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HEALTH & WELFARE PLAN LUNCH GROUP

June 6, 2024

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INDEX

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0

Health & Welfare Benefits
MONTHLY UPDATE

June 2024 Agenda

- Regulatory Update
- Impact of Investment Fiduciary Rule on HSAs
- H&W Plan ERISA Fiduciary Obligations

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1

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REGULATORY UPDATE

2

Health & Welfare Benefits
MONTHLY UPDATE

Regulations Status Update

Recently Finalized Rules

- DOL **Definition of "Employer"--Association Health Plan** Notice of Proposed Rulemaking to rescind 2018 AHP Rule (December 20, 2023); comment period ended February 20, 2024; Final Rule published in FR on April 30, 2024.
- DOL Proposed Rule on **Definition of an Investment Advice Fiduciary** and Proposed Changes to Related PTEs (Nov. 3, 2023); comment period ended Jan. 2, 2024; Final Rule published in FR on April 25, 2024.
- HHS Office of Civil Rights (OCR) Final Rule on the **HIPAA Privacy Rule and Reproductive Health Care** (Apl. 17, 2023); comment period ended June 16, 2023; Final Rule published in FR on April 26, 2024.
- HHS-OCR Proposed Rule on **Nondiscrimination in Health Programs and Activities (1557)** (Aug. 4, 2022); comment period ended October 2022; Final Rule published in FR on May 6, 2024.
- **STLDI, Independent, Non-Coordinated Excepted Benefits, Level Funded Arrangements** and Treasury Proposed Rule on **Tax Treatment of Certain Accident and Health Benefits** (July 12, 2023); comment period ended Sept. 11, 2023; Final Rule published in FR on April 3, 2024.
- HHS Final Rule **Notice of Benefit and Payment Parameters 2025 (Nov. 24, 2023);** comments period ended Jan. 8, 2024; Final Rule published in FR on April 15, 2024.
- Tri-Agency Proposed Rules on **Federal IDR Process Administrative Fee and Certified IDR Entity Fee Ranges** (Sept. 26, 2023); comment period ended Oct. 26, 2023; Final rule published in FR on December 21, 2023.

Health & Welfare Benefits
MONTHLY UPDATE

Regulations Status Update (cont.)

- Tri-agency Proposed Rules on **Federal IDR Operations** (Nov. 3, 2023); comment period ended Jan. 2, 2024 but was re-opened until Feb. 5, 2024.
- Tri-agency Request for Information on **Coverage of OTC Preventive Services** (Oct. 4, 2023); comment period ended Dec. 4, 2023
- Tri-Agency Proposed Rules on **MHPAEA** (Aug. 3, 2023); comment period ended Oct. 17, 2023
- Tri-Agency Proposed Rules on **Coverage of Certain Preventive Services Under the ACA** (Feb. 2, 2023); comment period ended April 3, 2023

Health & Welfare Benefits
MONTHLY UPDATE

Association Health Plan

Recently Finalized Rules

- DOL **Definition of "Employer"--Association Health Plan** Notice of Proposed Rulemaking to rescind 2018 AHP Rule (December 20, 2023); comment period ended February 20, 2024; Final Rule published in FR on April 30, 2024.
- ERISA 3(5) defines "employer" to include a bona fide group or association of employers.
- Pre-2018 Rule interpretative guidance was drawn from several ERISA opinion letters.
- Under the pre-rule guidance it was generally understood that no bona fide group or association of employers can exist if several unrelated employers without any genuine organizational relationship merely execute participation agreements or similar documents as a way to fund ERISA-covered benefits.
- The 2018 AHP Rule established alternative criteria that set the bar significantly lower than pre-rule guidance (e.g., allowed the provision of health coverage as a primary purpose).
- Rescission of the 2018 Rule raises the bar back to where it was under the pre-rule guidance.

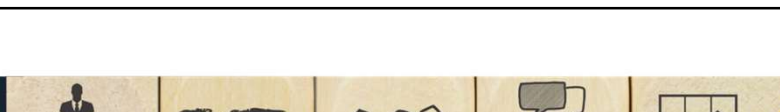
Health & Welfare Benefits
MONTHLY UPDATE

