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For Health Plan Sponsors—How to Use the CAA to Negotiate a Better Administrative Services Agreement

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Overview

- Everyone is swamped, trying to keep up with the new guidance issued under the Consolidated Appropriations Act, 2021 (CAA)
- Let's take a step back and look at how we can use the rules to assist us in drafting better agreements
- We can use the new rules to help:
  - Examine pricing provisions in an Administrative Services Agreement (ASA)
  - Understand if the right consultants are assisting with the RFP process
  - Understand ways to run a better Request for Proposal (RFP)
  - Be prepared for future litigation

Overview

- This is not meant to be a stressful webinar!
- We understand that many benefit practitioners are still in the process of digesting and understanding these rules—that is ok!
- It may be that you do not tackle many of these items until later this year, once you have a better understanding of the rules
- This webinar is meant to give you ideas about how to think about the rules—and not cause stress!

Agenda

- No Surprises Act
  - Key aspects of the rule to understand for pricing issues
  - Provisions to add to an ASA
- Prescription Drug & Health Care Reporting to the Agencies
  - Open issues with the current interim final regulations
  - Provisions to add to an ASA
- Transparency Reporting Rules (3 machine readable files)
  - Value of these rules to plan sponsors
  - Provisions to add to an ASA
- Disclosure Requirements for Brokers and Consultants
  - Understand if "reasonable compensation" is being paid and if there are conflicts
- Actions to Take

No Surprises Act in the CAA

- When the protections of this rule apply, the nonparticipating provider/facility is prohibited from balance billing plan participants
- Balance billing has been a concern of plan sponsors for years—especially when a participant was not able to choose the provider, such as for emergency services
- Due to this concern, plan sponsors implemented programs that had the third-party administrators (TPAs) for the plans negotiate bills with non-network providers
  - The TPA would negotiate a lower amount of the bill—usually less than the amount initially billed from the non-network provider, but more than what was owed to a network provider
  - The idea was that the plan could get the non-network provider to accept a certain amount as full payment, and the participant would not be balanced billed
  - The plan would be charged a large fee for this. It may be time to rethink these plan designs

No Surprises Act

- The regulations are generally applicable for plan years beginning on or after January 1, 2022
- The rules apply to protect against balance billing and out-of-network (OON) cost sharing for:
  - emergency services,
  - certain non-emergency services furnished by nonparticipating providers at participating facilities, and
  - air ambulance services furnished by nonparticipating providers of air ambulance services
- These rules do not apply to excepted benefits or retiree-only plans
  - The rules do apply to grandfathered plans
- The webinar will focus on the first 2 aspects of this rule
  - Air ambulance services are generally subject to similar rules with a few differences

No Surprises Act—Emergency Services

- If a plan provides benefits for "emergency services," the plan must cover the services subject to a number of conditions, as described in the slides
- This applies to emergency services both in an (1) emergency department of a hospital and (2) independent freestanding emergency department licensed separately from a hospital
- Emergency services include:
  - Initial Services—those to determine whether an **"emergency medical condition"** exists and pre-stabilization services; and
  - Post-Stabilization Services—additional services covered under the plan that are furnished by a nonparticipating provider or nonparticipating emergency facility after a participant is stabilized (unless the notice-and-consent rules apply)

No Surprises Act—Emergency Services

- An emergency medical condition is a medical condition manifesting itself through acute symptoms of sufficient severity that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the individual's health in serious jeopardy, impair bodily functions, or result in serious dysfunction of bodily organ or part
- Question:
  - How will this be administered? The regulations state that a plan must not use final diagnosis codes as the sole basis for limiting coverage required under the regulatory definition of an emergency medical condition
  - NOTE: using a prudent layperson standard provides more protection to the enrollee
  - A plan sponsor may want to obtain some reporting to show the number of claims denied and how it was determined that it was not an emergency medical condition

