Employer Fiduciary Alert

4 Things Employers Need to do Before January 1st

Fiduciary Best Practices for Employer Sponsored Health Plans

Intent

- Ensure regulatory awareness
- Minimize liability
- Improve plan for employees

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Impact on Outcomes

Before 408(b)(2) in Retirement

- Choice overload in fund offering
- Commissioned education specialist of site = lots of ancillary products sold
- Average cost to employee 2.50% to 3.25% and termination fees
- Fees eating up returns
- Low participation
- Company liabilities

Outcome

- Lawsuit
- Settlement of tens of millions

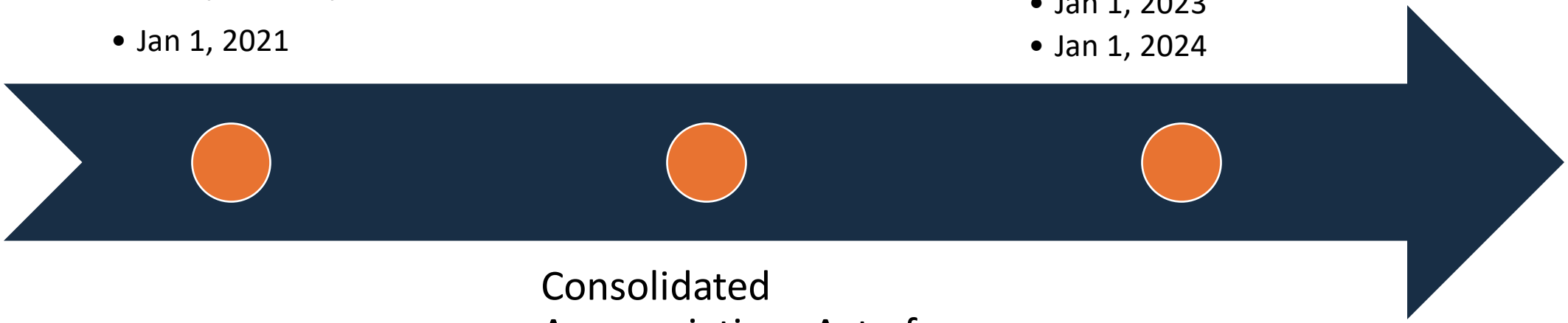
After 408(b)(2) in Retirement

- Prudent process established
- Appropriate fund line up
- Customized education and communication
- Average cost to employee less than 0.50%
- Transparent fees and services
- High participation, high deferrals
- Reduced company liabilities
- Better plan design

Outcome

- Average account balances over **$100,000**
- Employees able to retire on their terms

New Legislation



Hospital Price Transparency

- Jan 1, 2021

Consolidated Appropriations Act of 2021 (CAA)

- Jan 1, 2021

Transparency in Coverage (TICRA)

- Jan 1, 2022
- Jan 1, 2023
- Jan 1, 2024

Group Health Provisions of the Consolidated Appropriations Act (CAA)

Why Was the Legislation Created?

- Lack of clarity in the role of Plan Sponsor as the Fiduciary under ERISA/PHSA and specific responsibilities
- Contracts that restrict Plan Sponsors from full access to their data
- Lack of transparency in pricing and benefit plan administration
- Accountability for services provided
- Need for more aggressive enforcement of the federal Mental Health Parity and Addiction Equity Act of 2008

*The legislation was signed into law December 27, 2020 and established the **Plan Sponsor as the Fiduciary** under ERISA/PHSA/IRS tax code.*

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4 Key Areas of CAA

Employer Fiduciary responsibilities across 4 key areas:

- Removes gag clauses from service provider contracts on price and quality information
- Establishes reporting requirements (i.e. Rx)
- Requires the disclosure of direct and indirect compensation from all service providers
- Requires parity in substance abuse and mental health benefits

Urgent Issues to Address

1

Remove gag clauses from contracts before renewal

2

Review broker compensation and service disclosures

3

Determine broker compensation reasonableness

Prohibition of Gag Clauses

Plan Sponsor agreements with service providers must provide access to provider-specific cost or quality information for the Fiduciary to:

- Show that employee costs related to claims are expended in an efficient manner
- Provide enrollees with access to information to make informed, cost-effective healthcare decisions
- Share information with the Plan Sponsor to identify waste through comparative analytics

They must annually attest to the Secretaries of DOL, HHS and Treasury that the plan complies with the prohibition of gag clauses.

