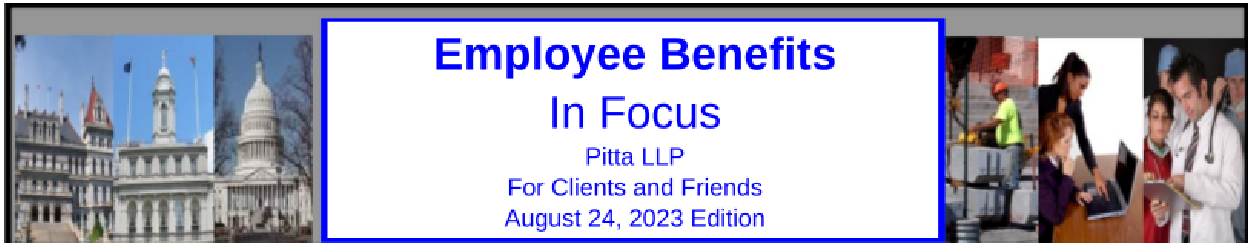

FEDERAL IDR PROCESS: FRIEND OR FOE?

Certain parts of the Independent Dispute Resolution ("IDR") process, an arbitration process designed to resolve payment disputes between payors and providers created under the No Surprises Act (the "Act"), has been called into question in a recent Texas federal district court case. In this case, Plaintiffs, Texas Medical Association, et. al., are medical providers who brought suit against the Departments of Health and Human Services, Labor and the Treasury (the "Departments") challenging a September 2021 interim final rule (the "September 2021 Rule") implementing the IDR process. Plaintiffs alleged that the Departments (1) by dramatically increasing the fee to participate in the arbitration process via a published Fee Guidance, precluded smaller providers from being able to participate and (2) restricted batching of claims in a way so as to preclude resolution of several claims in a single arbitration. Further, Plaintiffs alleged that in issuing the September 2021 Rule and the Fee Guidance, the Departments violated the notice and comment requirements mandated by the Administrative Procedure Act (the "APA").

The Act, which Congress enacted in 2020 primarily to address "surprise medical bills," directed the Departments to issue regulations both establishing the arbitration process and governing the arbitration proceedings. Accordingly, the Departments issued the September 2021 Rule, establishing that each party to an arbitration proceeding must pay an administrative fee at the time IDR is selected. In December 2022, the Departments issued a Fee Guidance, under which the initial fee established applicable to 2021 was $50. For 2022, the fee remained at $50. However, in late 2022, "citing surge in the volume of disputes and burgeoning costs associated with conducting dispute eligibility," the Departments increased the fee to $350 for 2023. See *Texas Medical Association et al v. United States Department of Health and Human Services et al*, Docket No. 6:23-cv-00059 (E.D. Tex. Jan 30, 2023), Court Docket.

Citing Supreme Court precedent, the Court held that the Fee Guidance was substantive guidance as opposed to interpretative guidance, thus requiring a notice and comment period under the APA, and therefore the Fee Guidance was vacated. The Court explained that the Fee Guidance was not interpretative guidance because it does not merely provide the Departments' construction of the Act or linguistic clarity to imprecise terms as required under the APA. The Court concluded that in fact, the Departments did not derive the $350 fee from vague statutory text, nor was the Fee Guidance interpretative. Rather, both the Act and the September 2021 Rule were clear and required that the amount of an administrative fee be established by the Departments to cover their projected expenses. However, in setting the fee at $350, the Departments applied their cost methodology to "would-be participants," impermissibly "binding" them to a $350 fee to participate in the IDR process. Id.

With respect to Plaintiffs' second claim, under the September 2021 Rule, items and services were permitted to be batched—or to be considered together in a single IDR—if they satisfied the following four (4) requirements set forth in the Act and later expanded in the September 2021 Rule: (i) items/services were furnished by the same provider or facility; (ii) payment for such items/services was made by the same group health plan or insurer; (iii) items/services were related to the treatment of a similar condition and (iv) items/services were furnished within a 30-day period or an alternative period to be used in limited situations "as determined by the Secretary." See 42 U.S.C. §§ 300gg-111(c)(3)(A).

