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HEALTH PLAN DEVELOPMENTS

Departments Finalize Portions of Surprise Billing Independent Dispute Resolution Regulations and Issue Related FAQs

On August 19, 2022, the U.S. Department of Labor (DOL), Department of Health and Human Services (HHS) and the Department of Treasury (the Departments) released a final rule (the Final Rule) and related set of Frequently Asked Questions (FAQs) regarding the independent dispute resolution (IDR) process under the No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021 (CAA). The Departments also issued an initial status report regarding the IDR process.

The No Surprises Act contains provisions intended to protect individuals from surprise medical bills issued for emergency services from out of network or non participating providers or facilities, non emergency services from non participating providers at in network facilities and certain air ambulance services.

In July 2021, the Departments issued an interim final rule (IFR) addressing, among other items, how to determine the cost sharing for services subject to the CAA using the qualifying payment amount (QPA). In September 2021, the Departments issued an IFR implementing the IDR process, which allows group health plans, insurers and out of network providers who cannot agree regarding the appropriate rate for certain services, to submit the dispute to an IDR entity for arbitration. In February and July of 2022, the U.S. District Court for the Eastern District of Texas vacated portions of the IFRs, creating a rebuttable presumption that the proposed payment amount closest to the QPA is the proper payment amount. The Departments issued the Final Rule to conform with the Court's rulings.

Requirements Related to Surprise Billing: Final Rule

The Final Rule is narrow in scope and seeks to address issues critical to the implementation and effective operation of the IDR process. Notable provisions of the Final Rule include:

- Information Plans and Issuers Must Disclose Regarding the QPA**.** Under the July 2021 IFR, plans must disclose to providers and facilities the QPA for each

item or service with each initial payment or notice of denial of payment when the QPA serves as the amount upon which cost sharing is based. The Final Rule expands on this requirement by requiring that plans and issuers disclose additional information if they "downcode" a billed claim. The Final Rule defines "downcoding" as a plan's alteration of the service code to another service code or alteration, addition or removal of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed.

If a QPA is based on a downcoded service code or modifier, the plan must provide the following additional information with its initial payment or notice of denial of payment: (1) a statement that the service code or modifier billed by the provider or facility was downcoded; (2) an explanation of why it was downcoded, including a description of which service codes or modifiers were altered, added or removed; and (3) what the QPA would have been had the service code or modifier not been downcoded.

- Payment Determinations Under the IDR Process**.** The Final Rule states that IDR entities should select the offer that best represents the value of the item or service under dispute after considering the QPA and all permissible information submitted by the parties. Although the IDR must consider the QPA, it is no longer the presumptive amount.

Additionally, the Final Rule directs IDR entities to evaluate whether the information submitted relates to the payment amount offer submitted by either party and whether the additional information is credible. The IDR entity should also evaluate the information to avoid "double counting" criteria already accounted for within the QPA or by any other information submitted by either party.

The Final Rule goes into effect 60 days after publication in the Federal Register and is generally effective for plan years on or after January 1, 2022.

FAQs Part 55

As noted, the Departments also issued a new set of FAQs to supplement the Final Rule and clarify other issues. The FAQs address various topics under the No Surprises Act and questions related to the ACA's Transparency in Coverage rule. Some of the highlights include:

Applicability to No Network and Closed Network Plans. The FAQs clarify how the No Surprises Act applies to plans with no network (*e.g.,* plans that use reference based pricing) or plans that extend only in network coverage to participants. According to the FAQs, the provisions that prohibit balance billing and limit cost sharing apply to these types of plans with respect to emergency services and air ambulance services. However, the provisions that prohibit balance billing and limit cost sharing for non emergency services apply only to services provided by a non-participating provider in a participating health care facility. Thus, if a plan does not have a network of participating facilities, the balance billing and cost-sharing provisions for non emergency services provided by non participating providers for a visit to participating facilities will never be triggered.

The FAQs also address how plans with no network calculate the out of network rate and cost sharing for out of network items and services subject to the surprise billing provisions of the No Surprises Act.

