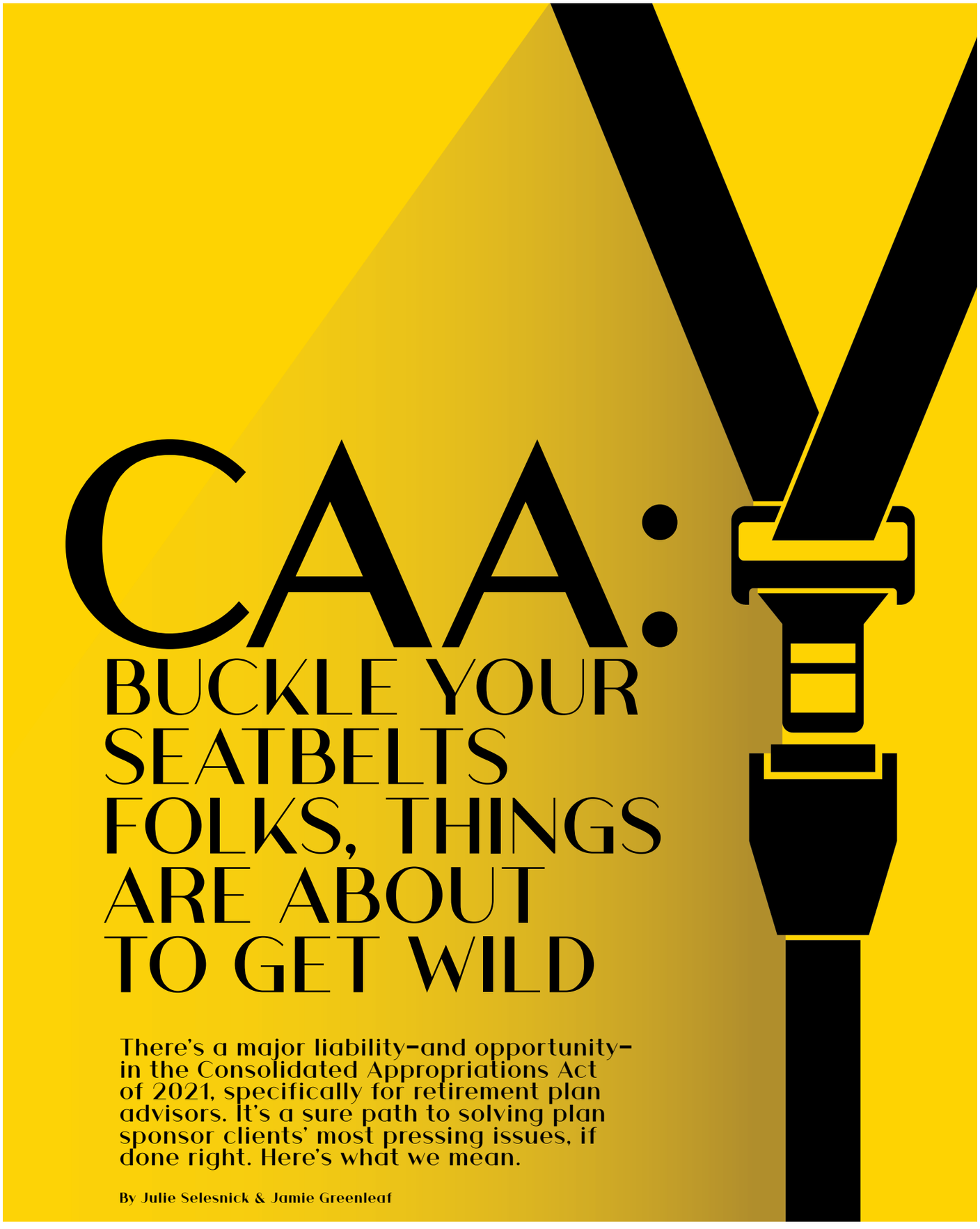

CAA: BUCKLE YOUR SEATBELTS FOLKS, THINGS ARE ABOUT TO GET WILD

There's a major liability–and opportunity–in the Consolidated Appropriations Act of 2021, specifically for retirement plan advisors. It's a sure path to solving plan sponsor clients' most pressing issues, if done right. Here's what we mean.

