IslerDare PC

*Employee Benefits Update* *October 18, 2021*

### *IMPORTANT DATES*

October 31:

- Provide notice of benefit restrictions under IRC Section 436 to participants if the AFTAP for a defined benefit plan is less than 60% and notice has not previously been provided

November 15:

- Confirm that 401(k) plan recordkeeper has provided 3rd quarter benefit statements, including fee disclosure information, to participants
- Distribute a Summary of Benefits and Coverage for each group health plan option. Also, provide any documents or notices that have not previously been provided.

# PART II INTERIM RULE ON SURPRISE BILLING AND PROPOSED AIR AMBULANCE REGULATIONS

## EXECUTIVE SUMMARY

On September 30, 2021, the Department of Health and Human Services, the Department of Labor, and the Department of Treasury (collectively, the "Departments"), along with the Office of Personnel Management ("OPM"), released an interim final rule entitled "Requirements Related to Surprise Billing; Part II" (the "Part II Interim Rule"), which is expected to take effect on January 1, 2022. This rule is the second in a series of regulations to provide additional individual protections under the No Surprises Act (see the August 2021 IslerDare newsletter describing the first series of regulations here), and focuses on the following:

- An independent dispute resolution process to determine out-of-network amounts between providers/facilities and health plans;
- Good faith estimates for uninsured individuals;
- A patient-provider dispute resolution process for uninsured individuals; and
- Expanded external reviews of denied claims for insured individuals.

Additionally, on September 16, 2021, the Departments released proposed regulations on new reporting and disclosure requirements to help collect data on the air ambulance provider industry, as contemplated by the No Surprises Act.

This newsletter highlights key parts of the Part II Interim Rule and the proposed regulations on air ambulance reporting as they relate to group health plans.

## *Requirements Related to Surprise Billing; Part II*

The Part II Interim Rule establishes new protections from surprise bills and excess cost sharing, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (self-pay) individuals, information regarding the patient-provider resolution process, and expanded rights to external review for insured individuals.

Independent Dispute Resolution Process.

The new rule establishes a federal independent dispute resolution process for determining out-of-network ("OON") rates for services for which balance billing is prohibited under the No Surprises Act. OON providers, facilities, providers of air ambulance services, group health plans, and health plan issuers may use this resolution process. Under this process, following a failed 30-day open negotiation, the parties may jointly select a third-party known as a certified independent dispute resolution entity to whom the parties will submit offers of payment along with supporting documents. The independent dispute resolution entity will work with the health plan and provider/facility to decide the payment amount and will issue a binding determination of the OON payment amount within 30 days, choosing the party's offer that best represents the appropriate OON rate for the items or services The presumption is that the qualifying payment amount (the "QPA" equal to the plan's median contract rate) is the appropriate OON rate, but that can be rebutted by a party through the submission of additional, specified information that clearly demonstrates that the value is materially different from the QPA.

Both parties are required to pay a $50 administrative fee (for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this service (for 2022 the range is set at $200 to $500 for a single determination and $268 to $670 for batched determinations). More details about the independent dispute resolution process and the deadlines can be found here.

Good Faith Estimates for Uninsured (Self-Pay) Individuals.

A provider/facility must provide an uninsured (self-pay) individual with a good faith estimate of expected charges after an item or service is scheduled, or upon request. The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided with the primary item or service.

Since it may take time for providers/facilities to develop systems and procedures for providing and receiving the required information, from January 1, 2022 – December 31, 2022, the Department of Health and Human Services will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (self-pay) individual does not include expected charges from other providers/facilities that are involved in the individual's care.

Patient-Provider Resolution Process for Uninsured (Self-Pay) Individuals.

A new dispute process will be available for uninsured (or self-pay) individuals who receive a good faith estimate described above and subsequently receive a bill that is "substantially greater" than the good faith estimate, which means the billed charges are at least $400 more than the estimate provided. An individual has 120 calendar days from the date of receipt of the bill to begin the dispute process with the provider.

A third-party dispute resolution entity will review the good faith estimate, the billed charges, and any additional information provided by the individual and the provider/facility. The information will then be used to determine if the additional charges are allowed; if the provider/facility must adhere to the good faith estimate that was previously provided; or if an amount lower than the good faith estimate is acceptable. Participating individuals will be charged an administrative fee of $25 (for 2022); however, this fee may be credited back if the dispute is resolved in favor of the individual.

Expanded Rights to External Review.

The new rule expands the scope of adverse benefit determinations eligible for external review to include determinations that question if a plan or issuer is complying with the surprise billing and cost-sharing protection of the No Surprises Act. In addition, grandfathered plans that were previously not subject to external review requirements will now be subject to external review requirements.

In conjunction with the Part II Interim Rule, a website was launched that focuses primarily on providing general information about the No Surprises Act provisions. Additional information will be posted over the next several months, including how to initiate an independent dispute resolution process in the federal portal.

## *Proposed Regulations on Air Ambulance Reporting*

The proposed regulations on air ambulance reporting will require group health plans and providers of air ambulance services to submit comprehensive data for each air ambulance claim and transport for the 2022 and 2023 calendar years, in order to develop a comprehensive public report on air ambulance services. The data will include, but not be limited to, information such as whether the services were provided on an emergency basis, whether the transport originated in an urban or rural area, the type of aircraft used, and whether the provider of the air ambulance service has a contract with the plan or issuer to provide air ambulance services. The 2022 and 2023 reports will be due by March 31, 2023 and March 30, 2024, respectively. Employers with insured plans have the option to contract with the insurance carrier to report the information, while self-funded plans will need to work closely with their third-party administrator to ensure that their reporting obligations are satisfied.

## *Additional Information*

For additional information regarding the Part II Interim Rule, the Proposed Regulations on Air Ambulance Reporting, or other employee benefits matters, please contact any member of our Employee Benefits and Executive Compensation Group listed below.

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