year.

Insurance carriers are responsible for submitting the data on behalf of an insured group health plan if there is a written agreement between the carrier and plan that the carrier do so. Self-funded group health plans can delegate the reporting responsibility to a third party in a written agreement, but the group health plan is still liable for a failure to submit the required information, regardless of any written agreement. Plan sponsors should consider whether any updates to their services agreements or contracts are needed to reflect the rules and services that may be provided in connection with the new air ambulance reporting requirements. Sponsors of self-funded group health plans that delegate the reporting requirement to third parties also should confirm each year that the data has been properly and timely reported.

## *Uptick in Appeals for Pre-2022 Air Ambulance Claims*

In light of these new rules impacting air ambulance claims that take effect January 1, 2022, we have observed an uptick in the number of first and second level appeals of pre-2022 claims, as air ambulance providers challenge their reimbursements from group health plans, perhaps in a last-ditch effort before balance billing is prohibited. If you have received this type of claim or appeal and need assistance with how to best respond, we would be happy to help.

## *Additional Information*

For additional information about the air ambulance regulations or No Surprises Act, and their impact on your group health plan, please contact any member of our Employee Benefits and Executive Compensation Practice Group listed below.

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