Health Plan Fiduciary Readiness

Best Practices: Five Things Group Health Plans Must Already be Doing to be in Compliance with their Fiduciary Obligations

1. Gag Clause Removal and Attestation

For purposes of a group health plan, a gag clause is a term in an agreement providing access to a health care provider or a network or association of providers that directly or indirectly restricts a health plan from sharing provider-specific cost & quality of care information with the plan's chosen business associates, or from electronically accessing de-identified claims and encounter information or data, on a per claim basis, for each participant or beneficiary in the plan, upon request and consistent with applicable privacy regulations.[1]

Gag clauses are mainly found in the health plan's agreement with a carrier third-party administrator ("TPA") or carrier network access administrator (if there is an independent TPA), and in the pharmacy benefit management ("PBM") agreement. This requirement applies to all applicable contracts (contracts that provide a group health plan with access to a health care provider or a network of providers) entered into or extended on or after December 27, 2020.

First "Attestation of Compliance" is due on or before December 31, 2023, covering contracts entered into/extended since December 27, 2020. A similar attestation will be due annually after that.

Beware: Plans that do not submit their attestation as required by law on or before December 31, 2023 may be subject to enforcement action.

2. Group Health Plan Service Provider Compensation Disclosures Under ERISA Section 408(b)(2)(B)

Any service provider who enters into a contract with a covered plan and reasonably expects to earn $1,000 or more in direct or indirect compensation related to a broad array of consulting and brokerage services provided to the plan must provide the plan fiduciaries with a compensation disclosure.

[1] Applies to all health plans, group and individual, ERISA and non, grandfathered, grand-mothered, church plans, etc. via Internal Revenue Code (Code) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9, as added by section 201 of Title II (Transparency) of Division BB of the CAA, as applicable.

The disclosure must be provided reasonably in advance of the parties entering into such contract or arrangement. The required disclosures are intended to provide the responsible plan fiduciary with sufficient information to assess the reasonableness of the compensation to be received and potential conflicts of interest that may exist as a result of a covered service provider receiving indirect compensation from sources other than the plan or the plan sponsor (e.g., an insurance broker receiving a commission from an insurance carrier upon placing their product with a plan).

This disclosure requirement applies broadly to health and welfare plans but only to ERISA-covered plans. It applies to ERISA-covered insured and self-insured plans, grandfathered plans, limited scope dental and vision plans, and plans with less than 100 participants.

Beware: This provision went into effect on December 27, 2021. Without receiving the disclosure, "No contract or arrangement for service between a covered plan and a covered service provider, and no extension of renewal of a such a contract or arrangement, is reasonable." It becomes a prohibited transaction, and the plan must terminate the contract as soon as practicable and report noncompliance to the DOL.

3. MHPAEA NQTL Comparative Analysis Reporting

Health plans cannot have separate treatment limitations and cost sharing requirements that apply only to mental health ("MH") / substance use disorder ("SUD") benefits are prohibited. There are six classifications of benefits which must be compared via comparative analysis annually: Inpatient in network, Inpatient out of network, Outpatient in network, Outpatient out of network, Emergency care and Prescription drugs.

Applies to ERISA and non-ERISA plans alike. These requirements took effect February 10, 2021, and group health plans must have their comparative analysis available upon request of the DOL (or CMS/relevant Agency if not an ERISA plan.)

Some examples of NQTLs include prior authorization requirements, concurrent review, formulary design, network adequacy, fail first policies, step-therapy protocols, reimbursement rates, and plan methodology for determining reasonable and customary. That is just a sampling; most plans have at least a dozen (and probably more) NQTLs that require comparison to ensure parity.

Beware: Plans subject to ERISA must make a copy of the comparative analyses available to participants, beneficiaries, and enrollees upon request. In addition to litigation risk, failure to comply with these requirements can result in penalties of up to $110 per day per affected participant for failure to furnish documentation on request, an IRS excise taxes of $100 per day per participant, and public disclosure of the plan's noncompliance.

4. Prescription Drug Data Collection and Reporting

Plans are required to submit data to the Centers for Medicare and Medicaid Services ("CMS") regarding, among other things, general information regarding the plan or coverage; the 50 most frequently dispensed brand prescription drugs, the 50 most costly prescription drugs by total annual spending, and the 50 prescription drugs with the greatest increase in plan expenditures over the preceding plan year; total spending by the plan or coverage broken down by the type of costs; and the average monthly premiums paid by participants, beneficiaries, and enrollees and paid by employers.

Plans must also report the impact on premiums of rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, including the amount paid with respect to each therapeutic class of drugs and for each of the 25 drugs that yielded the highest amount of rebates, as well as other remuneration under the plan from drug manufacturers during the plan year.

This rule applies to ERISA and non-ERISA plans, including federal employee health benefit plans. The report is due on June 1 each year and must contain the required information pertaining to the last calendar year (information for 2020 and 2021 was due no later than January 31, 2023). The purpose of requiring this data to be submitted is to identify major drivers of increases in prescription drug and health care spending, understand how prescription drug rebates impact premiums and out-of-pocket costs, and promote transparency in prescription drug pricing.

Beware: A plan TPA or PBM may submit information on the plan's behalf, but the plan should require that it is provided with a copy of what was submitted. Not only will that ensure the disclosure was made, but the plan can use that information to be a better plan fiduciary and make any necessary changes that might lower costs in the upcoming plan year.

5. Other Disclosures

(a) Machine Readable Files

The Transparency in Coverage ("TiC") Final Rules require non-grandfathered group health plans to disclose, on a public website, information regarding (1) in-network provider rates for covered items and services, (2) out-of-network allowed amounts and billed charges for covered items and services, and (3) negotiated rates and historical net prices for covered prescription drugs in three separate machine-readable files. **The third file is not yet required to be posted.** Group health plans are required to update the machine-readable files monthly and must clearly indicate the date that the files were most recently updated. If a group health plan does not have a public website, it may satisfy the requirements for posting the allowed amount file and the in-network file by entering into a written

agreement under which a service provider (such as a TPA) posts the allowed amount file and the in-network rate file on its public website on behalf of the plan.

Beware: However, if a plan enters into an agreement under which a service provider agrees to post the Allowed Amount file and the In-network Rate file on its public website on behalf of the plan, and the service provider fails to do so, the plan violates these disclosure requirements.

(b) Balance Billing Protections

ERISA and non-ERISA covered group health plans must now make certain disclosures regarding balance billing protections to participants, beneficiaries, and enrollees of the plan. The Departments consider use of the model notice in accordance with the accompanying instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met. Plans are free to use the model notice found here: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/no-surprises-act/surprise-billing-model-notice.docx.

Beware: There are several model notices that have been issued by the Departments; make sure to use the one for 2023 and beyond, linked above, for new disclosures. The other model notices are outdated and no longer appropriate to use.

(c) Price Comparison Tool

Most group health plans are required to disclose personalized pricing information for 500 covered items and service to their participants, beneficiaries, and enrollees through an online consumer tool, as well as by phone or in paper form, upon request. Cost estimates must be provided in real-time based on cost-sharing information that is accurate at the time of the request. The price comparison tool must also allow an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers, for the 500 items and services.

Beware: On January 1, 2024, group health plans will be required to disclose the personalized pricing information and provide individuals with an estimate of their cost-sharing responsibilities for ***ALL*** covered items and services (not just the 500 currently required).