No Surprises Act—Emergency Services

- A plan that covers emergency services must cover out-of-network emergency services in line with the following requirements:
  - without prior authorization or restrictions that are greater than in-network
  - not impose any administrative limitation that is more restrictive than the limitations that apply to emergency services received from participating providers and participating emergency facilities
  - with applicable cost-sharing requirements, meaning:
    - in-network cost sharing, based on a "recognized amount"
    - the cost-sharing must be applied to the in-network deductible and out-of-pocket maximum (OOPM)
  - the out-of-network provider/facility cannot balance bill the participant

No Surprises Act—Non-Emergency Services

- If the plan covers services other than emergency services that are furnished to a participant by a non-participating provider, with respect to a visit at a participating health care facility, then the protections of the rules are triggered, including no balance billing
- The protections do not apply if the participant consented to the treatment after having received specific disclosure/notice within designated timeframes (notice-and-consent)
- The notice-and-consent exception does not apply to providers of ancillary services or services furnished as a result of an unforeseen, urgent medical need arising at the time the service is furnished
  - Ancillary services include—(a) services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; (b) services provided by assistant surgeons, hospitalists, and intensivists; (c) diagnostic services; and (d) services provided by a nonparticipating provider if there is no participating provider who can furnish such service at the facility

No Surprises Act—Non-Emergency Services

- In other words, a non-participating provider that performs non-emergency services at a participating facility may proceed with providing the services and balance billing if it: (1) provides qualifying written notice AND (2) receives qualifying consent from the participant
  - EXCEPT, with regard to providers of certain urgent services and providers of ancillary services, who cannot use the notice and consent rules—and hence, no balance billing is permitted

No Surprises Act—Non-Emergency Services

- For these protected non-emergency services, the plan must comply with applicable cost-sharing requirements, meaning:
  - in-network cost sharing, based on a "recognized amount"
  - the cost-sharing must be applied to the in-network deductible and out-of-pocket maximum (OOPM)
  - the out-of-network provider/facility cannot balance bill the participant

No Surprises Act

- The next slides discuss the "recognized amount" and the Independent Dispute Resolution Process, which is applicable to claims protected by the No Surprises Act (NSA)

No Surprises Act

- The participant's cost-sharing must be calculated as if the total amount charged for such service is equal to the "recognized amount."
- The recognized amount is:
  - (a) an amount determined by an applicable All-Payer Model Agreement (AMA);
  - (b) if no AMA, an amount determined by a specified state law; or
  - (c) if there is no AMA or specified state law, the lesser of:
    - (1) the amount billed by the provider or facility, or
    - (2) the "qualifying payment amount" which generally is the median of the plan's contracted rates with participating providers for a similar item or service in the geographic region

No Surprises Act

- Only three states have an AMA--Maryland, Vermont and Pennsylvania (for certain types of claims)
- State set amount (if there is one in the applicable state) will apply for insured plans
- For most self-funded plans, the "cost-sharing" amount will be the qualifying payment amount (QPA)
- The QPA generally is the median of the plan's contracted rates with participating providers for a similar item or service in the geographic region

No Surprises Act

- Within 30 calendar days after the plan receives a complete/clean claim from the nonparticipating provider, the plan must send the provider **an initial payment or notice of denial of payment**
  - The initial payment should not be an installment amount, but rather the amount that the plan intends to be payment in full
- The total plan payment that must be made is the amount by which the "out-of-network rate" for such services exceeds the participant's cost-sharing amount for such services

No Surprises Act

- The out-of-network rate is:
  - (a) an amount determined by an applicable All-Payer Model Agreement (AMA);
  - (b) if no AMA, an amount determined by a specified state law;
  - (c) if no AMA or specified state law, the payment amount agreed to by the parties; or
  - (d) if none of the above, the amount determined through the independent dispute resolution (IDR) process