HIPAA Privacy Rule and Reproductive Health Care

Recently Finalized Rules

- HHS Office of Civil Rights (OCR) Final Rule on the **HIPAA Privacy Rule and Reproductive Health Care** (Apl. 17, 2023); comment period ended June 16, 2023; Final Rule published in FR on April 26, 2024.
- Prohibits use or disclosure of PHI
  - To conduct a criminal, civil, or administrative investigation into or impose criminal, civil, or administrative liability on any person for seeking, obtaining, providing, or facilitating reproductive health care, where such health care is lawful.
  - To identify any person for the purpose of conducting such investigation or imposing such liability.
- The Rule includes a presumption that the reproductive health care, when provided by someone other than the covered entity receiving the request for the PHI, was lawful, unless:
  - The covered entity receiving the request has actual knowledge that it was not lawful, or the person making the request presents factual information that demonstrates a substantial factual basis that the reproductive health care was not lawful.
- Attestation requirement: When plans receive requests for reproductive health care PHI, the plan must obtain a signed attestation that the use or disclosure is not for a prohibited purpose.
- Notice of Privacy Practices: NPPs need to be revised to support reproductive health care privacy.
- HIPAA Business Associate Agreements will need to be updated to address the prohibitions on uses or disclosures of PHI for Reproductive Health Care.
- HIPAA Policies and Procedures will also need to be updated too.

Health & Welfare Benefits
MONTHLY UPDATE



Nondiscrimination in Health Programs and Activities (1557)

- HHS-OCR Proposed Rule on **Nondiscrimination in Health Programs and Activities (1557)** (Aug. 4, 2022); comment period ended October 2022; Final Rule published in FR on May 6, 2024.
- Generally, any health program or activity that receives Federal financial assistance (FFA) from HHS or that is administered by an executive agency or by an entity established by Title I of the ACA is covered by the 2024 Rule (limited exemption for Federal religious freedom and conscience objections).
- Definition of "health program or activity":
  - Includes "health insurance issuer," which has implications for insurer TPAs and the self-insured plans they administer.
  - Does not include GHPs, though GHPs could be subject to the 2024 Rule if the GHP itself receives FFA.
- 2024 Rule does not apply to any "employer or other plan sponsor" of a GHP with regard to its "employment practices", including the "provision of employee health benefits", which "includes when the Federal financial assistance received is for their employee health benefits."
- Applies to telehealth; Medicare Part B is FFA.

Health & Welfare Benefits
MONTHLY UPDATE

Nondiscrimination in Health Programs and Activities (1557) (cont.)

What does a Covered Entity need to do to comply with the 2024 Rule?

- Provide an assurance when applying for FFA that it will comply as a condition of receiving the FFA. Duration of this obligation lasts for as long as FFA is extended.
- If CE employs 15+, CE must designate §1557 coordinator to ensure compliance, manage the grievance procedure, and coordinate training.
- Implement written policies and procedures, including a nondiscrimination policy, grievance procedures, language access procedures, effective communication procedures, and reasonable modification procedures.
- Provide training to the relevant employees to implement the policies and procedures.
- Must provide the following notices:
  - Notice of nondiscrimination, which must include (among other things) how to obtain language assistance services and appropriate auxiliary aids; contact information for the §1557 coordinator; how to file a grievance with the covered entity and a complaint with OCR.
  - Notice of availability of language assistance and auxiliary aids and services

Health & Welfare Benefits
MONTHLY UPDATE

Nondiscrimination in Health Programs and Activities (1557) (cont.)

Although the 2024 Rule is generally effective on July 5, 2024 (60 days after its May 6th publication in the Federal Register), the complexities of this rule require separate effective dates for various provisions:

Section 1557 Requirement	Date by which covered entities must comply
Designate a §1557 Coordinator	Within 120 days of July 5, 2024.
§1557 Policies and Procedures	Within one year of July 5, 2024.
§1557 Training	Following a covered entity's implementation of the policies and procedures, and no later than 300 days of July 5, 2024.
Notice of Nondiscrimination	Within 120 days of July 5, 2024.
Notice of Availability of Language Assistance Services and Auxiliary Aids and Services	Within one year of July 5, 2024.
Nondiscrimination in health insurance coverage and other health-related coverage (benefit design changes)	For health insurance coverage or other health-related coverage that was not subject to the 2024 Rule as of May 6, 2024, by the first day of the first plan year beginning on or after January 1, 2025.

Health & Welfare Benefits
MONTHLY UPDATE

Other Updates--HIPAA

Office of Civil Rights (OCR) issued FAQs that provide a general review of HIPAA's breach notification requirements in the context of the Change Healthcare breach.

