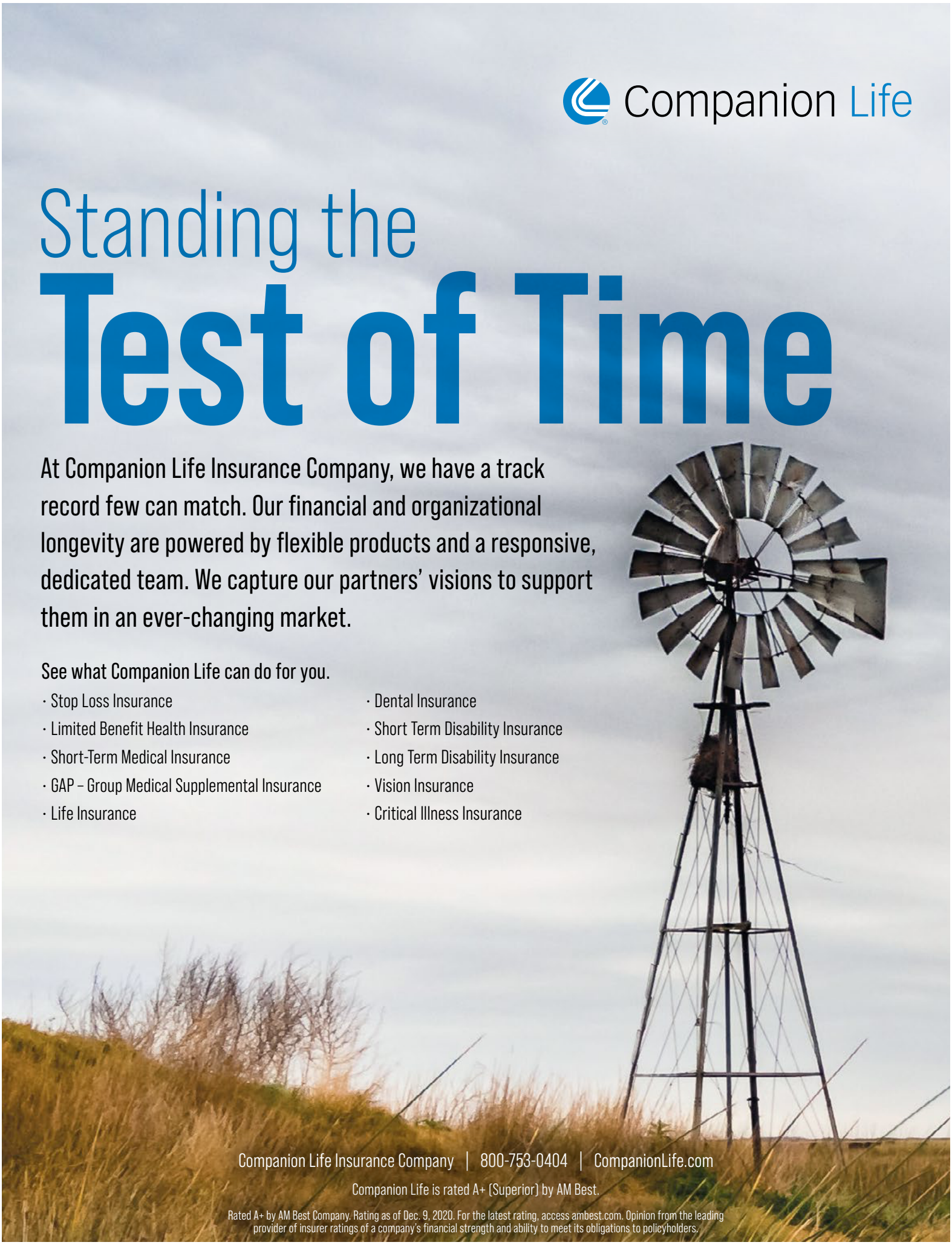
ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

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 Laurie Kirkwood 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, Amy, and Laurie are senior members in 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.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BROKER AND CONSULTANT DISCLOSURES FOR HEALTH CARE SERVICES

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA) was signed into law. 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.

These new rules apply to contracts and arrangements entered into, extended, or renewed on or after December 27, 2021 (one year from the date of enactment). The U.S. Department of Labor ("DOL') announced a temporary enforcement policy in Field Assistance Bulletin No. 2021-03 ("FAB 21-03") on December 30, 2021, noting that while they do not intend to issue comprehensive implementing regulations, they are requesting input as to whether any of the new statutory provisions would benefit from notice and comment regulations.

