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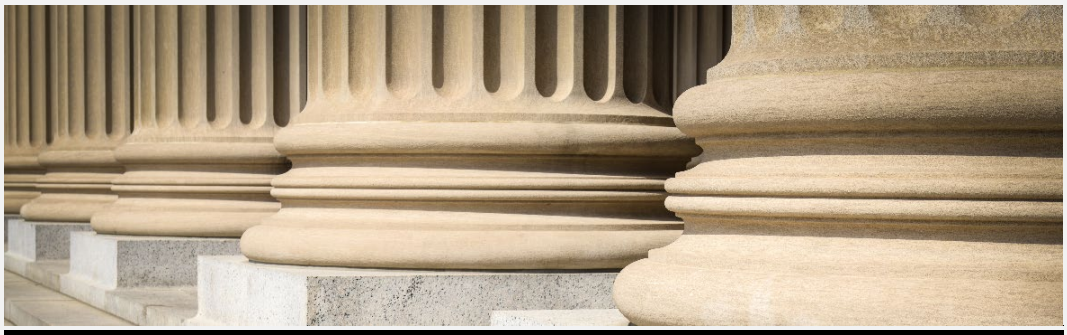

Rewards Policy Insider
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In this Issue:

Applying Surprise Billing Rules to Air Ambulance Services

In Rewards Policy Insider 2021-13 and 2021-14, we provided an overview of the new "Surprise Billing" rules that will take effect for plan years beginning on or after January 1, 2022, and how those rules will apply when participants receive emergency services and non-emergency services, respectively. But these new rules also apply to air ambulance services, which is the focus of this article.

Background

Broadly speaking, the new "surprise billing" provisions, which were enacted as part of the Consolidated Appropriations Act, 2021, are targeted at certain 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 or at an out-of-network facility. 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 Departments of Health and Human Services, Labor, and Treasury all have jurisdiction over certain aspects of these new rules, and the Agencies have jointly issued Interim Final Regulations (IFR) to implement them. Generally speaking, the new rules address three separate (but related) issues:

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

However, these rules only apply in certain circumstances. They most typically apply when a plan covers emergency services and a participant obtains emergency medical services at an out-of-network facility and/or from an out-of-network provider. Subject to an exception if certain specific notice and consent requirements are satisfied, the surprise billing protections also can apply if a participant obtains non-emergency services from an out-of-network provider at a network facility.

Surprise Billing Rules for Air Ambulance Services

Another common situation in which the rules apply is when a plan covers air ambulance services and a participant uses an out-of-network air ambulance provider. This is true even if the plan does not have any in-network air ambulance providers, as may often be the case.

If a participant receives air ambulance services from a nonparticipating provider, 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.

The rules for calculating a participant's cost-sharing obligation and the plan's responsibility to the air ambulance service provider are similar to those that

apply with respect to emergency and non-emergency services, but there are some differences.

For example, in the case of out-of-network air ambulance services, the participant cost-sharing amount is calculated simply as the lesser of the Qualifying Payment Amount (QPA) or the billed amount for the services. Unlike the cost-sharing requirements for emergency and non-emergency services, the statute does not reference All-Payer Model Agreements or a "specified state law" with respect to cost-sharing requirements for air ambulance services, and the IFR follows this distinction.

By comparison, the same definition of "out-of-network rate" for purposes of determining the plan's obligation to the provider or facility applies to both emergency and non-emergency services and to air ambulance services. However, the preamble to the IFR notes that the Airline Deregulation Act of 1978 broadly preempts state laws that relate to air ambulance providers. Based on that, the preamble states that the Agencies are "unaware of any instances in which an All-Payer Model Agreement or a specified state law might apply" in the context of air ambulance services. Thus, as a practical matter, the out-of-network rate for air ambulance services will be the amount the plan and provider agree upon or the amount determined by the Independent Dispute Resolution process.

When the new rules apply, they will prohibit out-of-network air ambulance 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.

The full text of the IFR is here.