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Real “gag clause” language

Proprietary Materials specifically includes any data and information, including any data provided to Plan Sponsor in the form of a data extract or otherwise, related to the *composition of the Carrier network* of Participating Providers, the *contracted (or "allowed" amounts) paid* to Participating Providers, the terms of the agreement between Carrier and the Participating Providers, and the discounts to Carrier offered by Participating Providers. Proprietary Materials also consist of any *analyses, compilations, studies or other documents* created on the basis of other Proprietary Materials.

All Proprietary Materials are the sole property of Carrier. Carrier will have the right to protect the confidentiality of the Proprietary Materials and *will not be required to make such Proprietary Materials available to anyone*. Plan Sponsor agrees to maintain the confidentiality of any Proprietary Materials Carrier provides, and *Plan Sponsor will not provide any Proprietary Materials to any other person, including any data extracts or summary information*, except to the extent such Proprietary Materials have been made available to the public without fault of the Plan Sponsor.

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Compensation Disclosure

Specific disclosure requirements apply to all service providers to assist the Plan Sponsor in determining what is "reasonable":

- Contracts where the service provider reasonably expects to receive **$1,000 or more in compensation** (direct or indirect) in connection with providing the services
- These rules will require the disclosure of, among other things, the service providers role in providing Fiduciary services, as well as the direct and indirect compensation received by service providers related to the health plan

The CAA establishes a timeline in which Plan Sponsors must immediately terminate service contracts that fail to disclose compensation.

Compensation Disclosure Requirements

<u>What</u> Information to Disclose?

- Direct compensation
  - Finder fees
  - Contracted fees
  - Commissions
- Indirect compensation
  - Compensation based on a structure not solely related to the contract with the covered plan
  - Reasonable estimate of any indirect compensation they or any affiliates or subcontractors reasonably expect to receive
- Transactional fees
  - A description of all transaction-based compensation.
  - A description of any compensation payable in connection with termination and, if applicable, how any prepaid amounts may be refunded and calculated.
- Written description of all the services they provide
- Fiduciary Status

Prescription Drug Disclosures

The CAA requires Plan Sponsors to report certain information to HHS, DOL, and Treasury, including:

- Top 50 brand drugs most frequently dispensed
- Annual amount spent by top 50 most costly prescription drugs by total plan/coverage spend
- Amount spent for the top 50 prescription drugs with the greatest prior year plan spend
- Total healthcare spend
- Premiums and rebates

Plan Sponsors will need an increased level of data from PBM's to meet reporting criteria.
Currently, this information is not available.

Annual reporting requirements demonstrate that the Plan Sponsors actions serve the economic interest of the enrollee.

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Mental Health & Substance Abuse Benefits Parity