This article is an updated version of our earlier article on the subject, with added clarification and confirmation provided in FAB 21-03.

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. In FAB 21-03, the DOL underscored that "a significant goal" of the new disclosure requirements is to enhance fee transparency, particularly for those arrangements that involve the payment of indirect compensation to service providers from third parties.

The DOL recognizes that service provider arrangements and compensation structures for group health plans are complicated and often required to conform to state law. These new statutory requirements and terminology, 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 the DOL encourages covered service providers to review Notices published in connection with the DOL's 2012 final rule governing pension plan disclosures in order to gain a better understanding of the new rules.

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.

In FAB 21-03, the DOL reasoned that the policy underlying the new disclosure requirements applies equally to limited scope coverage, like dental and vision, as it does to other group health coverage.

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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, long- and short-term disability insurance, and small employer health reimbursement arrangements, or "QSEHRAs". 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. 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) in order to avoid inadvertently subjecting the service provider to the disclosure requirement.

For example, if a service provider receives indirect compensation related to stop-loss coverage, and if payments for stop-loss premiums include any participant contributions rather than being paid entirely from employer assets, the indirect compensation would need to be disclosed.

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.

In this regard, rather than just reviewing compensation received by service providers traditionally thought of as providing consulting or brokerage services, a plan fiduciary may want to take inventory of all entities that receive any kind of compensation related to the plan, and then evaluate whether the entities satisfy a broad reading of the definitions of the services in the new rule.

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."

The consulting category appears especially broad. While it was initially 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), FAB 21-03 makes it clear that there is no requirement for brokers or consultants to be licensed as such in order for them to be providing consulting or brokerage services under the disclosure rule.

Whether the disclosure requirements cover a particular service provider appears to be driven more by the subject matter of the services than by how a service provider markets itself.

For now, it is advisable for plan fiduciaries and service providers to take an expansive approach when determining whether the new rule covers a particular provider. The parties will be held to a reasonableness and good faith standard when making such determinations.

If service providers "reasonably" expect to receive indirect compensation from a third party but then still claim to be exempt from the disclosure requirement, the DOL has warned that in the event of an audit, such service providers will be expected to explain "how a conclusion that they are not covered service providers is consistent with a reasonable good faith interpretation of the statute.".

With this standard in mind, 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.
- Wellness vendors.
- Disease management vendors including data analytics.
- On-site clinic managers.
- Any entity providing "compliance services" (including attorneys and actuaries).
- 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.
- 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, referrals, 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.

The DOL reiterates in FAB 21-03 that resolving ambiguities or uncertainties with respect to what and how to disclose should be done with the principal objective of the disclosure requirement in mind, which is to provide plan fiduciaries with the information needed to evaluate reasonableness of compensation and evaluate conflicts of interest.

The requirement to disclose cannot be avoided simply because services are "bundled" for a single fee, without any charges being attributable to distinct categories of services. If specific amounts are unknown, compensation can be disclosed in ranges, particularly if the occurrence of future events or other features of the services arrangement could result in compensation varying within a projected range.

In that regard, the DOL quotes guidance from pension plan disclosure regulations: "However, such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue. To ensure that covered service providers communicate meaningful and understandable compensation information to responsible plan fiduciaries whenever possible, the Department cautions that more specific, rather than less specific, compensation information is preferred whenever it can be furnished without undue burden."

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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, even if the effective date is on or after December 27, 2021, but any renewal or extension of a contract after the effective date is covered. For example, if a contract or agreement is executed on December 15, 2021, but not effective until January 1, 2022, then these new disclosure requirements would not apply unless and until the new contract or agreement is renewed or extended.

As for situations where an agent or broker enters into a contract or arrangement with a plan fiduciary though the use of a "broker of records" ("BOR") agreement, the date the contract or arrangement will be considered entered into is the earlier of (i) the date on which the BOR agreement is submitted to the insurance carrier or (ii) the date on which the group application is signed for insurance coverage for the following plan year.

Under either approach, submission or signature must be done in the "ordinary course" and not in a manner designed to avoid disclosure obligations under the new rule. The DOL indicates that further guidance may be provided on the BOR issue.

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. It may also be prudent to identify any service provider that receives any compensation at all related to the plan, especially indirect compensation, regardless of whether the plan has historically viewed the providers as consultants or brokers, and reevaluate their status in relation to the plan and under these new rules.
- 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. ■