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HEALTH AND WELFARE PLAN DEVELOPMENTS

DOL, HHS and IRS Issue Guidance Regarding No Surprises Act Independent Dispute Resolution Process

On September 30, 2021, the U.S. Department of Labor (DOL), Department of Health and Human Services (HHS) and the Internal Revenue Service (IRS) released an Interim Final Rule (the Rule) regarding the surprise medical billing protections under the No Surprises Act (the Act). The Rule details the independent dispute resolution (IDR) process that will establish the applicable out of network rate for protected services under the Act, including out-of-network emergency services, non emergency services by an out of network provider at an in network facility and out-of-network air ambulance services when plans and providers cannot reach an agreement on the payment amount. The Rule applies to both grandfathered and non grandfathered group health plans under the Affordable Care Act (ACA) and will be effective for plan years beginning on or after January 1, 2022. Highlights of the IDR process include:

- Parties Subject to IDR. Consistent with the Act's provisions, the IDR process is intended to govern disputes between group health plans, health insurance issuers, and nonparticipating providers, facilities and providers of air ambulance services. The Rule further confirmed that participants and dependents are not subject to the IDR process, as cost sharing is determined through procedures detailed earlier this year.
- Negotiation. Parties must participate in a 30 business day negotiation period before submitting a dispute to the certified IDR entity selected from the federal registry (IDR Entity). The parties may initiate negotiation within 30 business days after the provider or facility receives an initial payment or notice of denial of payment from the plan or issuer regarding the applicable item or service. To initiate negotiation, a party must send an Open Negotiation Notice to the opposing party. If the parties do not resolve the dispute within 30 business days following receipt of the Open Negotiation Notice, they may initiate the IDR process. If they wish, the parties may continue to negotiate throughout the IDR process until the date the IDR Entity submits a final determination.
- Batched Items and Bundled Services. In addition to single claims, the Rule specifies that parties may submit claims related to multiple services an individual received during an episode of care (bundling), or they may batch

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multiple qualified IDR items or services together for a single ruling. To qualify for batching, the items or services must: (1) be billed by the same provider or group of providers; (2) be related to the same plan; (3) be the same or similar items and services with comparable service codes; and (4) be furnished within the same 30 day period.

- Choosing an IDR Entity. To initiate the IDR process, a party must submit a written notice to the opposing party and to the federal agency in charge of the program within the four-day window beginning on the first day following the negotiation period. The party initiating the IDR must propose a certified IDR Entity from the federal registry. The opposing party then has three business days to object and propose an alternative certified IDR Entity. If the parties cannot agree on an IDR Entity, the overseeing federal agency will select one from the list of available candidates.
- Submission Requirements. Once the parties have selected (or have been provided) a certified IDR Entity, the Rule establishes a 10 business day period during which they must submit proposed offers of a total payment amount (the out-of-network rate). Along with their offers, the parties may submit additional information depending on whether they are a provider or a group health plan or insurer. Providers may submit information regarding the size of their facility and their practice specialty. Plans and insurers may provide information on their coverage area, relevant geographic region for purposes of calculating the qualifying payment amount (QPA) used to determine the participant's cost-sharing, insured status and the QPA for the same or a similar item or service as the item or service that is the subject of IDR.
- IDR Decision Making. Within 30 business days after the IDR Entity was selected by the parties, the IDR Entity must determine the appropriate out of network rate for the disputed item or service. Generally, the IDR Entity must select the offer closest to the QPA unless credible information submitted by a party certifies the out of network rate is materially different than the appropriate out of network rate. In reaching its decision, the IDR Entity may consider the information submitted by the parties, but may not consider usual and customary charges, the amount that would have been billed had the item or service not been protected, or the payment or reimbursement for the item or service as established by Medicare or Medicaid.
- Fees. At the outset of the IDR process, both parties must submit payment of the IDR Entity's full fee. Once it has reached a decision, the IDR Entity must reimburse the party whose offer it selected as the appropriate out of network rate, the full amount of the fee. If the parties continue negotiations during the IDR process and reach an agreement before receiving a final determination,

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each party will be reimbursed 50 percent of the IDR fee. Additionally, at the time the IDR Entity is selected, the parties must pay a non refundable administrative fee to cover the costs of participating in the IDR process.

To administer the IDR process, the Rule directs the federal government to establish a website that: (1) contains registries of certified IDR Entities; (2) allows parties to submit relevant claims and documentation; and (3) submit payment. The Rule also describes the qualification process for certified IDR Entities and the conflict of interest provisions that would disqualify a certified IDR Entity from rendering an impartial decision. It further subjects IDR Entities to strict privacy practices and regulations akin to requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which are intended to protect individually identifiable health information (IIHI) from unauthorized access or disclosure.