No Surprises Act

- There is an open negotiation period where the provider and the TPA will try to come to an agreement on the amount of the bill
- If the parties cannot come to an agreement, the IDR process can be initiated
- If the IDR process is initiated with respect to a service, the service is considered a "qualified IDR service" and the deciding entity is the "certified IDR entity"
- The parties must each submit an offer for a payment amount for the qualified IDR service
- The certified IDR entity must begin with the **presumption** that the QPA is the appropriate out-of-network rate

No Surprises Act—the IDR Process

- The certified IDR entity must also consider certain additional information submitted by the parties, such as:
  - the level of training & experience of the provider;
  - the market share held by the nonparticipating provider or the plan in the geographic region in which the service was provided;
  - the acuity of the individual receiving service; and
  - demonstrations of good faith efforts made by the nonparticipating provider or the plan to enter into network agreements and, if applicable, contracted rates during the previous four plan years.
- The certified IDR entity cannot consider:
  - usual and customary charges;
  - the amount that would have been billed by the provider if the protections of the No Surprises Act did not apply; and
  - the reimbursement rate payable by a public payer (such as Medicare).

No Surprises Act—the IDR Process

- For the certified IDR entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the service is materially different from the QPA
- Otherwise, the certified IDR entity must select the offer closest to the QPA

No Surprises Act—Qualifying Payment Amount (QPA)

- In summary, the QPA is used for most self-funded plans when the item or service has the protections of the No Surprises Act:
  - The participant's cost-sharing must be calculated as if the total amount charged for such service is equal to the "recognized amount" (which is often the QPA)
  - The certified IDR entity must begin with the **presumption** that the QPA is the appropriate out-of-network rate to be paid for the non-network provider services
- QPA is a key term! We need to consider how to use it in negotiating the terms of an ASA

No Surprises Act—Qualifying Payment Amount (QPA)

- Wow!!! QPA!!!
- Essentially, the amount that should be paid for these out-of-network claims protected by the NSA is the QPA (or something close to it)
  - Remember—QPA is median of in-network rates
    - Basically, the non-network provider should be paid in-network rates
- We need to address this in the ASA
  - We don't want to the parties to be agreeing to amounts over the QPA

No Surprises Act—Qualifying Payment Amount (QPA)

- We should be able to get reporting on the QPA!!
- Plans must disclose, in writing, with the initial payment amount or notice of denial given to the provider, when the QPA is the recognized amount:
  - the QPA for each service; and
  - that the QPA applies for the recognized amount (and determined in compliance with the rules)
- Plans must also inform the provider that it can obtain additional information about the QPA, upon request

No Surprises Act—QPA

- The system has changed! These are regulations that assist plan sponsors in determining an appropriate fee for emergency claims and certain non-emergency claims
- Because the system has changed, we should think about how plan pricing provisions in ASAs should change
- We have already seen some large employers make changes to the pricing terms to reflect the changes in these rules
- Most of the plan sponsors we work with have added a CAA amendment to the TPA agreement that contains the basic requirements for 2022 compliance with the CAA—knowing that CAA amendment will need to be revised later in 2022 to reflect additional guidance and thinking on these rules
- Those same plan sponsors are spending time in 2022 to digest the rules and consider alternative pricing provisions

No Surprises Act—QPA

- The IDR Process and the QPA are the critical aspects of the CAA
- Those rules are meant to assist plan sponsors in lowering health care costs and protecting plans and their networks
- We have been given these tools!
- We need to understand the rules and help plan sponsors implement them in the way that the CAA intended
- We have not seen many consultants take steps yet to change the pricing models based on these rules—which is understandable, given that we all need time to digest the rules
  - But we need to make this a priority!
- An example is to remove or revise "savings" programs and have a flat reimbursement rate for out-of-network claims not protected by the CAA

Common Design for Out-of-Network Claims

- Many plans state that eligible expenses covered by the plan for Out-of-Network services is:
  - (1) XXX% of the Usual, Customary and Reasonable (UCR rate) or
  - (2) determined by applying the negotiated rates agreed to by the Non-Network Provider (NNP) and the TPA
- The "negotiated rate" is often defined as the rate the TPA (or one of its vendors) negotiate with an out-of-network provider after the service was provided
  - This may include a "third-party network discount" which is where the TPA has access to contracts and discounts that certain third parties have with an out-of-network provider (sometimes referred to as "shadow networks" or "discounted rates")
- Layered on top of this is a savings program

