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Employee Benefits Management Directions

EMPLOYEE BENEFITS MANAGEMENT DIRECTIONS HEADLINES, Report No. 758, October 4, 2022

New independent dispute resolution requirements pose substantial challenges for health plans and health care providers, expert says

Effective January 1, 2022, the No Surprises Act (NSA), which Congress passed as part of the Consolidated Appropriations Act of 2021, is designed to protect patients from surprise bills for emergency services at out-of-network facilities or for out-of-network providers at in-network facilities. The NSA and its implementing regulations establish an independent dispute resolution (IDR) process to address disputes between out-of-network providers and health plans over the out-of-network rate for items or services paid by the health plans to the providers under the NSA. To find out more about the IDR process, **Wolters Kluwer** reached out to Laura Miller Andrew, Senior Counsel in the Executive Compensation and Employee Benefits and Health Care Practices of Smith, Gambrell & Russell, LLP.

WK: What is the IDR process?

> **Miller Andrew:** IDR is the process by which the out-of-network providers or health plans can dispute the rates paid or denied that qualify as surprise billing situations under the NSA. Before the IDR process can be used, disputes between out-of-network providers and health plans over the out-of-network rates for health services provided to the health plan must first attempt to negotiate the rate within 30 days after receiving the payment or denial from the health plan for the services provided. If that negotiation fails, either the health plan or the out-of-network provider may initiate the IDR process.

WK: Who can or must use it?

> **Miller Andrew:** The IDR process is available only if the parties cannot agree on a rate within that 30-day period mentioned above. Either the out-of- network provider or health plan is able to initiate the IDR process. Generally, fully-insured plans will use state IDR processes and self-insured plans will use the federal process.

WK: Generally, what are the steps of the IDR process?

Miller Andrew: Once the negotiation period listed above has elapsed, the initiating party (either the out-of-network provider or health plan) proposes an IDR entity and, if the non-initiating party rejects the proposal and the parties are unable to agree upon another IDR entity, the U.S. Departments of Labor, Health and Human Services, and the Treasury (the Departments) will select an IDR entity for the dispute.

Then the out-of-network provider or health plan each submit their offer for the out-of-network payment amount for a claim. The certified IDR entity then must review the submitted offers. In making its decision, the IDR entity will consider (1) the qualified payment amount (QPA), which is generally the plan or issuer's median contracted rate for the same or a similar service in the specific geographic area, and (2) all additional information submitted. The IDR entity will determine the offer that best reflects the appropriate out-of-network rate. This amount will be considered the value of the qualified IDR item or service.

The IDR entity issues a written decision submitted to the parties and the Departments, including an explanation of why the offer selected as the out-of-network rate best represents the value of the qualified IDR item or service. If the IDR entity relies on any additional information in selecting an offer, the written decision must include why the IDR entity concluded this information was not already reflected in the QPA.

WK: What changes did the regulations issued in August 2022 make to the process?

Miller Andrew: On Aug. 19, 2022, the Departments released a Final Rule, effective Oct. 25, finalizing NSA requirements relating to the IDR process. The new rule was issued in response to the concern that the presumptive use of the QPA in the IDR process favored health plans and insurers. Two court decisions, *Texas Medical Association v. HHS*, 6:21-cv-425-JDK (E.D. Tex. Feb. 23, 2022) and *Lifenet, Inc. v. HHS*, 6:22-cv-162-JDK (E.D. Tex. Jul. 26, 2022) questioned the Departments' ability to establish the QPA as the presumptive rate of reimbursement in such disputes, vacating those provisions as inconsistent with the statutory requirements of the NSA and for failure to satisfy notice and comment period requirements for rulemaking.

Under the Final Rule, the IDR entity must consider the QPA, but is no longer required to select the offer closest to the QPA. Rather, the IDR entity must select the offer that best represents the value of the item or service by first considering the QPA and then considering additional information submitted by the parties or requested by the IDR entity. A non-exhaustive list of additional information the parties can consider submitting is included in the Final Rule.

The Final Rule also establishes new disclosure requirements for health plans when the plan's "downcode" claim is included in calculating the QPA. Downcoding is defined as the alteration of a service code to another service code, or the alteration, addition, or removal of a modifier by a health plan, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed by the provider.