Finally, the Rule also amends federal regulations governing the external review of adverse benefit determinations. Specifically, the Rule provides that claims related to compliance with the surprise billing and cost-sharing protections under the No Surprises Act are subject to external review. Although grandfathered plans under the ACA are generally exempt from external review requirements, the Rule mandates that these plans must nonetheless provide for external review of claims covered by the No Surprises Act for plan years beginning on or after January 1, 2022.

Interested parties will have until December 6, 2021, to submit comments on the Rule. Because the IDR process will be effective for plan years beginning on or after January 1, 2022, plans and insurers should begin working with service providers and consultants to develop procedures that incorporate the Rule's various timelines and requirements.

RETIREMENT PLAN DEVELOPMENTS

Proposed Form 5500 Changes

The DOL, IRS and Pension Benefit Guaranty Corporation (PBGC) (collectively known as, the Agencies) have proposed significant revisions to the Form 5500 Annual Return/Report forms (Form 5500). In a notice published September 14, 2021, the Agencies announced proposed changes to the Form 5500 primarily relating to the amendments to the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code under the Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act). Some of the key

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proposals are as follows:

- Consolidated Form 5500 for Defined Contribution Retirement Plan Groups. Pursuant to the SECURE Act, the proposal adds a new direct filing entity called a Defined Contribution Group (DCG). All plans within a DCG could file a single consolidated return. Among other requirements, plans included in a DCG must (1) have the same administrator and named fiduciaries; (2) have the same trustee(s); (3) have the same plan year; and (4) provide the same investments. Although a DCG may file a single report, each plan within the entity must undergo a separate financial audit. Multiemployer plans are not eligible for DCG status.
- Financial Transparency and Accountability for Investment Assets. To improve accuracy of investment data, the proposal would update Schedule H of the Form 5500 and its instructions to a standardized electronic filing format. Further, the proposal would add disclosures to specify characteristics of individual investments and would require additional detail in direct expense reporting on Schedule H.
- Funding and Financial Reporting by Defined Benefit Plans. The proposal would also add several questions designed to increase data reporting of PBGC covered plans. Plans would be required to describe in detail their withdrawal liability calculations and assessments, including the interest rates used to calculate the present value of vested benefits. Plans with 500 or more participants would also be required to provide additional information about demographics, benefits and contributions.

Generally, if adopted, the proposed changes would be effective for plan years beginning on or after January 1, 2022. However, some changes related to participating employer information and pooled employer plan (PEP) provider information may be effective for 2021 plan year reporting.

PBGC Issues Special Financial Assistance Q&As

On September 21, 2021, the PBGC issued several additional questions and answers (Q&As) to provide information on ARPA's special financial assistance program for underfunded defined benefit pension plans. The Q&As addressed the potential impact of any changes to the PBGC's interim final rule (Interim Rule), which was previously discussed in our July 2021 Benefits Counselor. The PBGC is still reviewing comments to the Interim Rule and will move to publish a Final Rule when that review has concluded. The PBGC noted that the Agency is still accepting applications under the Interim Rule for certain priority groups during the comment review period. Finally, the PBGC clarified that plans which submit

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applications for special financial assistance before publication of the Final Rule will not see their financial assistance reduced by subsequent changes. If a plan submits an application while the Interim Rule is in effect, its financial assistance will be determined by the Interim Rule unless the Final Rule would result in a greater amount of financial assistance.

LITIGATION UPDATES

The Sixth Circuit's New Stance on Withdrawal Liability

A recent U.S. Court of Appeals for the Sixth Circuit decision could result in more challenges against multiemployer defined benefit pension plans regarding withdrawal liability assessments. In *Sofco Erectors Inc. v. Trustees of the Ohio Operating Engineer's Pension Fund*, Sofco challenged the Fund's assessment of more than $800,000 in withdrawal liability. To calculate Sofco's withdrawal liability, the Fund used a common method called the "Segal Blend," blending the PBGC interest rate with the interest rate used to determine a plan's minimum funding requirements. Ruling in favor of Sofco, the Court found that the Segal Blend does not result in an interest rate that is "the actuary's best estimate of anticipated experience under the plan." By rejecting use of the Segal Blend, the Sixth Circuit becomes the first circuit to weigh in on the issue, potentially opening the door to more withdrawal liability challenges that progress beyond individual arbitration.