Savings Program

- For the savings program, the TPA will negotiate with the NNP for a reduction in the bill
- A percentage of the amount that it saves—the difference between the NNP bill and the reduced bill—is billed to the plan
- As an example, assume that the savings program is 30%. So, if the initial NNP bill is $10,000 and the bill is negotiated down to $5,000, then the plan is charged 30% of the $5,000 savings ($1,500)
  - The $1,500 is the fee paid to the TPA

Savings Program

- Is this the appropriate design anymore? Why pay the TPA to get the protected NSA claims to QPA?
- The concern is that the NNP sends the plan a giant bill
- The TPA offers QPA plus 20% and the NNP accepts it
- It seems that the plan loses because it should just pay the QPA (or something close to it)
- The NNP wins because it gets more than the QPA
- The TPA wins because it charges a fee on the difference between the giant bill and the agreed upon payment amount

Savings Program

- Prior to the CAA, in many cases, the payments to the NNP were higher than QPA
  - This is one of the reasons that the NNP does not want to be in-network—it can get higher fees for being OON
- Now the NNP should be paid something close to the QPA—which is based on the median of the in-network contracted rates
- This is a key change under the CAA—for claims covered by the protections of the NSA, QPA is the presumed payment amount
- Why are plans paying a fee for the TPA to get the bill down to QPA?

Savings Program

- Assume that the NNP knows that under this revised structure, the QPA will almost always be HIGHER than any payments produced under these "shadow networks"
  - Again, prior to the CAA, in many cases, the payments to the NNP were higher than QPA
- Now, under the revised structure of the CAA, the NNP:
  - will refuse any payment under these discount programs
  - argue for a payment that is at least as good as the QPA during the "open negotiation period"
  - if the NNP is not satisfied, it will take its chances at getting paid a higher amount during the IDR process

Savings Program

- Remember one of the reasons that we had these savings programs—to protect again balance billing
  - The protection is now granted by the CAA for many of the most expensive claims
- For these NSA protected claims, the ASA should state that the default payment amount cannot exceed QPA (or, for certain complex issues, QPA plus xx%)
  - If the plan pays too high a rate to the NNP, it is a disincentive for that NNP be in the network or to send the plan a reasonably priced bill
- Basic summary—QPA is the default payment amount. Use this when negotiating the pricing terms in the ASA
  - Why pay the TPA a savings program fee to get the bill to QPA?

ASA Provisions

- For all other out-of-network claims—those not protected by the NSA—the ASA should state that the plan will pay 150% of the Medicare rate (or something like that)
  - If the participant is balance billed, that was the risk the person took for going out-of-network
- For many plans, the non-protected NSA claims are paid at UCR
  - The TPA uses some vendor and systems to determine this amount
  - This is often disputed by providers (or their attorneys)
- Make it clear in the plan that there is a flat reimbursement rate for these non-protected, out-of-network claims
  - UCR is fuzzy—a percentile of the Medicare rate is objective
- This will create certainty regarding the plan terms and encourage participants to go in-network
- The TPAs may push back against this design because it will reduce programs that create fees paid to the TPA

ASA Provisions

Some other terms to consider adding into the ASA:

- Define which entities cannot be considered for the in-network rate when determining the QPA
  - Remember that prior to the CAA, the "shadow networks" and "discount program networks" likely paid the NNPs an amount in excess of the network rate
  - These payments should not be considered in determining the median in-network rate for the QPA—and this is what the rule intended

ASA Provisions

- Require reporting for all NSA protected claims that shows:
  - the QPA for each service; and
  - the claims that were paid over the QPA—and the amount paid over the QPA
- NOTE: the federal government obtains similar reporting. The IDR entity is to produce a written report explaining their decision, and in cases where the IDR entity chooses an NNP offer that is over QPA, the IDR entity must explain what factors were relied on to pick an amount over QPA

Other Considerations

- Some other big picture considerations:
  - How long will it be until we see more predictability in claim costs for these NNP claims?
  - Will we see more providers going in-network, if it becomes clear that QPA is the payment amount?
  - Will plans stop having "savings programs" and other programs that protect claimants from balance bills for non-NSA protected claims?