By Julie Selesnick & Jamie Greenleaf

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THE CONSOLIDATED APPROPRIATIONS ACT OF 2021 (CAA) IS THE MOST SIGNIFICANT COMPLIANCE CHALLENGE EMPLOYERS HAVE ENCOUNTERED SINCE THE 2009 ENACTION OF THE AFFORDABLE CARE ACT, A.K.A, OBAMACARE. YET BARELY ANY EMPLOYERS ARE TALKING ABOUT IT OR RECEIVING GOOD ADVICE FROM THOSE ADVISING THEM ON HEALTH PLAN COMPLIANCE.

Transparency and a fiduciary process are here for health care plans. Employers are fiduciaries under ERISA, which means they are required to act prudently and "solely in the interest of participants and their beneficiaries." The opportunity (and obligation) to apply a fiduciary process to your health care plan can have a significant impact on improved costs and benefits.

This has always been required of ERISA-covered health plan fiduciaries. Still, until the passage of the CAA, the Department of Labor ("DOL"), which regulates ERISA-covered benefit plans, has focused its enforcement efforts almost exclusively on retirement benefit plans. Two critical provisions employers need to focus on right now are the removal of gag clauses in all contracts related to provider access and obtaining compensation disclosures from all covered service providers.[1]

The CAA amends the Employee Retirement Income Security Act of 1974 (ERISA), the federal law that sets minimum standards for voluntarily established employee benefit plans to protect plan participants and their beneficiaries and allows certain benefits, including health benefits, to be treated as tax-free compensation.

The CAA clarifies the fiduciary obligations of employers and other benefit plan fiduciaries under ERISA, including accountability for the reasonableness of plan costs. This should be very familiar to employers who sponsor ERISA-covered retirement programs and have dealt with 408(b)(2) for the better part of the last decade.

The 408(b)(2) disclosure regulations require covered service providers to disclose performance and compensation information that includes status as a fiduciary, fees collected, whether the fees are direct or indirect, and the services performed in exchange. Employers then must determine whether the fees are reasonable and free of conflicts of interest; if not, the contract or arrangement is a prohibited transaction that the employer must terminate. Under ERISA Section 502(i), a prohibited transaction can result in civil penalties of up to 5% of the amount involved.

Penalties can increase to 100% of the amount involved in the transaction if appropriate correction is not made within 90 days of a final order from the U.S. Department of Labor. It can also be deemed a breach of fiduciary duties which can result in litigation against an employer. Much like the practices in the retirement space, employers will need to benchmark or RFP their providers to ensure they have an unbiased way to determine reasonableness.