When a health plan uses a QPA based on a downcoded service code or modifier, additional information must be provided. This information includes a statement informing the provider that the billed service code or modifier was downcoded, an explanation which identifies the service codes that were altered and the modifiers that were altered, added, or removed in the downcoding and what the QPA would have been had the service code or modifier not been downcoded.

WK: What issues, if any, have you seen so far with the process?

Miller Andrew: Implementation of the NSA, specifically the new IDR requirements, poses substantial challenges for health plans and health care providers as they work to incorporate these new requirements into their existing practices and operations. Because of the time frames required for the IDR, health plans and health care providers must develop new and enhanced protocols and practices to ensure that claims are appropriately and timely adjudicated and submitted for resolution

through the NSA's IDR process. Of course, future litigation regarding aspects of the IDR may also be inevitable.

WK: Is there anything else you'd like to add?

Miller Andrew: The August Final Rule also specified that further rulemaking from the Department will be released. In fact, in conjunction with the issuance of the Final Rule, the Departments also released guidance materials, including FAQs, Charts and Facts Sheets. A new website was also introduced that provides additional guidance and links to various resources regarding the NSA (https://www.cms.gov/nosurprises/help-resolve-payment-disputes/Tips-for-Disputing-Parties). Practitioners should review these resources and be prepared for future guidance from the Departments.

Departments issue technical guidance on independent dispute resolution process

The Departments of Labor, Treasury, and Health and Human Services (Departments) have issued guidance related to the federal independent dispute resolution (IDR) process under the No Surprises Act (NSA). The guidance includes common mistakes and helpful tips for parties initiating an IDR dispute and technical assistance for certified IDR entities.

Determination of payment rates. Rules implementing the NSA established the IDR process, which providers (including air ambulance providers), facilities, and health plans can use to resolve payment disputes for certain out-of-network charges. Providers, facilities, and health plans can use this process to determine the payment rates for those services.

When a provider or facility gets a payment denial notice or an initial payment from a health plan for certain out-of-network services, the health plan, provider, or facility must start an open negotiation period that lasts 30 business days. At the end of the negotiation period, if the health plan and provider or facility haven't agreed on a payment amount, either party can begin the IDR process.

The IDR process brings in a third-party, known as a certified IDR entity, to decide the payment amount and requires the provider or facility and the health plan to submit payment offers to the dispute resolution entity and additional information supporting their payment offers.

Common mistakes. To ensure disputes are processed as quickly as possible, the Departments encourage parties to avoid the following common mistakes:

- incorrectly batching cases,
- incorrectly submitting disputes involving bundled qualified IDR items or services,
- failing to use the contact information provided with the initial payment or notice of denial of payment,
- failing to include the Qualifying Payment Amount (QPA) provided with the initial payment or notice of denial of payment, and
- failing to provide documentation of initiation of open negotiation, if the non-initiating party reports that open negotiation did not occur.

Technical assistance for certified IDR entities The Departments also issued technical assistance that discusses batching and bundling and eligibility for the IDR process. It also addresses what a certified IDR entity should do if the initiating party or non-initiating party fails to submit information in response to a certified IDR entity's request.

Batching requirements. The NSA and its implementing regulations allow for multiple qualified IDR items or services to be considered as part of a batched dispute when certain conditions are met. There is no limit to the number of qualified IDR items or services that can be included in a batched dispute, as long as the qualified items or services conform with the batching requirements set forth in 26 CFR 54.9816-8T(c)(3), 29 CFR 2590.716-8(c)(3), and 45 CFR 149.510(c)(3).

The technical assistance also indicates that revenue codes are not considered service codes for the purpose of batched disputes. As stated in the preamble to the interim final rules (Requirements Related to Surprise Billing; Part I) revenue codes are modifiers to service codes and indicate the department or place in the hospital where a procedure or treatment was performed. Qualified IDR items or services with different service codes (regardless of their revenue codes) may not be batched.

Self-insured plans. A batched dispute involving a self-insured group health plan may only include the one self-insured group health plan that is responsible for payment for all of the qualified IDR items or services in the batch. Qualified IDR items or services in a batched dispute that would be paid by different self-insured group health plans may not be batched as a single payment dispute.