Savings Program vs Value-Based Arrangements

- Value-Based Arrangements and Savings Programs are very different
- Value-Based Arrangements are agreements between the plan and providers for certain bonus payments based on the provider's ability to meet certain quality metrics
  - These bonus payments are not considered for determining the QPA
- These bonus payment arrangements are an important tool for plans to encourage high-quality care
  - TPAs may not yet have their systems programmed to separate these amounts from the in-network rates
    - Consider adding a provision to the ASA about this issue

No Surprise Act—Air Ambulance

- If a participant receives air ambulance services from a NNP and such services would have been covered by the plan if provided by a participating provider, then the plan must cover the services in a manner that is very similar to the Emergency Services rules
- One additional requirement is a reporting requirement

Air Ambulance Reporting

- A plan is required to provide two reports to IRS/DOL/HHS with information regarding claims data related to air ambulance services
- Proposed regulations have been issued that state that the required data will be submitted for calendar year 2022 by March 31, 2023, and for calendar year 2023 by March 30, 2024
- The required data includes transport information, certain claim adjudication information (including whether the claim was paid, denied, or appealed; denial reason; and appeal outcome) and claim payment information (including submitted charges, amounts paid by each payor, and cost-sharing amount)
- A data template and instructions for reporting will be provided by the applicable government agencies

Air Ambulance Reporting

- For the ASA provisions:
  - Consider adding similar pricing provisions as those added for the other NSA claims
  - Include that the TPA will complete the reporting obligations for the plan
  - Include that the plan sponsor will receive a copy of those reports

Where We Have Been & Where We Are Going!

- We have been discussing:
  - The protections of the No Surprises Act
  - That the plan should really just be paying the NNP the median of the in-network rate for the NSA protected services (QPA)
  - Revise/scrutinize the savings programs and other fees in the ASA
- We are moving on to discuss:
  - How public reporting on healthcare costs should put pressure on reducing in-network contracted rates
  - Ensuring that you have the right consultants assisting with monitoring the fees and running RFPs

Prescription Drug & Health Plan Reporting

- Under CAA, plans must annually submit prescription drug and health care reports to the DOL, HHS, and IRS (as applicable)
- This includes all group health plans, including grandfathered plans, but not excepted benefits, account-based plans (such as HRAs) and retiree-only plans
- The first reporting deadline was to be December 27, 2021, and subsequent deadlines were set for June 1 of each succeeding year
- This was revised so that there will be no enforcement actions against plans that submit the required data for the 2020 and 2021 reference years by December 27, 2022
- REMEMBER—this is reporting to the government agencies
  - It is a plan sponsor obligation, but the rules do not require that the reports be provided to the plan sponsor

Prescription Drug & Health Plan Reporting

- The following information must be reported:
  - Start and end dates of the plan year & total number of participants;
  - Each state where the plan or coverage is offered;
  - Top 50 brand prescription drugs by frequency and the total number of paid claims for each drug;
  - Top 50 prescription drugs by annual total spend and the total amount spent on each drug;
  - The 50 prescription drugs contributing to the biggest increase in plan costs compared to the prior plan year, and the total cost difference for each drug compared to the prior plan year;
  - Total medical and prescription drug spend broken down into various categories;
  - Average monthly premium paid, split between the employer & employee; and
  - Any premium or out-of-pocket cost impact due to rebates or other payments by drug manufacturers. This includes reporting on rebates or other remuneration paid by drug manufacturers to the plan sponsor by therapeutic class and for each of the top 25 drugs yielding the highest rebates or other remuneration.