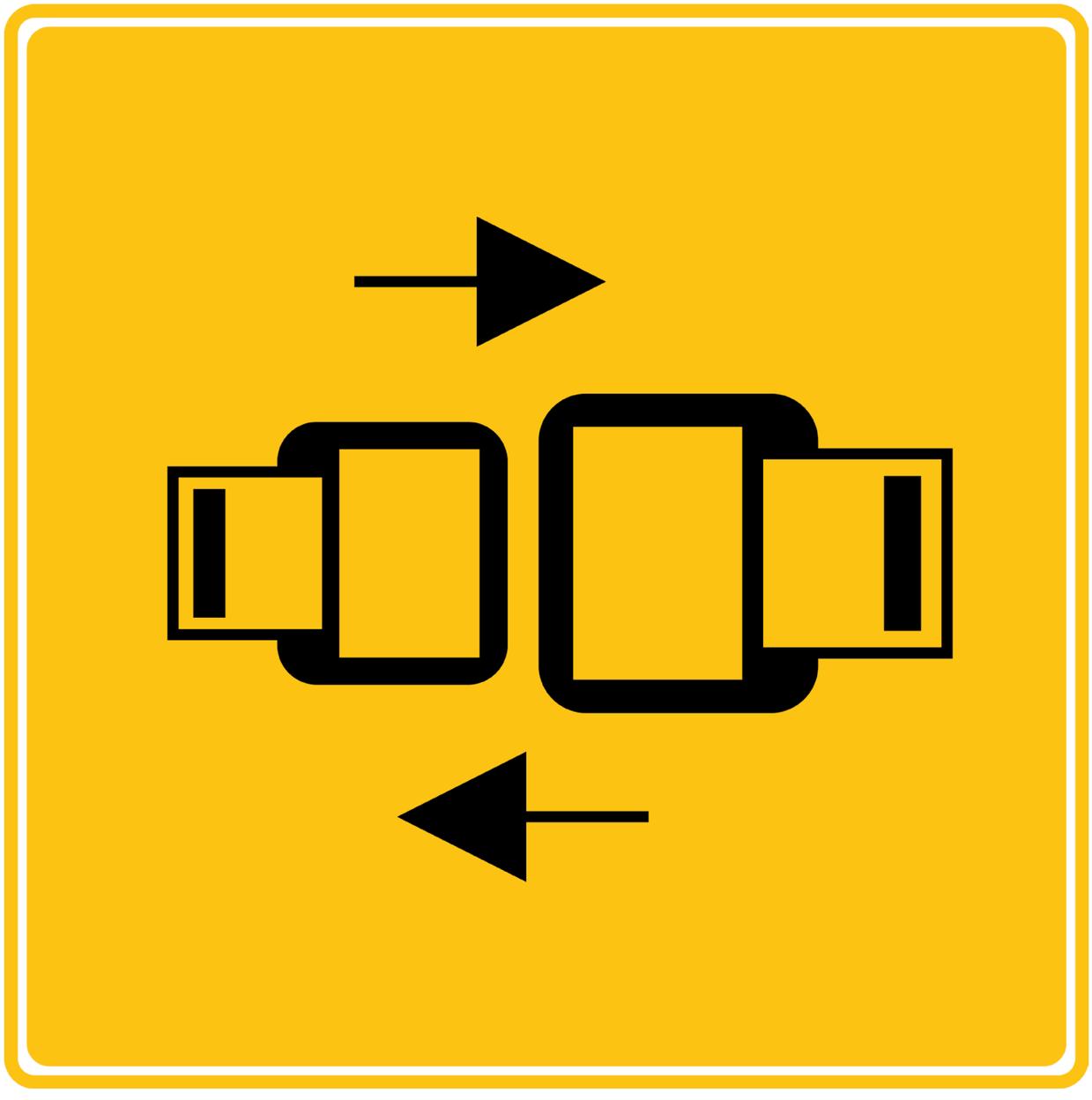
Because the terms in health care plans are so inaccessible and difficult to decipher, the CAA also adds a provision requiring gag clauses that prevent employers from accessing and sharing information related to cost or quality of claims under their health plan with relevant parties be removed from all contracts offering access to a provider or network of providers.

These gag clauses, currently ubiquitous in administrative service agreements, master service agreements, and network access agreements, prevent plan fiduciaries from obtaining information reflecting negotiated rates, gross charges, allowed amounts, and other data critical to understanding costs of care and are a major focus of the transparency initiatives found in the CAA.

Compensation disclosures and removal of gag clauses are the two provisions most likely to cause significant changes in the short term to how plan fiduciaries operate health plans, and the two provisions most likely to lead to litigation against non-compliant service providers and employers. As such, each requirement deserves a closer look.

ERISA SECTION 408(b)(2) COMPENSATION DISCLOSURES

One area of recent lawsuits concerns "secret" compensation from plan service providers. The CAA requires both direct and indirect compensation to be disclosed to employers by all "covered service providers" who anticipate earning more than $1,000 for work relating to a plan in any plan year.



Although this provision is limited to plans covered by ERISA, all plans, including public sector plans, a.k.a. non-federal governmental health plans, have the right (and obligation) to understand the compensation plan vendors are receiving in connection with their plan and determine whether such amounts are reasonable and whether any conflicts of interest exist that would necessitate finding a different vendor.

This right is reflected in a lawsuit filed at the end of 2021 by the School Board of Osceola County, Florida, against Gallagher Benefit Services, Inc. ("Gallagher"), alleging that Gallagher breached its contract with Osceola County and was receiving "secret insurance commissions over the years totaling millions of dollars" from insurance carriers it recommended to the board. The case recently settled but has opened the eyes of plan sponsors to the issue of indirect compensation.

Many plan service providers have taken the ill-advised position that the disclosure requirements apply only to brokers and consultants, despite guidance from the DOL telling plans to interpret this broadly and look to the disclosure rules governing pensions for additional guidance (guidance which requires broad categories of service provider disclosures). A letter written on Dec. 14, 2022, by the House Committee on Education and Labor to the DOL, unequivocally states that Congress intended for the disclosure provisions in the CAA to apply to PBMs and TPAs and asks DOL to issue further guidance clarifying this.

Knowing who is getting paid and how much is critical for all plan sponsors; as the DOL states in Field Assistance Bulletin ("FAB") 2021-03, "the adequacy of the disclosure should be measured against a principal objective of the statutory provision—which is to provide the responsible plan fiduciary

with sufficient information about the compensation to be received by covered service providers to allow the fiduciary to evaluate the reasonableness of the compensation and the severity of any associated conflicts of interest."

