Compliance Monthly Update: August 2023

A brief update on what happened the prior month in group health plan compliance at the federal level, organized chronologically. If you would like additional information, please reach out to the GBS Compliance Team.

Surprise billing IDR process (continuing) litigation and portal shutdowns. There were two new court rulings this month that struck down HHS guidance related to the No Surprises Act's independent dispute resolution (IDR) process. As a reminder, the No Surprises Act expanded patient protections to shield individuals from surprise medical bills for certain out-of-network emergency and non-emergency services and provides an IDR process to resolve payment disputes between health plans and providers.

- Following on prior court ruling that had vacated portions of HHS rules on the IDR process, on August 3, a federal court ruled that HHS violated the Administrative Procedure Act (APA) when it issued IDR process guidance that increased the IDR fee from $50 to $350 per disputing party and provided a batching rule that made it difficult to "batch" related claims for resolution in a single proceeding. The court ruled that HHS had improperly bypassed the APA's notice-and-comment requirement when it issued the fee and batching guidance. In response to the ruling, HHS announced the temporary suspension of the federal IDR process (including the ability to initiate new disputes) pending further instructions.
- On August 11, HHS issued FAQ guidance addressing the August 3 court ruling and in part announced a reversion back to the $50 IDR process fee until the agencies take action to set a new administrative fee amount.
- On August 24, the same federal court vacated additional portions of regulations implementing the surprise billing IDR rules regarding how to calculate the qualifying payment amount (QPA) when resolving disputes. The QPA generally is the median of the plan's contracted rates with participating providers for the item or service in the geographic region. The court vacated provisions that: allowed the inclusion of "ghost rates" (rates for services that a particular provider has not provided) and rates for providers outside the applicable specialty; excluded bonus or other incentive payments from the rate calculation; and allowed self-insured plan calculations to be based on the rates of other self-insured plans administered by the same TPA.
- In response to the August 24 decision, all federal IDR process operations have (again) been temporarily suspended in order to make changes necessary to comply with the court's opinion and order. The agencies indicate that disputing parties should continue to engage in open negotiation.
- This litigation seems unlikely to be resolved any time soon. There has been a growing backlog of IDR cases due to the continued litigation and the unexpectedly high number of filed disputes. The regulatory agencies previously advised they were considering improvements to speed up IDR determinations and payments. But, the continued litigation and the suspension(s) of the IDR process will exacerbate the growing backlog.

Updated model CHIP Notice released. The DOL has released a new model employer CHIP Notice (available HERE) with information current as of July 31, 2023. As a reminder, group health plans that maintain a plan with participants who reside in a state that provides premium assistance under Medicaid or CHIP have an annual notice requirement to notify employees of the potential opportunities for premium assistance. The model CHIP notice is updated periodically to reflect changes in the states that offer premium assistance and changes to the relevant state contact information.

DOL releases a publication for employees to help understand mental health benefits. The DOL released a publication titled "Understanding Your Mental Health and Substance Use Disorder Benefits" that is designed to help employees with the following (related to Mental Health Parity rules): (1) figure out whether your health plan must provide parity and follow these rules, (2) explains the protections the law provides, (3) highlights 'red flags' to look out for, (4) tells you how to learn about your mental health and substance use disorder benefits, and (5) walks you through what to do if coverage of your mental health and substance use disorder benefits has been denied. Following on the Mental Health Parity proposed rules and report to Congress that was released and discussed in last month's compliance update, this employee publication further demonstrates the regulatory agencies' enforcement focus and prioritization of the Mental Health Parity rules.

2024 ACA affordability percentage decreases significantly to 8.39%. The IRS announced ACA affordability percentage indexing adjustments for plan years beginning in 2024. The affordability percentage for 2024 is 8.39% (dropping significantly from 9.12% for 2023). This is by far the lowest affordability percentage since the ACA employer mandate took effect in 2015. As a reminder, the failure to offer affordable, minimum value coverage to full-time employees may result in employer shared responsibility penalties. So, the adjustments to the affordability percentage will be of interest to applicable large employers (ALEs) in setting their 2024 plan year employer contribution rates.

Tenth Circuit Court rules in favor of ERISA preemption of state PBM law. The Tenth Circuit issued a ruling that ERISA preempts provisions of an Oklahoma law regulating pharmacy benefit managers (PBMs). The state law was intended to curtail the power of PBMs and support independent pharmacies by imposing network restrictions that establish geographic parameters for PBM networks; prohibit PBMs from promoting in-network pharmacies by offering cost-sharing discounts; and require that every pharmacy willing to accept the PBM's terms be allowed into its preferred network. In addition, the law prevented PBMs from terminating a pharmacy's contract because one of its pharmacists is on probation with the state pharmacy board.

- As background, ERISA's broad preemption language has historically prevented states from regulating ERISA-covered plans if the state law included an impermissible reference to or had an impermissible connection with the ERISA-covered plan. An impermissible connection with a plan can arise when the state law dictates the benefit design of the plan, upsets nationally uniform plan administration, or imposes parallel or additional requirements on central matters of plan administration governed by ERISA.
- This court ruled that—in contrast with state PBM laws that have been held not preempted because they merely increase costs or altered incentives for ERISA plans without forcing them to adopt any particular coverage—here, the network restrictions governed central matters of plan administration and thus had an impermissible connection with ERISA plans. Also, the probation provision effectively dictated which pharmacies must be included in a plan's PBM network since PBMs could not oppose those employing pharmacists on probation. Therefore, the court held that the network restrictions and the probation provision were preempted as applied to ERISA plans.
- There will likely be continued state attempts to mandate benefit plan structure through PBM legislation, and therefore litigation will continue surrounding those attempts and the complicated ERISA preemption legal framework.