Plaintiffs challenged only one of the four requirements, as expanded by the September 2021 Rule, which would be met if items/services were "billed under the same service code, or a comparable code under a different procedural code system," Docket Case 6:23-cv-00059-JDK. Citing prior precedent, the Court held that the September 2021 Rule on batching is not a rule of agency procedure, as it governs providers and insurers and sets forth the requirements for submitting payment disputes to IDR which are adjudicated by third-party arbitrators. Further analyzing the challenged portion of the batching rule requirements, the Court held that the batching rule was not an internal housekeeping measure but one that governs private parties outside the context of the agency proceeding. The Court averred that by allowing batching only if items or services share the "same service code," the September 2021 Rule severely limited which claims providers and insurers could batch. *Id.* Finally, the Court held that because the September 2021 Rule on batching was not "procedural," but rather substantive guidance, the Departments were not exempted from the APA's notice-and-comment requirement.

Based on the foregoing, the Court issued a vacatur of the provisions set forth in the September 2021 Rule and Fee Guidance.

IRS GRANTS FURTHER RELIEF IN CONNECTION WITH REQUIRED MINIMUM DISTRIBUTIONS

On July 14, 2023, the Internal Revenue Service ("IRS") issued Notice 2023-54 (the "July Notice"), granting certain relief with respect to (1) distributions made between January 1 and July 31, 2023 to those attaining age 72 in 2023 and (2) those who inherited an account after 2019 from an individual who was receiving required minimum distributions ("RMDs") and would have been required to take a distribution in 2023. RMDs are minimum amounts that retirement plan account owners who reach age 72 (73 if they reach age 72 after December 31, 2022) generally must withdraw annually.

Under SECURE 2.0 Act of 2022, required beginning dates for mandatory distributions were increased to age 73 effective January 1, 2023, and to age 75 effective January 1, 2033. However, individuals attaining age 72 in 2023 may have taken an RMD early in 2023 before learning that they had the opportunity to further delay such distribution. In what appears to be an effort to even out the playing field, the IRS is now giving these individuals the opportunity to treat these distributions as rollovers by

extending the rollover deadline. Accordingly, individuals who attained or will attain age 72 in 2023 and who took a distribution between January 1, 2023 and July 31, 2023 will now have until September 30 to roll over such distribution if they so choose. Further, a payor or plan administrator is relieved from a failure to treat certain distributions as eligible rollover distributions if the distribution was made between January 1, 2023 and July 31, 2023.

The July Notice also provides that any individual who inherited an account after 2019 from an individual who was receiving an RMD and who failed to take a distribution in 2023 would not be penalized for failing to take such distribution. These distributions therefore are not required for 2023 but may be taken voluntarily if individuals so choose.

UTAH DISTRICT COURT REJECTS MENTAL HEALTH PARITY CLAIM FOR PLAN'S DENIAL OF COVERAGE FOR WILDERNESS THERAPY

Recently a United States District Court in Utah rejected a participant's claim that his group health plan impermissibly excluded "wilderness therapy" from coverage in violation of the Mental Health Parity and Addiction Equity Act ("MHPAEA"). The Plaintiff, an employee of DLA Piper, filed the Complaint individually and on behalf of his teenage daughter, asserting the three (3) following causes of action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"): (1) Recovery of Benefits, (2) Violation of the MHPAEA and (3) Request for Statutory Penalties. United States District Judge Dale A. Kimball granted third-party claims administrator Anthem Blue Cross Life and Health Insurance Company's ("Anthem") Partial Motion to Dismiss and DLA Piper LLP and the DLA Piper Welfare Benefit Plan's (the "Plan") Motion to Dismiss the Second and Third Causes of Action for failure to state a claim upon which relief may be granted (the first cause of action, for recovery of benefits, was not at issue in these motions). The case is *L.L. v. Anthem Blue Cross Life & Health Ins.*, No. 2:22CV208-DAK, 2023 WL 2480053 (D. Utah Mar. 13, 2023).