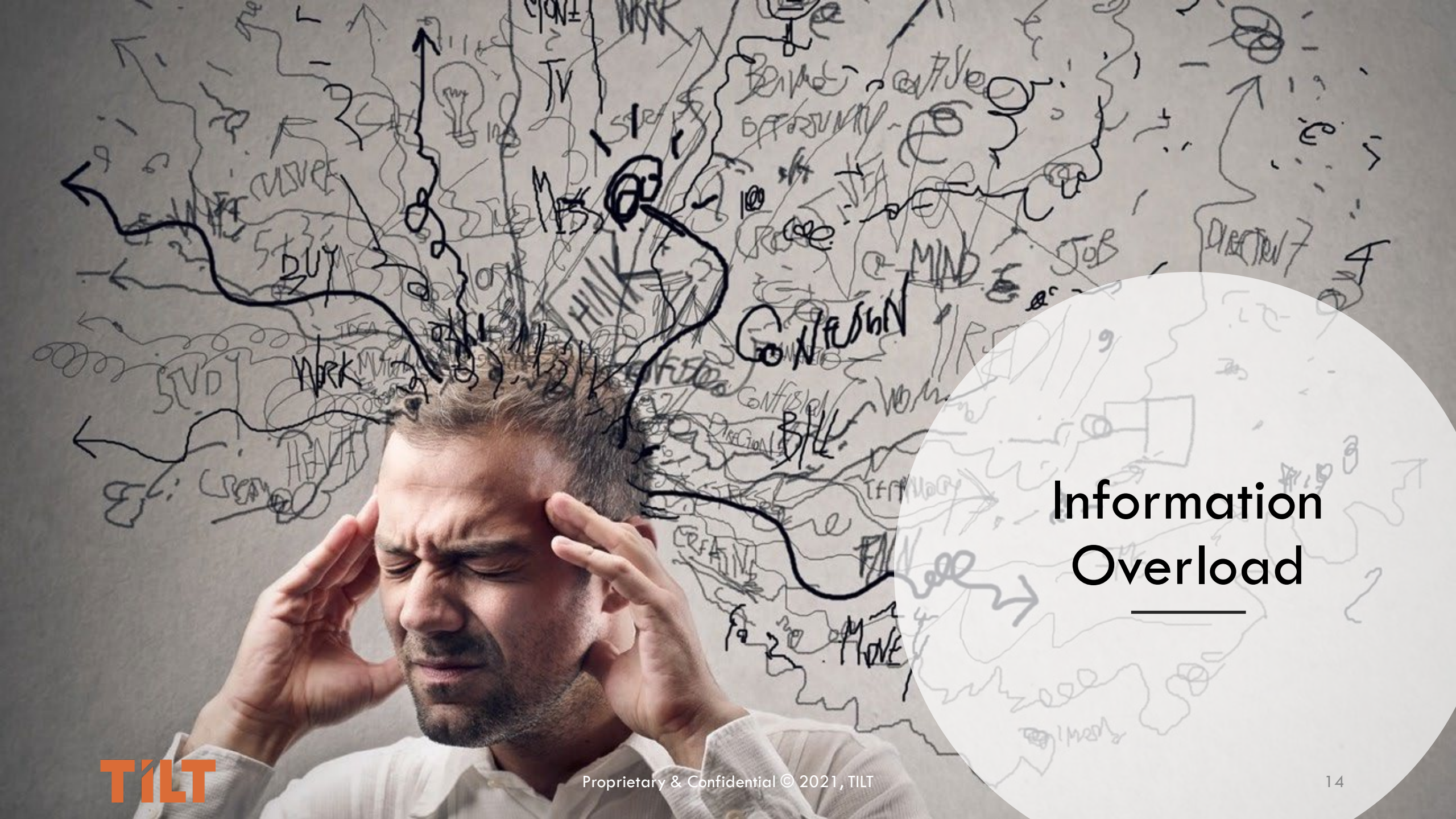
The CAA requires plan sponsors to analyze non-quantitative treatment limitations on MH/SA benefits to show parity with medical and surgical care:

- Quantitative treatment limitations include copay requirements or a restriction on the number of treatments
- Non-quantitative treatment limitations refer to network admission criteria, medical management programs, and coverage policies (i.e. access to substance abuse facilities)
- Guidance with respect to the required analysis is expected by July 2022

Currently Plan Sponsors attest to parity with quantitative limitations.