Applicability to Air Ambulance Services**.** The FAQs state that if a plan covers only emergency air ambulance services, the No Surprises Act does not require the plan to cover non emergency air ambulance services. The FAQs also confirm that the protections against surprise bills for air ambulance services furnished by a non participating provider apply to pick ups outside of the United States and provide guidance on determining the QPA in such scenarios.

Applicability to Behavioral Health Crisis Facility**.** The FAQs clarify that the No Surprises Act applies to emergency services in a behavioral health crisis facility to the extent the services meet the definition of "emergency services" and are provided in connection with a visit to a facility that meets the definition of an "emergency department of a hospital" or "independent freestanding emergency department."

General Disclosure for Protections Against Balance Billing**.** The No Surprises Act requires plans to make specific disclosures to individuals regarding the CAA's balance billing protections. The FAQs clarify that a plan without a public website may satisfy the website posting requirement by entering into a written agreement under which the plan's insurer or a third party administrator (TPA) posts the information on its public website, where information is typically made available to participants. The FAQs reiterate that the plan remains responsible if the TPA or insurer fails to post the required information.

Additionally, plans subject to the state balance billing obligations are required to provide information on only applicable state laws, not all state laws. Also, the FAQs note that HHS has revised its standard notice, consent forms and model disclosures. Until the end of 2022, providers and facilities generally may use either the initial or revised versions; beginning January 1, 2023, they must use the revised versions.

Initial Payments or Notices of Denial of Payment, Related Disclosures and Initiation of Open Negotiation Periods and Federal IDR Process**.** The FAQs provide that the initial payment should be an amount that the plan reasonably intends to be payment in full; however, the initial payment is not required to be the QPA. Additionally, the FAQs clarify that the "notice of denial of payment," which is separate from a claim denial notice, means a written notice from the plan to the provider or facility stating that payment will not be made and explaining the reasoning.

Transparency in Coverage—Machine Readable Files. The Transparency in Coverage rule requires that plans make machine readable files publicly available on the plan's website. The FAQs explain that plans can satisfy this requirement by entering into a written agreement under which a TPA posts this information on the plan's behalf. The plan remains responsible if the TPA fails to satisfy this obligation.

Fifth Circuit Rules DOL Opinion on the Status of Data Marketing's Health Plan is Unlawful

In *Data Mktg. P'ship, LP v. United States Dep't of Lab*., the U.S. Court of Appeals for the Fifth Circuit upheld a district court's vacatur of a DOL advisory opinion regarding whether a health coverage arrangement for a limited partnership was covered by the Employee Retirement Income Security Act of 1974 (ERISA). However, the Court remanded the case to the district court for further proceedings to consider the proper interpretation of "working owner" and "*bona fide* partners."

Data Marketing Partnership, LLP (Data Marketing) offers a health insurance plan to individuals who have their electronic data tracked by downloading a software on their personal devices. Data Marketing considers these individuals as partners in its business. As a result, thousands of individual limited partners are eligible to participate in Data Marketing's group health plan.

Data Marketing requested an advisory opinion from the DOL regarding whether

the health coverage arrangement qualified as an employee welfare benefit plan under ERISA and is, therefore, exempt from state insurance law. The DOL found that ERISA did not cover the Data Marketing health plan because the limited partners were not *bona fide* partners or working owners.

In 2019, Data Marketing challenged the DOL's advisory opinion. The district court concluded that the DOL's advisory opinion was arbitrary and capricious and found that Data Marketing's health coverage arrangement was a single employer ERISA plan. The district court issued an injunction precluding the DOL from refusing to acknowledge the plan's status as an ERISA plan.

On appeal, the Fifth Circuit concluded that the DOL's opinion was arbitrary and capricious because the DOL failed to reasonably consider relevant issues and reasonably explain the advisory opinion. According to the Court, the DOL ignored prior advisory opinions defining the term "working owner." However, the Court determined that the district court did not correctly interpret the words "working owner" or "*bona fide* partner." Ultimately, the Court upheld the district court's vacatur of the DOL's advisory opinion but vacated the injunction because it was based on the interpretative questions that the district court must further address on remand.

