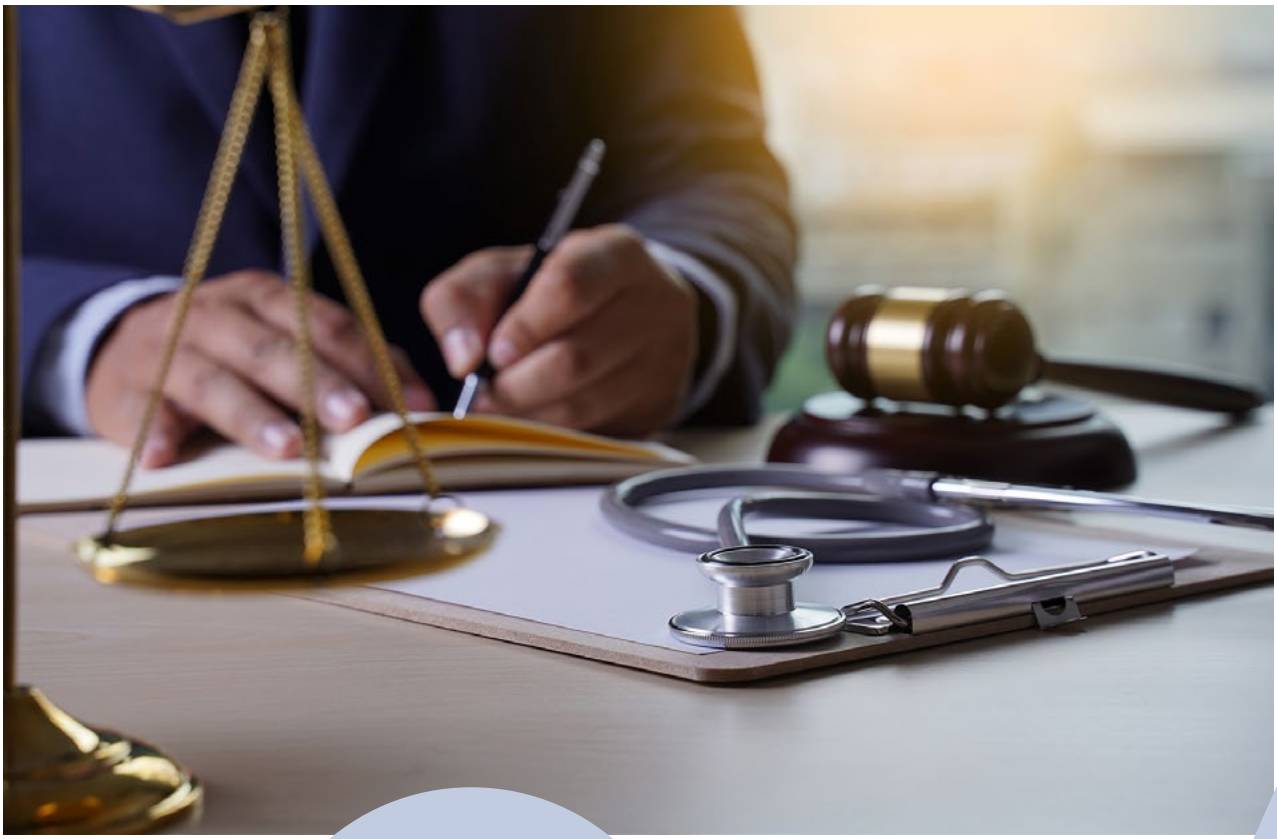

ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Earl Porter provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken and Amy are senior members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

GROUP HEALTH PLAN PROVISIONS OF THE CONSOLIDATED APPROPRIATIONS ACT: A DEEPER DIVE

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. In addition to funding the government and further COVID-19 relief, the CAA included significant provisions impacting health benefit coverage.

Over the next several articles we will discuss four of the provisions relevant for group health plans: (1) expanded relief for health and dependent care flexible spending arrangements; (2) new expanded compliance requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA); (3) new reporting requirements for commission and similar compensation; and (4) new requirements to limit surprise billing.