- No breach report has been filed with OCR as of the date of the FAQs. Breaches reported to OCR are not posted the same day; OCR can take up to 14 days to verify reported breaches before posting.
- CEs are ultimately responsible for ensuring breach notifications occur. OCR states that "Affected covered entities should coordinate with Change Healthcare and UHG on who will be providing breach notifications."
- BAs must provide notice to CEs of a breach without unreasonable delay an in no case later than 60 days from discovery date.
- OCR will not consider the 60-calendar day period from discovery of a breach by a CE to start until affected CEs have received the information needed from Change Healthcare or UHG.
- Only one entity—which could be the CE itself or its BA—needs to complete notifications to affected individuals, HHS, and the media. CEs affected by this breach that ensure that Change Healthcare performs the required HIPAA-compliant breach notifications have no additional HIPAA breach notification obligations.
- OCR quotes from UHG's website: that they "are not announcing an official breach notification at this time. To help ease reporting obligations on other stakeholders whose data may have been compromised as part of this cyberattack, UnitedHealth Group has offered to make notifications and undertake related administrative requirements on behalf of any provider or customer."

Health & Welfare Benefits
MONTHLY UPDATE

Other Updates—Gag Clause Instructions

DOL, HHS, and IRS have jointly updated the Submission Instructions and User Manual for the Gag Clause Prohibition Compliance Attestation (GCPCA):

- Webform and template allow for precisely defining the date range to which the attestation applies.
- Employer plan types are expanded to include 3 categories for GHPs: (1) ERISA group health plan (GHP) or sponsor of ERISA plan,* including a plan sponsored or established by a union; (2) (Non-Federal) governmental group health plan; (3) Church plan
- "Reporting Entity" changed to "Responsible Entity" and Responsible Entity types expanded in the instructions to clarify that ERISA group health plan (GHP), or sponsor of ERISA plan, includes a plan sponsored or established by a union.
- Clarified labels in webform and template regarding types of provider agreements: (1) Medical network; (2) Pharmacy benefit manager network; (3) Behavioral health network; (4) Other
- Modified attestation language to remove forward-looking agreement actions to accommodate date range and information provided through the submission process: I attest that […] the group health plan(s) […] on whose behalf I am signing ~~will not enter into an agreement, and has not, subsequent to December 27, 2020~~has not, for the dates specified and as provided in the foregoing information, entered into an agreement with a health care provider, network or association of providers […]

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ERISA Investment Fiduciary Rule – A First Look for HSAs

12

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MONTHLY UPDATE

ERISA Fiduciary Rule: Top Line Issues for HSAs

- Does the rule apply to HSAs?
- When does the rule apply?
- What HSA-related service are subject to the rule?
- What is investment advice?
- Can an HSA service provider receive investment related compensation?
  - PTE 2020-02 and its expanded application to NBTs
- What does PTE 2020-02 Require

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A Little History

- Original definition of fiduciary
  - 1975 5 Part test
    - Investment related recommendation
    - Advice provided on a regular basis
    - Pursuant to mutual understanding
    - The advice will serve as primary basis for decision making
    - The advice is individualized
- DOL believed changes needed
  - Did not apply to rollovers to IRAs
  - Misleading statements and disclaimers regarding fiduciary status made 1975 rule too easy to avoid
  - Environment has changed. In 1975, rule primarily applicable in context of advisers and (more sophisticated) DB plans
- An example: The vacation home chat

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Does the Rule Apply to HSAs

- Yes. Consistent with 2020 proposed rule (and 2016 proposal) HSAs (like IRAs) are covered by the Investment Fiduciary Rule.
- This means entities that provide investment recommendations (Now broadly defined) and receive compensation must comply with rule (and PTE 2020-02) or they engage in a prohibited transaction

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When does the Rule apply?

- Effective generally 150 days after published (9/23/24)
  - One year phase in period if comply with Impartial Conduct Standards and acknowledge fiduciary status in writing
- This period is much shorter than period (even without extensions) under 2016 proposal
- But won't the Rule be tied up in litigation?
  - Litigation will most definitely ensue, and many argue that the new Rule is essentially the same as the old Rule invalidated by the Fifth Circuit

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In what situations does the Rule apply?

- A person is a fiduciary if . . .

  The person either directly or indirectly (e.g., through or together with any affiliate) makes professional investment recommendations to investors on a regular basis as part of their business and the recommendation is made under circumstances that would indicate to a reasonable investor in like circumstances that the recommendation is based on review of the retirement investor's particular needs or individual circumstances, reflects the application of professional or expert judgment to the retirement investor's particular needs or individual circumstances, and may be relied upon by the retirement investor as intended to advance the retirement investor's best interest.

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MONTHLY UPDATE

In what situations does the Rule apply?

- An individual making an investment recommendation is a fiduciary if they:
  - Make a professional investment recommendation and receive compensation
  - On a regular basis as part of their business
  - Under circumstances that a reasonable investor would believe
    - is based on the investor's needs or individual circumstances,
    - reflects the exercise of professional judgment to the investor's circumstances,
    - And may be relied upon to advance the investor's best interest.