However, if the certified IDR entity finds that both the open negotiation notice and the IDR initiation notice were supplied in accordance with the applicable regulations to the self-insured plans that are represented in the inappropriately batched dispute, the certified IDR entity may allow the initiating party to resubmit the inappropriately batched dispute as correctly batched or single disputes for the separate plans.

Eligibility for the IDR process. The technical assistance also sets forth detailed steps for IDR entities to follow if a non-initiating party that is a plan or issuer, states that it did not receive the open negotiation notice from an initiating party that is a provider, facility, or provider of air ambulance services. In addition, it addresses how to proceed when the non-initiating party states that it never received the notice of IDR initiation from the initiating party.

Failure to submit required information. If a certified IDR entity requests that a party submit information by a certain date, and the party fails to timely submit the information, the certified IDR entity should resolve the dispute based on the information that has been submitted by the parties by the applicable deadline. Accordingly, any party that fails to submit required information in accordance with a request from a certified IDR entity bears the risk that its failure may negatively affect the outcome of the IDR process for that party.

SOURCE: https://www.cms.gov/nosurprises

Constitutional, Religious Freedom Restoration Act challenges to ACA achieve mixed success

The U.S. Secretary of Health and Human Services ultimately ratified certain agency actions such that there was no violation of the Appointments Clause, held a federal district court in Texas. A group of natural persons and two business entities objected, mainly on religious grounds, to certain Patient Protection and Affordable Care Act (ACA) health insurance coverage mandates. The objectors did not want to buy or offer certain mandated coverage so they sued the HHS Secretary, the United States, and other government actors. On the parties' cross-motions for summary judgment, the court variously held that the Preventive Services Task Force (PSTF) had violated the Appointments Clause, but the Advisory Committee on Immunization Practices (ACIP) and the Health Resources and Services Administration (HRSA) did not; PSTF did not violate Article II's Vesting Clause; the preventive-services provisions did not violate the nondelegation doctrine; but the pre-exposure prophylaxis (PrEP) drugs to prevent HIV infection coverage mandate violated the self-insured business entity's rights under the Religious Freedom Restoration Act (RFRA). Inasmuch as only the one self-insured business entity established standing, but that was sufficient, for now, for all of the objectors to survive the government's cross-motion for summary judgment, the court expected the parties to file supplemental briefs for any further decision regarding relief

Background. Six natural persons and two business entities challenged the constitutionality and legality under RFRA of the ACA's preventive-care mandates. Each wanted to obtain or provide health insurance that excluded or limited the coverage of certain ACA preventive-care mandates. They cited mainly religious objections to having to pay for or provide coverage for items like PrEP drugs to prevent HIV infection, the HPV vaccine, and contraceptives.

The objectors asserted five claims against the HHS Secretary; the Secretary of the Treasury; the Secretary of Labor; and the United States. They alleged that (1) the preventive-care mandates violated the Appointments Clause; (2) the preventive-care mandates violated the nondelegation doctrine; (3) 42 U.S.C. § 300gg 13(a)(1) violated the Vesting Clause; (4) the preventive-care mandates, as a matter of statutory interpretation, applied only to ratings, recommendations, or guidelines in place at the time Congress passed the ACA; and (5) the PrEP mandate violated RFRA. The district court previously dismissed the objectors' statutory interpretation claim for failure to state a claim. The court had also dismissed the religious objections to the contraceptive mandate as barred by res judicata.

The objectors moved for summary judgment on the remaining claims. The government actors filed a cross-motion for summary judgment on the basis that the objectors lacked standing and could not prevail on the merits.

Standing. The court said it was beyond question that religious employers had Article II standing to challenge a government mandate if it infringed on religious liberty. *Hobby Lobby Stores, Inc. v. Sebelius*, 723 F.3d 1114, 1154 (10th Cir. 2013) (Gorsuch, J., concurring), aff'd sub nom. *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014). The self-insuring business entity presented the easiest case because it faced a $100 per-employee, per-day penalty for failure to comply with the mandates. The court found that the entity established competent evidence that § 300gg-13 invaded its interests, and the invasions were concrete and actual, hence that entity suffered injury in fact. Because that one objector established standing to survive the government actors' cross-motion for summary judgment, the other objectors also survived the motion without further inquiry. However, the court noted that each objector would eventually have to show "much more" to establish their respective standing when it comes time to decide whether they are entitled to relief.