Prescription Drug & Health Plan Reporting

- The regulations provide that third-party reporting entities, such as PBMs, may submit the information for the plan
- The rules also allow for the third-party reporting entities to report the relevant information across all of the plans it administers in a given market segment
- That means the information will be reported on an aggregate basis
  - This could leave fiduciaries without access to important information about its plan
- Ask for separate information about the plan to be provided to the plan sponsor—and don't be surprised if you cannot obtain it, but still ask!
- Add in the ASA that the TPA/PBM is responsible for filing the reports

Transparency Reporting Rules

- The ACA requires most health plans to disclose in-network provider negotiated rates, historical out-of-network allowed amounts for providers, and in-network negotiated rates and historical net prices for all covered prescription drugs at the pharmacy-location level
- These disclosures must be made through three machine-readable files posted on the plan's website in a standardized format and updated monthly
- **This is information that is available to the public**
- With respect to the in-network rates and out-of-network allowed amounts, for plan years beginning on or after January 1, 2022, the applicable Departments (IRS/DOL/HHS) deferred enforcement until July 1, 2022
- The requirement related to prescription drugs is deferred indefinitely, pending additional rulemaking
  - BOO!!! We want this information! It is the only prescription drug information that is provided on a plan basis

Transparency Reporting Rules

- Understand which entities need to report information for these files
  - Major medical TPAs
  - What about other entities that administer one of the smaller benefits offered under the major medical plan
    - Need to consider how those will be reported, as the major medical TPAs will not include this data
  - Consider which plans don't need to report information for these files
    - Not required for excepted benefits
    - Not required for retiree-only plans
- Add to the ASA that the TPA is obligated to timely disclose these reports on its website

Transparency—Self-Service Tools

- The ACA transparency rules also require plans to develop an internet-based, self-service tool to disclose to enrollees, upon request, specified cost-sharing information for covered services, including negotiated rates for in-network providers and allowed amounts for out-of-network providers
- This is phased in, so that the plan year starting on or after January 1, 2023, plans must provide this disclosure service with respect to 500 items and services identified in the regulations
  - Note that prescription drugs are not on the list of 500
- Full implementation for all items and services is required for plan years beginning on and after January 1, 2024
- Add compliance with this rule to the ASA
- This is information that the enrollee can obtain—and share!

Transparency

Some things to consider about these transparency rules:

- The Prescription Drug & Health Plan reporting is really for the government to see what is driving up healthcare costs
- The Transparency Reporting Rules (3 machine readable files) is public information
  - We will see a lot of new vendors in this space that will be combing through this data
- The Transparency Self-Service Tools is to help enrollees understand the costs of services
  - This has become more critical due to the rise of HDHPs—and everyone having to pay a lot of money before the plan coverage kicks in
  - We also think that the new data analyst vendors in this space will use this information
    - They, too, are covered under health plans!
- Remember this for the later discussion in these slides about Action Items!

Broker & Consultant Compensation Disclosures

- Under the CAA, certain service providers to health plans are required to disclose information to a responsible plan fiduciary about the **direct and indirect compensation** the service provider expects to receive in connection with its services to the plan (ERISA Section 408(b)(2))
- The requirements apply to entities that provide statutorily-defined "brokerage services" or "consulting" to ERISA-covered group health plans who expect to receive $1,000 or more **in direct or indirect compensation** in connection with providing services
- The information generally must be disclosed to the responsible plan fiduciary--in advance--of when the plan and the service provider enter into a contract or arrangement
- Only contracts or arrangements that are entered into, extended or renewed on or after December 27, 2021, are required to comply with the new disclosure requirements

Broker & Consultant Compensation Disclosures

- The CAA amends the prohibited transaction exemption provisions in ERISA Section 408(b)(2) that govern service provider arrangements with ERISA plans
- Those rules apply when there are ERISA plan assets involved
  - Participant contributions (such as premium payments) are plan assets—even if not required to be held in trust due to the application of a DOL non-enforcement policy to the trust rules (i.e., if the sole reason that a plan would be considered funded is the presence of participant contributions under a cafeteria plan)
- There will be some push back on these rules
  - Brokers and consultants may state that they are paid by the plan sponsor and not with plan assets
  - They may claim that certain amounts do not need to be disclosed
  - We need to push back on this!