HHS Posts FAQs on the Electronic National Medical Support Notice System

On August 2, 2022, the HHS Office of Child Support Enforcement (OCSE) issued frequently asked questions regarding its Electronic National Medical Support Notice system (e NMSN). E NMSN is a system to exchange National Medical Support Notices (NMSN) between state child support agencies, employers, TPAs, plan administrators and unions. An NMSN is a medical child support order used by a child support agency to obtain group health coverage for a child. An NMSN is deemed a Qualified Medical Child Support Order (QMCSO) under ERISA if properly completed.

E NMSN is a voluntary system that is available at no cost to users. The FAQs indicate that OCSE receives NMSN files from child support agencies and provides the files to secure servers designated by participating employers within one day of receipt. According to the FAQs, because e NMSN is electronic, there are many benefits, including allowing health coverage to begin sooner, the data being more accurate and reliable than a paper process, and allowing child support agencies to notify users that health coverage is no longer ordered.

An employer, plan administrator or TPA can register to use e NMSN by

completing e NMSN profile forms on the OCSE website and submitting the completed forms via email.

Fifth Circuit Rules in Franciscan Alliance

The U.S. Court of Appeals for the Fifth Circuit upheld a district court decision that HHS cannot enforce certain interpretations of section 1557 of the Affordable Care Act (ACA) against a group of faith based providers. Specifically, the Court affirmed in *Franciscan Alliance, Inc. v. Becerra*, 2022 WL 3700044 (5th Cir. 2022) a permanent injunction prohibiting HHS from requiring the providers to perform or provide insurance coverage for gender transition procedures or abortions.

Franciscan Alliance originally filed the lawsuit challenging parts of the 2016 ACA section 1557 regulations prohibiting discrimination in health programs and activities based on gender identity or termination of pregnancy. The district court vacated portions of the 2016 rule. It later issued an injunction barring HHS from interpreting or enforcing ACA section 1557 and the regulations in a manner that would require Franciscan Alliance to perform or provide insurance coverage for services related to gender transition or abortion in violation of the provider's religious beliefs. The Fifth Circuit upheld the injunction. The Court found that this action was necessary, in part, based on recent HHS actions, including the recently proposed regulations HHS issued in August 2022.

RETIREMENT PLAN DEVELOPMENTS

IRS Extends Deadlines to Adopt Plan Amendments Under the CARES Act and SECURE Act

The Internal Revenue Service (IRS) has extended the deadline for retirement plans to adopt amendments to reflect certain provisions under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), the Setting Every Community Up for Retirement Enhancement Act (SECURE Act) and the Further Consolidated Appropriations Act or Bipartisan Miners Act (Miners Act). The IRS announced the extension on August 3, 2022, in Notice 2022 33 (the Notice).

Under the Notice, nongovernmental qualified retirement plans and Internal Revenue Code section 403(b) plans, including collectively bargained plans, have until December 31, 2025, to adopt applicable amendments. Qualified governmental retirement plans and 403(b) plans have until 90 days after the end of the third regular legislative session of the legislative body with the authority to amend the plan beginning after December 31, 2023. Governmental 457(b) plans have until the later of: (1) 90 days after the close of the third regular legislative

session of the legislative body with authority to amend the plan that begins after December 31, 2023; or (2) if applicable, the first day of the first plan year beginning more than 180 days after the plan receives notice that the plan was administered in a manner inconsistent with section 457(b).

The extended deadlines apply to plan amendments reflecting provisions under the SECURE Act generally and amendments to lower the in service distribution age to 59 1/2 in pension or governmental 457(b) plans under the Miners Act. Regarding the CARES Act, the extended deadlines apply to amendments to defined contribution plans to reflect the waiver of required minimum distributions for 2020. However, the Notice does not extend the deadline for adopting other plan amendments under the CARES Act, such as those reflecting the optional coronavirus related distribution and loan relief. Plan amendments reflecting those provisions must be adopted by the end of the first plan year beginning on or after January 1, 2022.