Appointments Clause. Turning to the merits, the court reviewed how the circuits have so far unanimously agreed that ratification may cure Appointment Clause problems. The court resolved that because the HHS Secretary effectively ratified the ACIP and HRSA actions, the court did not need to address the Appointments Clause issues regarding those two agencies. The court granted summary judgment to the government actors.

However, the outcome was different with respect to the PSTF and the binding power of its recommendations. PSTF recommends "evidence-based items or services" with an "A" or "B" rating. The court found that the HHS Secretary did not have authority, as a political actor, to direct what services were covered under § 300gg-13(a)(1), and so he could not ratify PSTF's decisions on that subject. After a lengthy analysis, the court held that because the President had not appointed the PSTF officers with Senate confirmation, those appointments violated the Appointments Clause. The court granted partial summary judgment in favor of the objectors on their Appointments Clause claim because the PSTF appointment process deviated from Article II constitutional requirements. The court appeared to admonish the government actors that they overlooked the constitutional problems of attempting to penalize citizens without a binding law.

Removal. The court held that the objectors' removal claim failed because they did not identify any removal restrictions on PSTF members. While the political insulation language of § 299b-4(a)(6) prohibited the HHS Secretary from directing what services were covered under § 300gg-13(a)(1), it did not prohibit the Secretary or the President from removing PSTF members. The court noted again that the unconstitutional appointment of PSTF members needlessly "complicated" the removal analysis. Nonetheless, the PSTF members did not have statutory tenure, so the court concluded they were removable at will. The court granted summary judgment to the government actors as to the Vesting Clause claim.

Nondelegation. As to any nondelegation issues, the court found that the objectors overlooked the binding Fifth Circuit precedent of *Big Time Vapes, Inc. v. FDA*, 963 F.3d 436 (5th Cir. 2020). The Fifth Circuit found that Congress had delineated a "general policy" with respect to preventive care. The instant court likewise found that Congress delineated a general policy to expand insurance coverage for various preventive services. The preventive-service provision outlined a "minimum" level of coverage. The agencies had also preexisted the ACA, so Congress had already given them an express purpose. Congress also limited the authority it delegated. For example, it limited the ACIP's authority to "immunizations." The court declined to predict any future Supreme

Court reexamination of the nondelegation doctrine, so it granted summary judgment to the government actors on the violation of the nondelegation doctrine claim.

RFRA. The court held that the PrEP mandate substantially burdened the owner of the self-insured business entity as to the exercise of religion. The court said the government actors did not dispute the law, but instead inappropriately disputed the correctness, rather than the sincerity, of the owner's religious beliefs. The court concluded the government actors failed to show a compelling government interest in the PrEP mandate and that the mandate was the least restrictive means of furthering that interest. Accordingly, the court granted summary judgment in favor of the self-insured entity as to the claim that the PrEP mandate violated RFRA. The court reserved as to the other objectors.

The court said it expects the litigants to brief the large number of remaining issues as to each objector.

SOURCE: *Braidwood Management Inc. v. Becerra,* (N.D. Tex.), No. 4:20-cv-00283-O, September 7, 2022.

Survey finds 4 in 10 workers will scale back on employee benefits during open enrollment due to inflation

New research from The Hartford, a leading provider of employee benefits and absence management, found 40 percent of U.S. workers reported inflation will make them scale back on the employee benefits they choose during open enrollment. In addition, 48 percent of U.S. workers said inflation is making it difficult for them to pay for their benefits.

"With our current economic environment, it is an ideal time for workers to take stock of what benefits they currently have rather than automatically rolling over the same benefits they chose in previous years," said Dana MacKinnon, head of relationship management strategy and enrollment for Group Benefits at The Hartford. "I encourage workers to take extra time this year to reflect on what changes have occurred in their life and select the benefits that best fit their individual needs and budget to help protect their finances in the long-run."

Younger workers were more likely to report they would cut back on benefits compared to older peers. More than half of the workers ages 18-34 (51%) reported they are likely to scale back on their benefits compared to those ages 35-54 (41%) and those ages 55+ (25%).