BROKER AND CONSULTANT DISCLOSURES FOR HEALTH CARE SERVICES

The CAA contains new service provider disclosure requirements for "brokerage services" and "consulting" services and requires group health plan fiduciaries to take action if they do not receive those disclosures. The effective date of this provision is December 27, 2021 (one year from the date of enactment). We expect future guidance from the DOL to fill in some of the gaps and ambiguities in the statutory provisions.

Background

ERISA Section 406 provides that furnishing services between a plan and a "party in interest" is a prohibited transaction. A party in interest includes any person providing services to a plan. Looking at ERISA Section 406 alone, this would make almost all arrangements between plans and plan service providers prohibited transactions.

There is an exception, however, in ERISA Section 408(b)(2) for contracts or arrangements for services with a party in interest if the arrangement is reasonable, the services provided are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid.

Current DOL regulations require retirement plan service providers to disclose both the direct and indirect compensation they receive. The DOL reasoned that it is impossible for a "responsible fiduciary" to know whether compensation or an arrangement is reasonable unless that plan fiduciary knows what compensation the service provider receives for each service rendered.

Therefore, under those regulations, an arrangement with a service provider where such disclosures are not made is not "reasonable" and could generally result in a prohibited transaction (with certain exceptions when the plan fiduciary takes action for the service provider's failure to disclose). Finding that there were significant differences between service provider arrangements with welfare plans and with retirement plans, the DOL did not issue guidance for welfare plans at that time.

The CAA now institutes disclosure requirements for certain service providers to "group health plans" by amending Section 408(b)(2) of ERISA. These statutory requirements, in many ways, mirror the regulatory requirements applicable to retirement plans and are modeled on the regulatory provisions.

Some of what is below, therefore, may be familiar for plan fiduciaries and plan sponsors who are acquainted with the required retirement plan disclosures. The CAA's rules will likely be new for many group health plan brokers and consultants, and planning should begin immediately on how these disclosures will be implemented.

Covered plans and covered service providers

The CAA's amendment to ERISA Section 408(b)(2) covers "group health plans," which are defined as employee welfare plans that provide "medical care." Significantly, the CAA does not exempt what are known as "excepted benefits" from this definition of a group health plan.

So the CAA sweeps in not only traditional fully insured and self-funded group medical plans but also dental and vision plans, health FSAs, on-site clinics (except those that are limited to only rendering first aid to employees during working hours), many employee assistance programs, and health reimbursement arrangements (HRAs).

Examples of plans that are not group health plans are group term life insurance, accidental death and dismemberment insurance, and long- and short-term disability insurance. Also, while HSAs are generally not group health plans, the HDHP that accompanies an HSA is a group health plan.

Disclosure is required only if the service provider receives $1,000 or more in certain types of compensation pursuant to the consulting or brokerage contract or arrangement. Compensation includes "direct compensation" from the covered plan itself or "indirect compensation," which is compensation from any source other than the covered plan, the plan sponsor (often the employer), the service provider, or an affiliate of the service provider.

In other words, if the only compensation that the service provider receives derives directly from the employer, then disclosure is not required. This could arise, for example, with a consulting agreement for a self-funded group health plan where the employer is responsible for all fees associated with the agreement, no fees are paid with plan assets, and the service provider does not receive compensation from any other source for the plan.

Plan assets can take the form of amounts paid from a formal trust or amounts paid with any participant contributions. So to avoid reporting, care must be taken to ensure that the service provider is not paid with any participant contributions (and that it does not receive indirect compensation).

It appears that disclosure will be required for an insured arrangement, where a portion of the premiums that generate the insurance commissions are paid by plan participants, because those commissions will be deemed to be paid by the plan.

Disclosure is required regardless of whether the services are performed, or the compensation is received, by the service provider, its affiliate, or its subcontractor.

The CAA's amendment to ERISA Section 408(b)(2) covers two types of services as "covered service providers": brokerage services and consulting.

The definition of brokerage services includes a "selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, benefits administration (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services."

Consulting services are nearly identical but do not need to involve "brokerage" and include services "related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third party administration services."

We must wait for further clarification of these definitions, but the consulting category appears especially broad. It is unclear whether consulting just includes advising on the selection of service providers such as TPAs or pharmacy benefit managers or whether it also applies to the service providers themselves when they "consult" (e.g., a TPA consults on plan design or a pharmacy benefit manager consults on a plan's drug formulary).