GAG CLAUSE REMOVAL

A "gag clause" is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. Gag clauses in this context might be found in agreements between a plan and a health care provider; a network or association of providers; a third-party administrator ("TPA"); or another service provider offering access to a network of providers.

The CAA requires that all gag clauses be removed from these contracts so that plan fiduciaries and their business associates can access plan claims data including financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract; provider information, including name and clinical designation; service codes; and any other data element included in claim or encounter transactions.

Several lawsuits have now been filed against carriers by parties demanding access to their health plan's claims data, and on Feb. 23, 2023 the Department of Labor (DOL) issued further guidance on the removal of "gag" clauses, meant to ensure plans and vendors understand what types of contractual provisions are gag clauses and facilitate plan access to claims data, including instructions on where and how to file attestations and for reporting carrier non-compliance to its enforcement division.

PURPOSE OF THESE NEW RULES

Both of these requirements—the removal of gag clauses and provision of compensation disclosures—are aimed at helping plans overcome their current information deficit, which makes plan administrators unable to fulfill their duties, particularly under ERISA, where "[t]he duties of prudence and loyalty" 'govern' a responsible plan fiduciary's decisions to hire" plan service providers "and to ongoing monitoring of service provider arrangements."

The storm is here. Many employers and unions, sick of paying more each year in exchange for less, are determined to get healthcare costs under control.

EMPLOYER CALL-TO-ACTION

Regarding compensation disclosures: Gather and review your compensation disclosures and be prepared to attest that you have received them. Make sure any disclosure you receive is compliant, as thus far, many are not. Again, gathering the disclosures is just the first step—the reason you are collecting them is to review them and make two critical determinations—first, that the amounts paid in compensation are reasonable, and second, that the compensation does not create any untenable conflicts of interest.

Regarding gag clauses: review your service provider contracts governing access to a provider or network of providers and determine who is performing the attestations around the removal of gag clauses. Suggestion:

1. Do not let the service provider file an attestation on your plan's behalf if you are not sure it is the truth, as any liability for filing a false attestation remains with the plan, not the service provider.
2. If you are unsure what a gag clause is or cannot effectively negotiate access to your plan's data, seek outside help.
3. Remember—you are the responsible fiduciary, and the buck stops with you.

But removing the gag clauses is just the first step—they are removed so that plans will access their plan claims data and then act upon what they find.

This means that once the gag clauses are removed, plans should immediately seek access to their plan's claims data and, once obtained, have that data analyzed to determine if claims are paid in accordance with the governing contractual provisions, that overpayments aren't made and, if they are, they are properly recovered.

CONCLUSION

Looking ahead, plan sponsors will need to establish, adhere to, and document their prudent fiduciary process surrounding both of these requirements.

These new laws pose dramatic risks and increase exposure to enforcement action by a federal agency or private litigation by plan participants, as well as major opportunities for every group health plan in the U.S. to finally understand the costs involved and to cut inappropriate expenditures and vendors out of their plan.

All plans should be working with trusted service providers, consultants, and legal teams to use these and other new CAA reporting requirements to provide higher quality, more cost-effective healthcare to their employees and minimize the risks of regulatory oversight, enforcement actions, penalties, and litigation from federal agencies and private litigants. NNTM

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Footnotes

[1] This doesn't mean there aren't other new requirements that Employers also must pay attention to ASAP, such as the Mental Health Parity non-quantitative treatment limitations (NQTL) comparative analysis reporting and Rx data reporting, but those topics are not addressed here..

[2] Internal Revenue Code section 9824, ERISA section 724, and Public Health Service (PHS) Act section 2799A-9(a)(1).

[3] See, e.g., *Clancy v. UHC et al.* (Memorandum in Support of Motion for Partial Summary Judgment filed February 10, 2023, Order Noticing Settlement issued April 18, 2023); *Owens v. Minor, Inc. et al. v. Anthem Healthplans of Virginia, Inc.* (Complaint filed February 13, 2023); *Trustees of the Int'l Union of Bricklayers and Allied Craftworkers Local 1 et al. v. Elevance, Inc. et al.* (Complaint filed Dec. 5, 2022).

[4] https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/field-assistance-bulletins/2021-03 (in response to Q5).