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In what situations does the Rule apply?

- The Rule would apply whenever an "investment recommendation" is made for a "fee or other compensation."
  - Investment recommendation is defined very broadly, and could pick up almost any activity where an investment (or deposit) is made and compensation is paid to an HSA bank, custodian, or service provider
- For example . . . Consider for HSAs
  - Offering a menu of investments
  - Offering a deposit option
    - Deposit status as outside purview of SEC cited as one reason for why Rule needed
  - Employer involvement
  - Call center activity
  - Robo-advice

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What HSA services are subject to the rule?

- The Rule could apply with regard to the selection of mutual fund investments, menus of investment options, and deposit options
  - No practical menu or platform exception for HSAs
    - Providing a selective list of securities is most likely a recommendation
    - Conundrum
      - Rule describes exception for "providers who merely identify investment alternatives using objective third-party criteria (e.g., expense ratios, fund size, or asset type specified by a plan fiduciary)" as long as no recommendation is made.
      - But, if you provide a selective list of what is appropriate, that could be a recommendation
- Is there an exception for sales or RFP response prior to engagement
  - Rule discusses a "hire me" exception that is applicable if the circumstances would not cause a reasonable person to believe that the salesperson's recommendation is based upon the individual's circumstances or that it may be relied upon as advancing his or her best interests.
- Disclaimers are not controlling
- Limited exception for investment education
  - No new definition
  - See Interpretive Bulletin 96-1

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Agency Commentary on HSAs

- Based on the commenters' descriptions of HSA operations, the Department agrees that HSA providers may fall within the analysis regarding platform providers . . . which confirms that providers who merely identify investment alternatives using objective third-party criteria (*e.g.*, expense ratios, fund size, or asset type specified by the plan fiduciary) to assist plan sponsors and plan fiduciaries in selecting and monitoring investment alternatives, *without additional screening or recommendations based on the interests of the retirement investor,* would not be considered under the final rule to be making a recommendation. . . .
  - a provider does not make a recommendation merely by offering a preset list of investments as part of a variable annuity, or offering a menu of pre-selected HSA investment options, without additional facts.
  - In this context, the parties can also define their relationship pursuant to paragraph (c)(1)(iv) [disclosure regarding fiduciary status] so long as they conform their other actions and communications accordingly.
  - The Department does not agree, however, that mere website disclosure that the investment menu provider is not undertaking to provide impartial investment advice or to give advice in a fiduciary capacity should be dispositive, as suggested by one commenter. In this context, as in other contexts, one must consider all the relevant facts and circumstances and apply them to the tests set forth in the rule. For example, such website disclosure, even if reviewed by the retirement investor, would not defeat fiduciary status to the extent it was inconsistent with other communications and actions by the firm or financial professional that met the terms of the rule's objective test and demonstrated that the recommendation was given from a position of trust and confidence
- However, to the extent that a person satisfies the rest of the rule's requirements to any of these retirement investors, the Department does not see a reason to treat them differently or provide a lower level of protection for them than other plans covered by ERISA Title I or Title II.
- To address commenters' concerns about prohibited transaction relief, the Department has accepted the commenters' recommendation to allow IRS-approved non-bank trustees and custodians to rely on the prohibited transaction relief in PTE 2020–02 when they are serving in these capacities with respect to HSAs.

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So what if the Investment Fiduciary definition applies?

- Receipt of compensation is a prohibited transaction
  - IRC 4975 penalties apply
- Compensation allowed if the requirements of PTE 2020-02 satisfied

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MONTHLY UPDATE

What does PTE 2020-02 Require ?

- Acknowledge Fiduciary Status in writing
  - Must be an actual acknowledgment not a "may be a fiduciary if . . ."
- Impartial Conduct Standard
  - Care and Loyalty obligation (fka "BIC" or "Best Interest" requirement)
  - Reasonable Compensation and Best Execution
  - No Materially Misleading Statements
- Policies and Procedures
- Pre-Transaction Disclosures
  - Care and Loyalty Obligations
  - Fees and Conflicts
- Retrospective annual review and reporting
- 10 year bar on services for certain convictions
  - Including flagrant noncompliance with rule

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Changes from Prior Best Interest Contract Requirements

- Contract requirement dropped
- No warranty requirement
- 2020-02 expanded to pick up
  - Robo advice
  - NBTs