Broker & Consultant Compensation Disclosures

- In a DOL Field Assistance Bulletin (FAB 2021-3), the DOL announced a temporary enforcement policy stating that it will not treat a service provider as failing to make the required disclosure so long as the service provider makes a disclosure in accordance with a good faith, reasonable interpretation of the statute
  - Essentially, the DOL is not issuing regulatory guidance at this time (just this FAB, which is not regulations)
- Among other things the guidance states:
  - service providers may look to prior DOL guidance developed for service providers of retirement plans;
  - the requirements apply with respect to insured and self-insured group health plans; and
  - the requirements apply with respect to "excepted benefit" group health plans.

Broker & Consultant Compensation Disclosures

- Think about how fees for 401(k) plans have changed in the last decade based on the ERISA Section 408(b)(2) rules for those plans
- Over a decade ago, almost all 401(k) plans paid fees that were commission based. A broker would sell a plan to a client, and then would collect fees on the mutual funds inside the plan--a commission
- The larger the plan grew, the larger the commission payments grew. If the company's 401(k) plan grew rapidly due to a great stock market, would that be an appropriate reason to increase the amounts paid to the broker?
- Now, most 401(k) plans do not pay these commissions to the brokers
- However, a vast majority of health plans do pay the brokers a commission based on premiums
  - So if the plan's premiums increase due to high claims or other market factors (such as a loss of a network, so more claims are paid out-of-network or legislative actions that require additional health plan benefits), is this a reason to pay the broker more money in commissions

Broker & Consultant Compensation Disclosures

- We need more guidance on this issue—and this will be a separate webinar discussion!
- At the moment, consider if the consultant/broker has disclosed all information
- Review the information and determine if you can understand the amount it receives as direct and indirect compensation
  - Some disclosures are very difficult to understand
  - If you cannot understand the disclosure, ask them to provide additional information or ask for a meeting to discuss the disclosure
  - Ask for data on how much the compensation has increased year-over-year

Broker & Consultant Compensation Disclosures

- For the initial phase of this rule, before any additional DOL guidance is issued, consider if the plan fiduciary should send a letter to the broker/consultant for detailed information about compensation
- The request should be broad and include all types of potential compensation
  - All commissions
  - All service fees for assisting with placing the coverage
  - Bonuses (such as on the loss ratio/profitability)
  - Compensation contingent on meeting certain sales goals or retention goals
  - Overrides
  - Any non-cash compensation (trips, dinners, parties)
- The letter should also request a live meeting to go through the data

Broker & Consultant Compensation Disclosures

- It is a fiduciary obligation to determine if the service provider is being paid reasonable compensation for services
- A fiduciary must also understand if there are any potential conflicts of interest
- We cannot ignore these obligations

Broker & Consultant Compensation Disclosures

- Putting this together:
  - Understand the pricing provisions in the ASA
  - Understand if you have the right consultants helping to negotiate fees
  - Is the consultant/broker being paying a reasonable amount for the services
    - Do you really understand how much they are paid?
  - Remember the fiduciary obligations—and that many times, the company (its Board) is a named fiduciary

Fiduciary Obligations

- Most companies (or their employee benefits committees) are fiduciaries of the Health Plan
- Two key responsibility of fiduciaries:
  - run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses (the Exclusive Benefit rule) and
  - to act with the care, skill, prudence and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims (the Prudent Expert rule)