Renewed Scrutiny on Individual Arbitration Clauses

In *Smith v. Board of Directors of Triad Manufacturing, Inc.*, the Seventh Circuit confirmed that arbitration clauses that prospectively waive a party's right to pursue statutory remedies may be unenforceable. In *Smith*, an Employee Stock Ownership Plan (ESOP) attempted to compel arbitration of a participant's claims that the ESOP had overpaid for company stock. The ESOP's arbitration clause, which was contained in the plan document, barred the participant from seeking any remedy that would provide relief to any person other than the participant. The Seventh Circuit found that the arbitration clause was unenforceable because it prevented the participant from seeking several forms of relief available under ERISA, including the removal of the ESOP trustee, which would implicitly benefit other participants. The *Smith* decision should serve as an important reminder for plan sponsors to carefully craft their arbitration clauses to avoid potential conflicts with federal law.

AT&T Survives Excessive Fee Challenge

A recent district court case out of California may provide plan sponsors a

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roadmap for defending against excessive fee challenges. In *Alas v. AT&T Services, Inc.*, 245,000 participants of AT&T's 401(k) plan brought claims against the company, claiming that the plan incurred excessive recordkeeping expenses and failed to accurately report those expenses on its annual Form 5500 filings. Finding for AT&T, the Court noted that the plaintiffs failed to present evidence to support their claim that the Form 5500 disclosures were inaccurate when the company demonstrated thorough compliance with the DOL's Form 5500 instructions. Regarding the plaintiffs' excessive fee claims, the Court noted that the company provided extensive evidence that it had prudently monitored the plan's recordkeeping expenses. Company representatives had periodically reviewed recordkeeper disclosures and invoices and hired outside experts to evaluate the reasonableness of recordkeeper fees. In sum, by following the right process and maintaining detailed records of its actions, the company presented a comprehensive record that demonstrated compliance with ERISA's fiduciary standards.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

Form 5500 Filing Deadline for Calendar Year Plans with Extensions. For plans that obtained an extension for filing their Form 5500, the Form 5500 must be filed by October 15, 2021.

SAR Deadline for Calendar Year Plans*.* Plan administrators must distribute Summary Annual Reports (SARs) within nine months of the plan's year end (*e.g.*, for plan years that ended on December 31, 2020, the SAR was due September 30, 2021). However, if a plan has received an extension for filing its Form 5500 (*i.e.*, due by October 15, 2021), the nine month SAR deadline is extended to December 15, 2021.

Retirement Plan Compliance Deadlines and Reminders

1. QDIA Notice. Plan sponsors of defined contribution retirement plans that utilize a qualified default investment alternative (QDIA) must provide an annual notice to all participants at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2021, and December 2, 2021.
2. Retirement Plan Automatic Enrollment Notice. Plan sponsors of defined contribution retirement plans with an eligible automatic contribution arrangement or a qualified automatic contribution arrangement must provide an annual notice to all participants, on whose behalf contributions

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may be automatically made to the plan, at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2021, and December 2, 2021. Plan sponsors may combine the automatic enrollment notice with the QDIA notice.

3. Safe Harbor 401(k) Plan Notice. Plan sponsors of safe harbor 401(k) plans must provide participants with an annual safe harbor notice that describes the safe harbor contribution and other material plan features at least 30 days, but not more than 90 days, prior to the beginning of the plan year. Plan sponsors of calendar year plans must provide this notice between October 3, 2021, and December 2, 2021. Plan sponsors may combine the safe harbor notice with other required notices, such as the QDIA notice.

Health Plan Compliance Deadlines and Reminders

1. Medicare Part D Notice of Creditable Coverage. All group health plans that offer prescription drug coverage to Medicare eligible employees (under either an active plan or a retiree plan) must provide an annual creditable coverage disclosure notice to their Medicare eligible participants and dependents no later than October 15, 2021. The Centers for Medicare and Medicaid Services (CMS) provide a model notice that can be accessed through the CMS website. Plan sponsors should review the model notice to ensure it accurately reflects the provisions of their plan.

2.Health Plan Open Enrollment Requirements.

- Plan sponsors of group health plans must issue a new Summary of Benefits and Coverage (SBC) to participants and beneficiaries covered under the plan in conjunction with open enrollment. Group health plans without open enrollment must issue the SBC no later than 30 days prior to the beginning of the plan year (December 2, 2021, for calendar year plans).
- Plan sponsors of health reimbursement arrangements (HRA) must offer participants an annual opportunity to opt out of and waive all future reimbursements from their HRA. This notice of opt out can be provided with open enrollment materials.

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