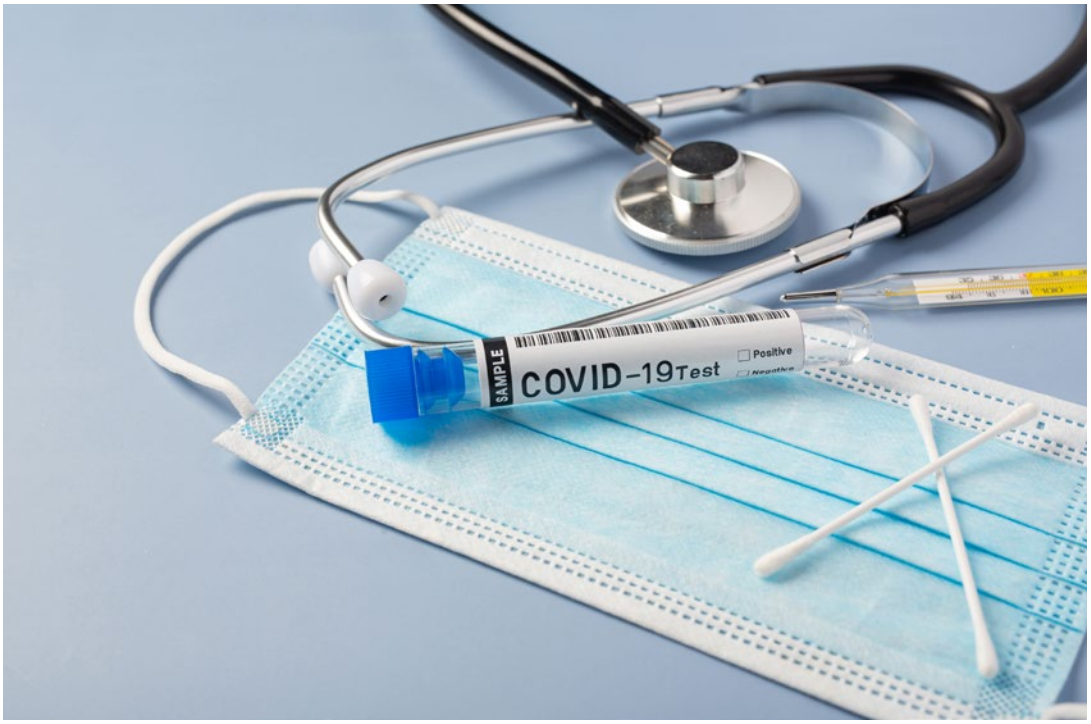


ONGOING LITIGATION OF INTEREST TO EMPLOYER GROUP HEALTH PLANS

Written By Corrie Cripps

With COVID-19 temporary coverage mandates, transparency in coverage rules, and implementation of the No Surprises Act (NSA) provisions, the first quarter of 2022 has been a busy one for group health plan sponsors and third party administrators (TPAs). As policy changes and compliance issues continue to evolve this year, there is also a wide variety of court cases to watch, as they will have implications for employer-sponsored health plans.

COVID-19 TESTING PAYMENT

The Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) require group health plans to cover the cost of COVID-19 diagnostic testing and related services, but the CARES Act doesn't specify a reimbursement amount for out-of-network providers. Instead, the law states these items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the plan will pay the cash price publicly posted on the provider's website, or such other amount as may be negotiated by the provider and plan.

As a result, there are lawsuits involving both payers and providers. For example, a Texas medical lab (Diagnostic Affiliates of Northeast Houston) is suing United Healthcare Services, Inc. in federal court alleging that the insurer failed to properly reimburse for COVID-19 testing services (*Diagnostic Affiliates of Northeast Houston v. United Healthcare Servs.*, No. 21-cv-0131 (N.D. TX Jan. 18, 2022)).

From a payer perspective, Premera Blue Cross is suing a COVID testing company (GS Labs), in Western Washington District Court, alleging that the lab attempted to exploit the pandemic through price gouging for its services (*Premera Blue Cross v. GS Labs*, No. 2:21-cv-01399 (W.D. WA filed Oct. 14, 2021)).

Plan sponsors should monitor these cases and review how payment is processed for out-of-network COVID test claims with their TPAs.