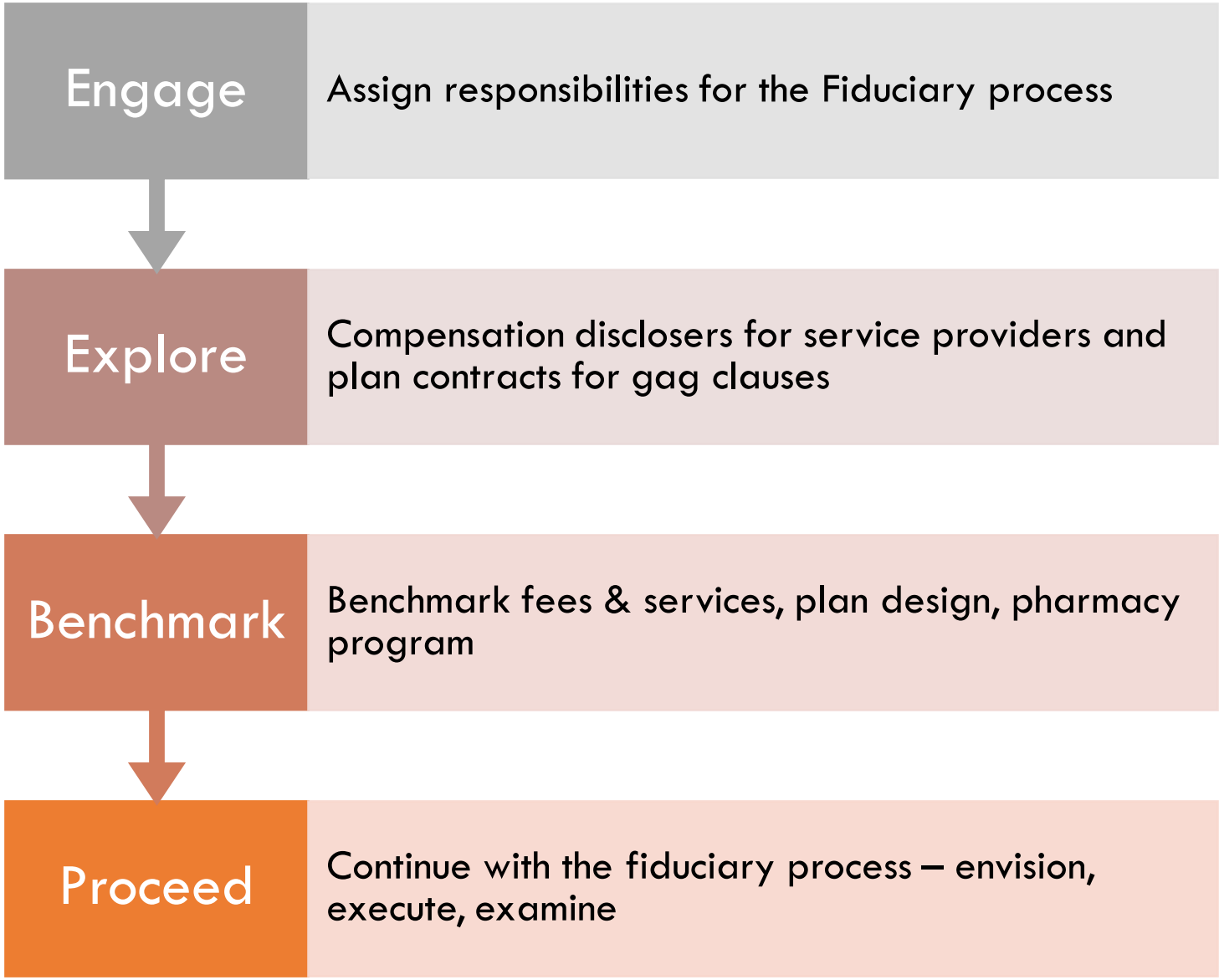
Going forward, they must attest to nonquantitative limitations.

Plan Sponsors will need time and resources to work with service providers on identifying how plan provisions are actually administered.



Information Overload

Next steps


Engage
Assign responsibilities for the Fiduciary process
Explore
Compensation disclosers for service providers and plan contracts for gag clauses
Benchmark
Benchmark fees & services, plan design, pharmacy program
Proceed
Continue with the fiduciary process – envision, execute, examine

Resources

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- Understanding Your Fiduciary Responsibilities Under a Group Health Plan
  – The US Department of Labor
- An Overview of the Group Health Plan Provisions of the Consolidated Appropriations Act and the Final Transparency in Coverage Regulations
  – Trucker Huss
- Disclosure to Welfare Plan Participants: A Fiduciary Duty
  – Wagner Law Group
- Timeline for Transparency Laws and Surprise Medical Billing
  – Segal Consulting
- Consolidated Appropriations Act Requirements to Increase Health Plan Transparency
  – Ogletree Deakins

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