Plan Assets

- A fiduciary must protect plan assets and ensure they are used for a proper purpose (benefits and direct expenses)
- For health plans, plan assets include all contributions made by participants and beneficiaries
  - Generally, participants pay some portion of the insurance premiums
  - In addition, most plans have a large deductible

Fiduciary Obligations/Protecting Plan Assets

- ERISA requires the fiduciaries to hire experts/service providers where needed
- In selecting any service provider for a plan, a fiduciary must:
  - thoroughly review and investigate the service provider's qualifications;
  - follow a process that avoids self dealing, conflicts of interest or other improper influence;
  - continuously monitor the performance of the service provider in the job for which he or she has been engaged; and
  - pay only "reasonable compensation" for the services provided

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Lawsuits

- 2020 was a record-setting year for litigation under ERISA
- Over 200 new ERISA class actions were filed, an all-time record that represents an 80% increase over the number of ERISA class actions filed in 2019 and more than double the number filed in 2018
- Although the number of new ERISA cases filed in 2021 did not match 2020's record, there were still a significant number of new cases filed
- Many of the lawsuits relate to **fiduciary breaches for excessive fees for retirement plans**

Disclosure

- As we discussed, the ACA final transparency regulations require that:
  - Detailed information about the plan's negotiated rates be **publicly disclosed** and updated monthly, starting July 1, 2022
  - Detailed information about cost-sharing amounts for all services covered by the plan be available to enrollees, phased in starting January 1, 2023

Be prepared!

- These transparency rules will change health care pricing forever
- When this information becomes public, we anticipate that class action lawyers will use it to bring lawsuits against health plans to claim that fiduciaries have not taken appropriate actions to rein in healthcare costs
- It will be critical for fiduciaries to conduct a rigorous RFP process for health plan services and to document that process

Lawsuits

At a very basic level, in some of these retirement plan cases:

- Plan participants sue the plan sponsor (the company and its board), which are named as a fiduciary in the plan document, for the breach of its fiduciary duty to monitor the retirement plan Committee that it appointed
- The Committee (a named fiduciary) and the individual members are the parties responsible for selecting vendors & monitoring fees
- The claim is that the Committee members breached their fiduciary duties by allowing the plan to pay unreasonably high recordkeeping fees
- We may see similar claims for health plans—given that participants pay premiums and have high deductibles and other expenses (copays and coinsurance)

Action Items

- Draft a robust CAA amendment to the ASA and include things such as:
  - Which plans are impacted by the CAA (consider if these provisions will/will not be applied to a retiree-only plan)
  - Removal of, or change to, the savings programs
  - Add that the QPA will not consider "shadow" networks
  - Reporting on the QPA and when the plan pays amounts over the QPA
  - Retention of documents regarding the notice-and-consent exception
  - Requirements about the notice provisions for continuity of care
  - Obligations about the provider directory
  - Assistance with mental health parity testing
  - Reporting obligations for the transparency rules
  - Other CAA provisions

Action Items

- Drafting a detailed amendment ensures that:
  - the parties agree on the TPA's responsibilities for the CAA provisions
  - the parties agree on how the CAA provisions will work
  - the parties understand the types of reports that the plan sponsor can expect from the TPA
  - the plan sponsor can reexamine all fees
- The TPA may say—don't worry, see our materials about these CAA services and we are not charging for the CAA services in 2022
  - the marketing materials are not a part of the contract
  - in almost all cases, there are fees being charged for the CAA services—mostly through the savings programs

Action Items

- Ensure that brokers/consultants provide you with all information about direct & indirect compensation
  - Ensure that you can understand the report
  - Consider scheduling a meeting to review the disclosure and come prepared with questions
  - Evaluate whether it is the reasonable compensation for the services provided
  - Evaluate if there are any conflicts

Action Items

- Be prepared to run new RFPs soon
  - Hire data analysists to review the information publicly disclosed by the TPAs and insurance carriers
  - Review where your claim costs are compared to other similar entities
  - Review how often—and how much—the TPA pays over QPA
- Document your process!

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