In the summer of 2019, Plaintiff's daughter was admitted to Wingate Wilderness Therapy, a licensed treatment facility in Kenab, Utah, to address problems with depression, anxiety, self-harm, suicidal thoughts, anger, drug abuse, and performance in school. *Id.* Anthem denied coverage for the treatment, which it deemed "investigational and not medically necessary," averring that there was no proof that wilderness therapy "improves health outcomes." *Id.* The Plaintiff followed the appeals process and exhausted his administrative remedies with the Plan, which included an evaluation from an external review agency. This lawsuit followed.

Under MHPAEA, plans may not place limitations on mental health and substance abuse disorder benefits that are more restrictive than limitations placed on medical and surgical benefits. *Id.* at *2. In this case, Plaintiff argued that Anthem impermissibly excluded wilderness therapy as a mental health benefit while allowing analogous medical and surgical benefits. However, to succeed on an MHPAEA violation claim, a plaintiff must plead facts demonstrating how a plan considers medical and surgical

treatment claims differently than mental health treatment claims. Conclusory statements that there is a disparity are insufficient. Here, the Defendants argued that the Plan's policy on wilderness therapy applied not only to mental and behavioral health treatments but to treatments for all diagnoses, including medical conditions. The Court agreed that the Plan's language, which explicitly applied wilderness therapy exclusions to all types of treatment, contradicted the allegation of an MHPAEA violation. Plaintiff also argued that the wilderness therapy program was not "investigational." But this assertion – that the Plan made an incorrect benefits determination – likewise did not help Plaintiff to plausibly allege an MHPAEA violation because this claim did not analogize comparable medical or surgical benefits.

Plaintiff's Third Cause of Action, seeking statutory penalties against Anthem under 29 U.S.C. § 1132(c) for its alleged failure to produce requested Plan documents, was also dismissed. ERISA requires plan administrators to produce plan documents within thirty (30) days of a participant's written request. 29 U.S.C. § 1024(b)(4). Courts may impose penalties on plan administrators who fail to provide copies of these requested documents. Here, critically, Plaintiff requested the documents from Anthem, the claims administrator, rather than from DLA Piper, the plan administrator. Because Plaintiff did not allege that he ever requested documents from DLA Piper, nor allege any facts suggesting an agency relationship between the two entities, the Third Cause of Action for statutory penalties was also dismissed.

A FEW REMINDERS

(Based on calendar-year plans)

These reminders are for informational purposes only and are not intended to replace your regular compliance calendar as they do not include all deadlines that may be applicable to your plan.

AUGUST

DEFINED CONTRIBUTION PLANS

- **Second Quarter Pension Benefit Statements**
  - August 14, 2023 is the deadline by which benefit statements for the quarter ending June 30, 2023 must be sent to participants and beneficiaries.

SEPTEMBER

HEALTH AND WELFARE PLANS

- **Summary Annual Report ("SAR")**

- September 30, 2023 is the deadline by which health and welfare plans must distribute the SAR to all plan participants.

DEFINED BENEFIT PLANS

- **Actuary Certification**
  - September 30, 2023 is the last day by which the actuary must certify the 2023 AFTAP to avoid October 1, 2023 presumption that the 2023 AFTAP is less than 60%.
- **SAR**
  - September 30, 2023 is the deadline by which the SAR must be distributed to all plan participants unless the defined benefit plan is covered by the Pension Benefit Guaranty Corporation's ("PBGC") termination insurance program; PBGC-covered DB plans are required to furnish their participants with an annual funding notice instead.

DEFINED CONTRIBUTION PLANS

- **SAR**
  - September 30, 2023 is the deadline by which the SAR must be distributed to all plan participants.