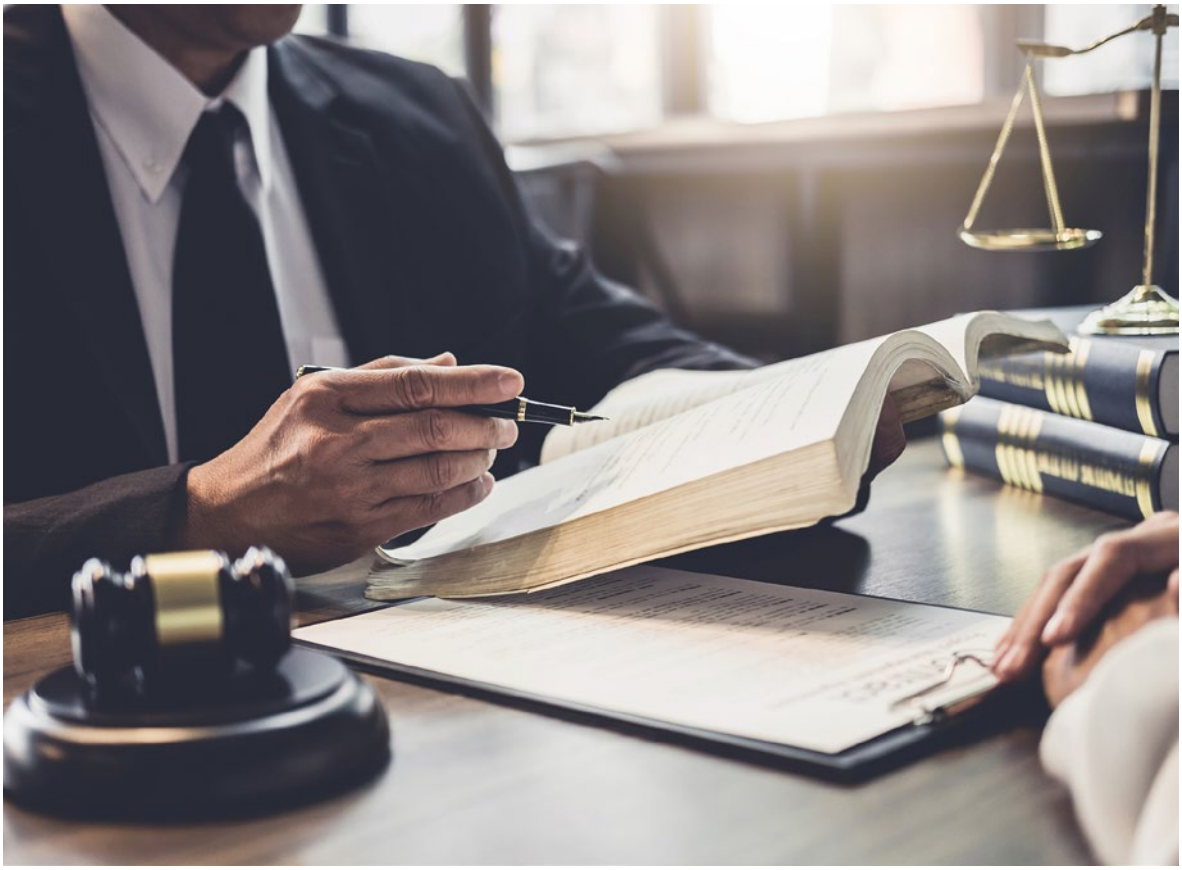
ACA'S PREVENTIVE CARE MANDATE

The Affordable Care Act's (ACA's) preventive care mandate (under Section 2713 of the Public Health Service Act) requires non-grandfathered group health plans to cover, without cost-sharing, in-network, certain preventive care services. These services are identified by the US Preventive Services Task Force, the Health Resources and Services Administration, and the Advisory Committee on Immunization Practices.

The entire preventive care mandate is being litigated in a case called *Kelley v. Becerra* (*Kelley v. Becerr*a, No. 20-cv-00283 (N.D. TX filed July 20, 2020)). The plaintiffs in Kelley argue that Section 2713 is unconstitutional and unenforceable because it violates the "nondelegation doctrine," the Appointments Clause, and the Vesting Clause. The plaintiffs are asking the court to declare that all preventive service mandates under Section 2713 are no longer required to be covered.

They further argue that some of the recommendations—to cover contraceptives and pre-exposure prophylaxis (PrEP) to prevent HIV—also violate the Religious Freedom Restoration Act (RFRA).

A decision is expected this year and could significantly impact the coverage of preventive services in group health plans.



ACA SECTION 1557

The US Department of Health & Human Services (HHS) is expected to issue a revised ACA Section 1557 rule this year, which will be the third version of this rule.[1] ACA Section 1557 is the law's nondiscrimination provision that prohibits health programs or facilities that receive federal funds from discriminating based on race, color, national origin, age, disability, or sex.

There are ongoing legal challenges to the two previous iterations of the rule (from the Obama administration and from the Trump administration). The district court orders for these cases will stay in place unless overturned.

A decision from the US Supreme Court is expected soon in *Cummings v. Premier Rehab Keller* (*Cummings v. Premier Rehab Keller,* No. 20-219 (US filed Aug. 21, 2021)). In this case, a physical therapy provider refused to provide Jane Cummings (who is deaf and legally blind) with an ASL interpreter to help treat her chronic back pain.

Cummings sued, alleging that the refusal is a form of disability discrimination, and is asking for damages for the emotional distress caused by her experience. The court is deciding whether damages for emotional distress can be awarded under Section 504 of the Rehabilitation Act of 1973 and Section 1557. This will be an important case to watch, as it involves discrimination claims brought under Section 1557 by individuals.