This extension is a welcome relief for plan sponsors, as it will provide time for the additional guidance to be issued before plans are amended to reflect applicable CARES Act and SECURE Act provisions. However, the Notice does not extend the effective date for operational compliance, meaning plans must be administered in accordance with mandatory provisions of these laws before the postponed amendment deadline.

Seventh Circuit Dismisses Excessive Fee Suit Against Oshkosh

The U.S. Court of Appeals for the Seventh Circuit recently affirmed the dismissal of an excessive fee case in *Albert v. Oshkosh Corporation*. In this case, a former employee and participant in Oshkosh's 401(k) plan alleged that Oshkosh, its Board of Directors and the plan's administrative committee breached their ERISA fiduciary duties and engaged in prohibited transactions. Among other allegations, the participant asserted that the fiduciaries caused the plan to pay excessive recordkeeping fees by failing to solicit competitive bids; paid excessive investment management fees, which would have been lower if the fiduciaries invested in higher cost share classes because the "net expense" would be lower due to revenue sharing; and that the plan failed to provide a detailed explanation of how revenue sharing payments were calculated in the plan's Form 5500.

Regarding the recordkeeping fees, the Court found that the participant failed to allege that the recordkeeping fees were excessive relative to the services rendered. The Court also explained that the duty of prudence does not require fiduciaries to regularly solicit bids from service providers.

With respect to excessive investment management fees, the participant advanced a novel theory that the plan should have offered higher cost share classes of certain mutual funds because the "net expense" of those funds would be lower based on the revenue sharing they offered. According to the Court, this theory was flawed because it assumed that the revenue sharing proceeds would have been rebated to plan participants. The Court also dismissed the participant's claim that the fees for investment advisors were excessive because the participant did not provide a basis for comparison to determine whether such fees were excessive.

Finally, the Court found that plans are not required to disclose detailed information on how revenue sharing is calculated in Forms 5500 and dismissed the participant's related claim.

GENERAL DEVELOPMENTS

DOL Updates Independence Requirement for Auditors Under ERISA

On September 6, 2022, the DOL published Interpretative Bulletin 2022 01 (IB 2022 01), setting forth updated guidelines for determining when a qualified public accountant is independent for purposes of auditing an employee benefit plan under ERISA.

ERISA section 103 requires that an accountant be independent for purposes of the audit requirement but does not define the term "independent." As a result, the DOL issued an Interpretive Bulletin (IB) in 1975, setting forth guidelines for determining when an auditor is considered independent. According to the DOL, IB 2022 01 revises and restates the 1975 IB on accountant independence to eliminate outdated and unnecessarily restrictive provisions.

More specifically, IB 2022 01 makes two key changes to the DOL's previous guidance:

- Period During Which Accountants Are Prohibited from Holding Financial Interests in the Plan or Plan Sponsor. The 1975 IB stated that an accountant was not independent if the accountant, the accountant's firm, or a "member" of the firm has a "direct financial interest or material indirect financial interest" in the plan or plan sponsor "during the period covered by the financial statements."

Under IB 2022 01, an accountant may accept a new audit engagement despite

holding publicly traded securities of a plan sponsor during the period covered by the financial statements, provided the accountant, firm, partners, shareholder-employees, professional employees of the firm, and their immediate families, have disposed of any holdings of such publicly traded securities before the period of professional engagement. The "period of professional engagement" begins when an accountant signs an initial engagement letter (or other agreement) or begins to perform any audit, review or attest procedures, whichever is earlier.

This exception provides accountants with a "divestiture window" between the time when there is an oral agreement or understanding that the accountant will perform the plan audit and when the audit begins.

- Definition of "Office" for Purpose of Determining Who Is a "Member" of the Firm. Under the 1975 IB, the term "member" is defined as "all partners or shareholder-employees in the firm and all professional employees participating in the audit or located in an office of the firm participating in a significant portion of the audit." IB 2022 01 updates the definition of "member" by adding a definition of "office" for purposes of determining when an individual is "located in an office" of a firm participating in a significant portion of the audit.