Approach to benefits selection. While many workers noted they will select fewer benefits this year, The Hartford's August 2022 Future of Benefits Pulse Survey found more than half (55%) of workers admitted at their age, they should know more about their employee benefits beyond medical, dental and vision than they currently do. The research indicates that clearer communications could help, with 37% of workers saying the names and descriptions of their employee benefits make them hard to understand.

According to the national survey, many workers automatically make the same benefits choices as the previous year, which is the most common approach among working Americans when selecting benefits:

- Thirty percent of U.S. workers are "rollers," typically rolling over the same benefits choices they made the previous year;
- Twenty-eight percent of workers are "planners," keeping up to date on benefits throughout the year so they are prepared at enrollment time;
- Twenty-two percent of workers are "analyzers," analyzing the coverage and crunching the numbers for all of their benefits choices;
- Twelve percent of workers are "consulters," typically needing to consult with someone else before making their benefits selections; and
- Eight percent of workers are "avoiders," tending to ignore all the open enrollment emails and would prefer not to think about their benefits.

To help U.S. workers fully understand their benefits options and make informed decisions to protect themselves and their families, employers can:

- Communicate all year long about benefits so they are better prepared at decision time. Many workers (39%) indicated they typically enroll in benefits as soon as the open enrollment window opens;
- Offer a variety of tools to reach their workforce such as emails, webinars, one-on-one support from benefits counselors, educational videos, interactive decision support tools and even social media. Forty-eight percent of U.S. workers have used social media platforms to learn about benefits, with YouTube and Facebook being the most common platforms used;
- Use clear language and personalized messaging to demonstrate how the insurance products relate to their lifestyle rather than simply listing what benefits are being offered; and
- Highlight the services that may come with the insurance coverage such as an employee assistance program (EAP) or will preparation services.

The survey showed that many workers (39%) said their overall health has improved thanks to the benefits and services offered by their company. As a leading provider of employee benefits products and services, including leave management, group life and disability insurance, as well as other voluntary products, The Hartford is committed to helping employers support the overall wellness of their workforce.

SOURCE: https://www.thehartford.com

Does FMLA cover employees for their mental health illness?

Q *Can our employees take FMLA for their mental health illness?*

A Eligible employees may take FMLA leave for their own serious health condition or to care for a spouse, child, or parent because of their serious health condition. A serious health condition can include a mental health condition. Mental and physical health conditions are considered serious health conditions under the FMLA when they require (1) inpatient care or (2) continuing treatment by a healthcare provider, such as an overnight stay in a treatment center for addiction or continuing treatment by a clinical psychologist.

The DOL's Wage and Hour Division has clarified that a serious mental health condition requiring continuing treatment by a health care provider includes:

- Conditions that incapacitate a person for more than three consecutive days and require ongoing medical treatment, either multiple appointments with a health care provider, including a psychiatrist, clinical psychologist, or clinical social worker, or a single appointment and follow-up care (for example, prescription medication, outpatient rehabilitation counseling, or behavioral therapy); and
- Chronic conditions (such as anxiety, depression, or dissociative disorders) that cause occasional periods when a person is incapacitated and requires treatment by a health care provider at least twice a year.

Employers may require the employee to submit a certification from a health care provider to support the need for FMLA leave. Although the information provided on the certification must be sufficient to support the need for FMLA leave, a diagnosis is not required.

The Wage and Hour Division provides the following example: An employee is occasionally unable to work due to severe anxiety. She sees a doctor monthly to manage her symptoms and uses FMLA leave to take time off when she is unable to work unexpectedly due to her condition and when she has a regularly scheduled appointment to see her doctor during her work shift.

SOURCE: DOL Wage and Hour Division Fact Sheet #28O: Mental Health Conditions and the FMLA (May 2022).

EMPLOYEE BENEFITS MANAGEMENT Highlights

With this EMPLOYEE BENEFITS MANAGEMENT newsletter, the following items have been updated in this Report:

- Laws enacted at ¶2820.
- Current interest rates at ¶6550.
- Duration of disability benefits at ¶30,040.

- Reimbursement for expenses at ¶38,060.
- Pension payments in labor contracts at ¶136,030.
- Limitations on luxury car deductions at ¶150,575.