If it is the latter, then the disclosure requirement would potentially include not only insurance brokerage firms serving in a consulting capacity to self-funded plans but a host of other service providers, including:

- TPAs (both for self-funded group health plans and for health FSAs and HRAs).
- Stop-loss carriers, stop-loss panels, and stop-loss consortiums.
- Pharmacy benefit managers.

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- Employee assistance program vendors.

What must be disclosed

The covered service provider must provide the following information (including the information of any affiliate or subcontractor):

- A description of the services provided.
- If applicable, a statement on whether the covered service provider will serve as an ERISA fiduciary.
- A description of all direct compensation the covered service provider reasonably expects to receive in connection with the services. There are several different ways compensation can be expressed, including a monetary amount or a formula.
- A description of all indirect compensation that the covered service provider reasonably expects to receive. This includes "compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan." We will need to wait for further guidance on what this would include, but it could relate to items such as a vendor providing brokers with gifts, trips, etc., for the amount of business they place with the vendor or even the vendor being a financial sponsor at a client-facing event held by the brokerage firm.

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- A description of the arrangement under which the indirect compensation is paid.
- Identification of the services for which an indirect compensation will be received.
- Identification of the payer of the indirect compensation.
- A separate description of any compensation that is set on a transaction basis (such as commissions, finder's fees, or other similar incentive compensation based on business placed or retained) that will be paid among the covered service provider, affiliate, or subcontractor.
- A description of any compensation that the covered service provider will receive upon termination of a contract or arrangement.

Timing of disclosure

Disclosures must be made to the responsible plan fiduciary "reasonably in advance" of the date of entering into, extending, or renewing any contract or arrangement.

Changes to the information disclosed must be provided as soon as practicable, but generally not later than 60 days from the date on which the covered service provider is informed of the change.

If, however, a covered service provider acting in good faith and with reasonable diligence makes an error or omission with disclosure, the contract or arrangement may still be reasonable if the correct information is provided within 30 days after the error or omission is discovered.

The effective date of this provision is December 27, 2021. Contracts entered into before this date are not subject to these requirements, but any renewal or extension of a contract after the effective date is covered.

What if the disclosure is not made?

Upon discovery of a disclosure violation, a responsible fiduciary can avoid a prohibited transaction by taking the following actions.

First, the responsible fiduciary should request, in writing, that the covered service provider make full disclosure.

Second, if the covered service provider refuses to make full disclosure or does not respond within 90 days, then the DOL must be notified of the failure within 30 days following the earlier of the refusal to respond or the lapse of the 90-day period to respond. Section 408(b)(2) specifies the information that must be provided to the DOL.

Finally, if the disclosure failure relates to past services, then the responsible fiduciary must make a determination on whether to retain the covered service provider based on ERISA's fiduciary prudence standards. If the failure relates to future services, then the responsible

fiduciary must terminate the contract or arrangement as expeditiously as possible as consistent with those prudence standards.

Summary and action items

The clear intent of the CAA was to mirror the disclosure requirements of retirement service plan providers. Plan sponsors and fiduciaries may be familiar with this process from their experience with their retirement plans, but work still needs to be done. Actions for plans sponsors and fiduciaries include:

- Identify any person or entity that consults in any way with a group health plan and all brokers for any group health plan and determine if they are a covered service provider.
- Determine whether any covered service provider receives any direct compensation from any group health plan and the amount of that compensation.
- If known, determine whether the covered service provider receives any indirect compensation and the amount of that compensation.
- Prepare, once effective, to make a demand to any service provider that has not provided adequate disclosure.
- Establish and document that a responsible fiduciary actually reviews the disclosures and determines that the compensation arrangement for consulting or brokerage services is reasonable.

Group health plan brokers and consultants have a much heavier burden. They will need to analyze all instances when they receive either direct compensation or indirect compensation. The identification of any indirect compensation is especially crucial because the reason for this provision was a belief that group health plan brokers and consultants are receiving forms of "hidden" compensation.

Also remember that these disclosures apply to all group health plans regardless of size as long as the compensation threshold is met. Finally, the disclosures must be designed and formatted to include all required information. This may require new software or revisions to existing software to automate these extensive disclosure requirements. ■