THE WAGNER LAW GROUP

December 30, 2022

Federal Agencies Issue Group Health Plan Guidance

On December 23, 2022, new guidance applicable to group health plans was issued by federal agencies, as described more fully below. The Center for Medicare and Medicaid Services issued updated fee guidance in connection with the Federal Independent Dispute Resolution process (the "Federal IDR Process") under the No Surprises Act rules for arbitrating disputes as to the fees a plan must pay providers who cannot balance bill the plan's participants. Likewise, the Departments of Treasury, Labor, and Health and Human Services (the "Departments") issued guidance with respect to required reporting on prescription drug and health care spending.

I. No Surprises Act Fee Guidance

The No Surprises Act directs the Departments to establish the Federal IDR Process, which must be followed by nonparticipating facilities, nonparticipating providers, nonparticipating air ambulance services, group health plans, and health insurance carriers to resolve disputes that cannot be successfully negotiated. It is used following the end of an open negotiation period to determine the out-of-network rate for out-of-network emergency services, certain items and services provided by nonparticipating providers at in-network facilities, and the payment for qualified services provided by nonparticipating providers of air ambulance services, when a specified state law or All-Payer Model Agreement does not apply and there is no agreement between the plan/insurer and the provider as to the appropriate payment to be made.

One part of that process is that each party must pay a nonrefundable administrative fee for participating in the Federal IDR Process. The administrative fee is established annually in a manner so that the total administrative fees collected for a year are estimated to

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be equal to the amount of expenditures estimated to be made by the Departments to carry out the Federal IDR Process for that year. On October 31, 2022, the Departments announced that the 2022 administrative fee of $50 would be continued in 2023. On December 23, 2022, however, the Departments amended the October 31, 2022 fee guidance for 2023 to increase the administrative fee from $50 to $350, "due to supplemental data analysis and increasing expenditures in carrying out the Federal IDR Process since the issuance of the 2023 guidance." The Departments indicated that during the first several months of the Federal IDR Process, data system challenges prevented the Departments from being able to aggregate reliably certain data points that could be used to calculate the administrative fee. Also, the Departments substantially underestimated the demand for use of the Federal IDR Process. Over 164,000 disputes were initiated between the opening of the Federal IDR portal and December 5, 2022, a case load nearly 10 times greater than the Departments' initial estimation. Further, noninitiating parties challenged the eligibility of over 68,000 disputes for the Federal IDR Process The process of determining whether a dispute is eligible for the Federal IDR Process has been a more significant burden than the Departments and certified IDR entities had anticipated. To address this backlog, the Departments engaged government staff and contractor resources to conduct preeligibility reviews.

II. Reporting on Prescription Drug and Health Care Spending

Section 204 of Title II of Division BB ("Section 204") of the Consolidated Appropriations Act, 2021 required group health plans and health insurance issuers to report to the Departments a variety of very detailed information related to prescription drugs and other health care expenditures. The data required to be submitted under Section 204 falls into two categories: information that cannot be aggregated, such as general plan and reporting entity identifying information at the beginning and end of a plan year; and information that can be aggregated across plans, such as those in the same state and the same market. The data is reported on the RxDC module in the Health Insurance Oversight System, a federal system of records established by the Center for Consumer Information and Insurance Oversight division of the Department of Health & Human Services. In November 2021, the Departments issued interim final rules to implement these provisions. Those interim final rules also indicated that the Departments would not initiate enforcement action against a plan or issuer that did not report the required information by the first statutory deadline for reporting (December 27, 2021), or the second statutory deadline for reporting (June 1, 2022), and that instead submitted

information for both the 2020 and 2021 reference years by December 27, 2022.

In FAQ Part 56 about the Affordable Care Act and the Consolidated Appropriations Act, the Departments have now provided additional enforcement relief. For the 2020 and 2021 data submissions that were due on December 27, 2022, the Departments will not take enforcement action with respect to any plan or issuer that uses a good faith, reasonable interpretation of the regulations and the Prescription Drug Data Collection Reporting Instructions, which provide specific instructions as to the manner in which the information required under Section 204 is to be reported.

The Departments also provided a submission grace period through January 31, 2023, and will not consider a plan or issuer out of compliance with these requirements provided that a good faith submission of 2020 and 2021 data is made on or before that date. To further facilitate the submission process, the Departments, at least for the 2020 and 2021 reference years, have provided a number of clarifications and flexibilities, including:

- allowing multiple submissions by the same reporting entity;
- allowing submissions by multiple reporting entities;
- allowing a reporting entity that is submitting required data, within each state and market segment, to aggregate the data at a less granular level than that used by the reporting entity that is submitting the total annual spending data;
- permitting the submission of plan list and plan year data by email rather than through the Health Insurance Oversight System portal; and
- making optional the reporting of:
    - vaccine national Drug Codes, and
    - amounts not applied to the plan's deductible or to the plan's out of pocket maximum.

Data for the 2023 reference year is currently scheduled to be due June 1, 2023.

III. What This Means for Your Health Plan

Group health plans have been inundated with new and complicated compliance requirements over the last couple of years. As detailed regulations and other guidance are issued implementing those requirements, significant increases in administrative costs and delays should be expected. Sponsors of group health plans should be aware of these changes to ensure the changes are being adequately communicated to affected parties and plan documents are being updated to reflect the

changes.

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