In the DOL's view, substance should govern the office classification, and expected personnel interactions and an individual's assigned reporting channels might be more important than their physical location. Accordingly, IB 2022 01 defines the term "office" as a "reasonably distinct subgroup within a firm, whether constituted by formal organization or informal practice, in which personnel who make up the subgroup generally serve the same group of clients or work on the same categories of matters regardless of the physical location of the individual."

Seventh Circuit holds that Alight Solutions LLC Must Comply with DOL Subpoena in Cybersecurity Investigation

The U.S. Court of Appeals for the Seventh Circuit recently affirmed a district court's decision in *Walsh v. Alight Solutions LLC*, enforcing an administrative subpoena issued by the DOL. As part of an investigation into alleged cybersecurity breaches, the DOL issued a subpoena to Alight Solutions LLC (Alight), a recordkeeper and administrative service provider for employee benefit plans. The DOL began investigating Alight upon discovering that Alight processed unauthorized distributions of plan benefits due to cybersecurity breaches in its ERISA plan clients' accounts. According to the DOL, Alight failed to report, disclose

and restore those unauthorized distributions.

The DOL subpoena sought documents related to a cybersecurity breach that potentially resulted in ERISA violations. Alight produced some documents but objected to many of the subpoena's requests. The district court granted the DOL's petition to enforce the subpoena with some modifications.

On appeal, Alight argued that the subpoena is unenforceable because the DOL lacks authority to investigate non fiduciaries, the subpoena's demands are too indefinite and unduly burdensome, and that the district court abused its discretion by denying Alight's request for a protective order to limit production of certain sensitive information.

The Court found that Alight's fiduciary status does not affect the DOL's investigatory authority under the statute. ERISA authorizes the DOL to investigate whether *any person* has violated a provision of the statute or its regulations.

Additionally, the Seventh Circuit disagreed that the subpoena was too indefinite, noting that Alight has not argued that the subpoena is unclear. The Court was also unpersuaded by Alight's argument that complying with the subpoena would require thousands of hours of work. According to the Court, Alight did not detail why compliance was unduly burdensome or demonstrate that responding would "threaten the normal operation of its business." The Court further noted that case law supports the notion that large production requests are not necessarily unduly burdensome.

Finally, the Court found that the district court did not err in denying Alight's request for a protective order to shield from disclosure certain confidential information that it is contractually obligated to protect. Although this information is sensitive, the Court found that Alight failed to demonstrate how its disclosure to the DOL would result in the information being revealed to a third party.

UPCOMING COMPLIANCE DEADLINES AND REMINDERS

General Benefits

Form 5500 Filing Deadline for Calendar Year Plans With Extensions. Plan administrators generally have seven months after the end of a plan year to file a Form 5500, including applicable schedules and attachments. For plan years ending December 31, 2021, the Form 5500 filing deadline was July 31, 2022. However, for plans that obtained an extension, the Form 5500 must be filed by October 17, 2022 (typically, the extension deadline is October 15; however,

because this deadline falls on a Saturday, the Form 5500 may be filed on the next business day).

Summary Annual Report Deadline for Calendar Year Plans. Plan administrators whose plans must provide summary annual reports generally must distribute them within nine months after the plan's year-end (*e.g.*, for plan years that ended December 31, 2021, the deadline is September 30, 2022). However, if a plan has received an extension for filing its Form 5500, the nine month deadline is extended by two months.

Retirement Plans

Annual Funding Notice. Calendar year-defined benefit plans with 100 or fewer participants generally must provide an annual funding notice to required recipients by the earlier of the Form 5500 due date or the date of the Form 5500 filing, including extensions.

Health and Welfare Plans

Medicare Notice of Creditable Coverage. Plans that provide prescription drug coverage to Medicare Part D eligible individuals must notify these individuals whether the drug coverage they have is creditable or non creditable by October 14, 2022. The Centers for Medicare and Medicaid Services (CMS) has developed model disclosure notices.