FEDERAL IDR PROCESS OF THE NSA

The No Surprises Act (NSA) of the Consolidated Appropriations Act, 2021 (CAA) contains extensive provisions intended to protect consumers from surprise medical bills for services provided by nonparticipating providers or facilities.

Many medical providers and facilities take issue with the presumption in the federal independent dispute resolution (IDR) interim final rule (IFR) that the qualifying payment amount (QPA) is the correct reimbursement amount for out-of-network services. Provider groups argue that the law lists many factors that an arbitrator may consider, such as the out-of-network provider's experience and training, and does not give presumptive weight to the QPA.

On February 23, 2022, a federal judge in Texas struck down a narrow piece of the NSA IFR dealing with the IDR process (***Texas Med. Ass'n v. HHS***, No. 21-0425 (E.D. Tex. Feb. 23, 2022)). The lawsuit was led by the Texas Medical Association (TMA), which argued that parts of the IDR rule are inconsistent with the NSA and should be invalidated. The judge agreed and vacated these provisions on a nationwide basis. An appeal is expected.

The TMA lawsuit is one of six NSA-related lawsuits filed by health care providers. Plan sponsors should monitor these provider lawsuits, since they could impact the amount health plans must pay out-of-network providers for protected services under the NSA.

The federal agencies have indicated they will issue a final IDR rule by May 2022.

MENTAL HEALTH PARITY

The CAA further enhanced federal mental health parity protections, with an emphasis on compliance regarding non-quantitative treatment limitations (NQTLs) on mental health and substance use disorder (MH/SUD) benefits.

As federal enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) for employer-sponsored health plans continues to increase, plans should be aware of several class action lawsuits related to plan coverage of MH/SUD benefits.

- In a class action lawsuit against UMR, Inc., the plaintiffs, who were denied coverage for residential treatment of mental health or substance abuse issues, ask for a declaratory judgment that clinical criteria used by UMR to deny coverage are overly restrictive and breach generally accepted medical care standards (***Berceanu v. UMR Inc.***, No. 3:19-cv-00568 (W.D. WI Dec. 15, 2021)). Further, they seek a determination that the administrator acted in an arbitrary and capricious manner by adopting these guidelines.
- In a class action lawsuit against United Behavioral Health (UBH), six plaintiffs allege UBH unlawfully denied coverage for medically necessary mental health and substance use disorder treatment (***Beach v. United Behavioral Health***, No. 3:21-cv-08612 (N.D. CA filed Nov. 4, 2021)). The lawsuit is challenging a UBH coverage policy that allegedly causes UBH to deny coverage for certain services merely because they are provided in a residential treatment setting, even though UBH accepts that the services themselves are medically necessary.
- The complaint filed in ***Deighton v. Aetna Life Insurance*** by a proposed class of health plan participants allege that Aetna applies disparate limits to residential mental health/substance abuse facilities and rehabilitation amenities, in violation of MHPAEA. (***Deighton v. Aetna Life Ins. Co.***, No. 2:21-cv-07558 (C.D. CA filed Sept. 21, 2021)).

The Department of Labor's (DOL's) published enforcement reports suggest that the DOL is continuing to investigate compliance with MHPAEA. To ensure compliance, self-insured health plans should consider conducting periodic claims audits and reviews, and can use the DOL's self-compliance tools to assist with this.[2]

DIALYSIS BENEFITS

Marietta Memorial Hospital Employee Health Benefit Plan v. DaVita, Inc. is a case scheduled for argument before the Supreme Court of the United States on March 1, 2022 (Marietta Mem'l Hosp. Emp. Health Benefit Plan v. DaVita, Inc. (No. 20-1641 (US filed May 21, 2021)).

The case concerns the Medicare Secondary Payer Act (MSPA), which prohibits group health plans from considering a plan participant's eligibility when the individual has end-stage renal disease (ESRD) and from providing different benefits to these individuals than from other covered participants. The case also involves how much plans must reimburse their members for dialysis treatment costs.

The outcome of this case could have a significant impact on dialysis benefits in employer-sponsored group health plans.

CONCLUSION

For plans and TPAs, being well-informed on regulatory developments is always of the upmost importance. Due to rapid changes in the regulatory landscape, plan sponsors should review their plan documents as well as their plan administration procedures to ensure they are compliant. ■

Corrie Cripps is a plan drafter/compliance consultant with The Phia Group. She specializes in plan document drafting and review, as well as a myriad of compliance matters, notably including those related to the Affordable Care Act.

References

1 Department of Health and Human Services, Statement of Regulatory Priorities for Fiscal Year 2022, October 2021, https://www.reginfo.gov/public/jsp/eAgenda/StaticContent/202110/Statement_0900_HHS.pdf, (last visited February 28, 2022).

2 Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA), October 23, 2020, https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf, (last visited February 28, 2022).