Bipartisan Infrastructure Bill Includes Employment and Benefits-Related Revenue Provisions

Buried deep within the 2,000+ page bipartisan infrastructure bill (the "Infrastructure Investment and Jobs Act" or "IIJA") that the Senate passed on August 10 are a couple of employment and employee benefits-related provisions intended to raise revenue to partially offset the bill's cost.

Single-Employer Pension Funding Stabilization

As reported in Rewards Policy Insider 2021-15, the IRS has just recently issued guidance on the single-employer pension funding relief provisions included in the American Rescue Plan (ARP) Act.

One of the ARP changes was to delay the widening of the interest rate stabilization corridor. Before the ARP, the corridor was scheduled to begin expanding from 90% to 110% in 2020, to 85% to 115% in 2021, and then

continuing to expand each year until it reached 70% to 130% in 2024 and beyond.

The ARP actually reduces the corridor to 95% to 105% for the period from 2020 through 2025, and then returns it to 90% to 110% for 2026. From there, it continues to expand each year until it reaches 70% to 130% in 2030 and beyond.

The IIJA would keep the 95% to 105% corridor in place through 2030. It would then begin to widen again in 2031 until it reaches 70% to 130% in 2035 and beyond.

Employee Retention Tax Credit

The IIJA also would amend the employee retention tax credit to make it applicable only to wages payable before October 1, 2021. Under current law it is applicable for wages payable before January 1, 2022.

Additionally, it would make minor changes to the definition of "recovery startup business," which is a new business that can qualify for a credit of up to $50,000 per month even if it does not meet the requirements for suspended operations or decline in gross receipts.

Outlook

As noted, the Senate passed the IIJA on August 10 by a 69-30 margin. It now goes to the House, where Speaker Pelosi has agreed to put it to a vote no later than September 27. The September 27 deadline is a compromise between Speaker Pelosi and a group of moderate Democrats who objected to a previous plan to delay a House vote on the IIJA until the Senate approves a more controversial $3.5 trillion budget reconciliation bill that includes paid family and medical leave for all workers, universal pre-K, tuition-free community college, and other Democratic priorities.

The House and Senate have both passed the budget reconciliation blueprint, and House Committees are starting the process of pulling together the various pieces of the House's budget reconciliation bill. That work is expected to be done by mid-September, with a final House vote coming soon after.

Assuming the budget reconciliation bill clears the House, all eyes will turn to the Senate where two key Democrats – Senators Joe Manchin (WV) and Kyrsten Sinema (AZ) – have already expressed reservations about the $3.5 trillion price tag. Since no Republicans are expected to support the reconciliation bill, even a single defection by a Senate Democrat will prevent the bill from passing.

An issue to watch is whether progressive Democrats in the House will be willing to support the IIJA if the reconciliation bill falters in the Senate.

Rewards Policy Insider will provide updates on both the IIJA and the budget reconciliation bill as developments warrant.

Compliance Reminder: Group Health Plans Must Provide Part D Creditable Coverage Notice by October 15

Each year, by October 15, group health plans that provide prescription drug benefits must notify all Medicare-eligible participants if the plan's prescription drug coverage is "creditable coverage."

The written notice must go to all Medicare-eligible participants and their dependents, regardless of whether they are covered as active employees, COBRA beneficiaries, or retirees. This would include those who are age 65 and older, as well as those who are Medicare-eligible due to disability or end-stage renal disease. Some group health plans merely provide the notice to all participants in order to avoid inadvertently overlooking someone who should have received it.

In addition to the annual creditable coverage notice, a notice must also be provided at certain other times – such as when a Medicare-eligible individual first joins the group health plan.

The notice is important because individuals who do not enroll in Medicare Part D when they first become eligible will be subject to a late enrollment period unless they maintain other creditable coverage.

In order for a group health plan's prescription drug coverage to be "creditable," its actuarial value must equal or exceed the actuarial value of standard prescription drug coverage under Medicare Part D. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

In addition to the creditable coverage notice to participants, group health plans also must report its creditable coverage status to CMS each year using the Online Disclosure to CMS Form. This annual disclosure is generally required no more than 60 days before the beginning of each plan year, as well as within 30 days of any change in a plan's creditable coverage status.

For additional information on these requirements, including links to official model notices of creditable coverage, see the CMS website.