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MONTHLY UPDATE

DOL Model Disclosure Form

Model Disclosure Covering Care and Loyalty Obligation

- We are making investment recommendations to you regarding your [H S A] as fiduciaries within the meaning of Title I of the Employee Retirement Income Security Act and/or the Internal Revenue Code, as applicable, which are laws governing retirement accounts. The way we make money or otherwise are compensated creates some conflicts with your financial interests, so we operate under a special rule that requires us to act in your best interest and not put our interest ahead of yours.
- Under this special rule's provisions, we must:
  - Meet a professional standard of care when making investment recommendations (give prudent advice) to you;
  - Never put our financial interests ahead of yours when making recommendations (give loyal advice);
  - Avoid misleading statements about conflicts of interest, fees, and investments;
  - Follow policies and procedures designed
  - Charge no more than what is reasonable for our services; and
  - Give you basic information about our conflicts of interest to ensure that we give advice that is in your best interest;

Additional language required to address

- Material facts related to services and fees
- Material facts related to conflicts of interest

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MONTHLY UPDATE

Policies and Procedures

- Must be designed to ensure compliance with Impartial Conduct Standard
- Must mitigate conflicts of interest
  - Impact on incentive/sales compensation
  - Special rule in context of proprietary funds
- Must provide to DOL within 30 days of request

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MONTHLY UPDATE

Pre-Transaction Disclosure

- All material facts related to terms of relationship including
  - Material fees and costs
  - Types of services provided and any limitations
- All material facts related to any conflicts of interest associated with the recommendation

Steps to Compliance

- Evaluate if/when an investment recommendation is made:
  - Sales situation
  - Investment menu offering
  - Deposits
  - Call center
- Evaluate steps necessary for PTE 2020-02. Create infrastructure for . . .
  - Acknowledge Fiduciary Status in writing
  - Impartial Conduct Standard
    - Care and Loyalty obligation (fka "BIC" or "Best Interest" requirement)
    - Reasonable Compensation and Best Execution
    - No Materially Misleading Statements
  - Policies and Procedures
  - Pre-Transaction Disclosures
    - Care and Loyalty Obligations
    - Fees and Conflicts
  - Retrospective annual review and reporting
- Discuss whether/when/how to pull the trigger

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Welfare Plans-- Fiduciary Checkup

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Who Are the Fiduciaries

- "Plan Administrator" (ERISA §3(16)).
- The "Named Fiduciary" in welfare plan documents (ERISA §402).
- Any person using discretion in administering and managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control (ERISA §3(21)(A)).
- Identify plan fiduciaries through formal delegation. This can be done in plan documents and establishing a health and welfare benefits committee.
- Consider a committee charter to set forth committee responsibilities and any limitations on authority

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MONTHLY UPDATE

Fiduciary Duties

- Fiduciary duties:
  - Acting solely in the interest of plan participants and their beneficiaries and with the exclusive purpose of providing benefits to them and paying reasonable plan expenses;
  - Acting prudently;
  - Following the plan documents (unless inconsistent with ERISA);
  - Holding plan assets in trust (special rules for certain welfare plans paid out of an employer's general assets).
- Certain "settlor actions" are not governed by ERISA such as establishing, amending, or terminating a plan as well as aspects of plan design.

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MONTHLY UPDATE

General Practices

- Ensure that plan fiduciaries understand the extent of their fiduciary responsibilities (e.g., responsibility for plan documents, administrative compliance and vendor oversight) through fiduciary training.
- Consider regular meetings with counsel (inside or outside when necessary) to raise issues, vendor monitoring and learn of new developments. How frequently—bi-weekly, monthly, quarterly?
- Timely deposits of participant contributions and forwarding to insurance companies where applicable ("low hanging fruit" for DOL).
- Use of participant contributions exclusively for plan benefits or reasonable plan expenses.
  - Defining what is the "plan" when multiple benefits are offered.

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MONTHLY UPDATE

General Practices

- Identify plan assets--even for benefits paid out of an employer's general assets-- and apply assets to the appropriate "plan".
  - Participant contributions are always plan assets;
  - Rebates or credits from parties in interest can be plan assets (technology/communication/innovation credits from ASOs/TPAs/PBMs);
  - MLR rebates;
  - Special issues for stop loss insurance and making sure premiums are ***not*** paid with plan assets.
- Review plan document/SPD to be sure it conforms to plan operations and make necessary updates.
- After making plan amendments, ensure that participants are provided with an updated summary plan description or summary of material modifications. Retirement plan electronic safe harbor is ***not*** applicable to welfare plans.
- When was the last update to the SPD? Are all ERISA welfare benefits covered by an SPD whether a wrap or otherwise (e.g. EAP, wellness, disease management, onsite clinic, ERISA-covered voluntary benefits, severance, prepaid legal services etc.)? Does the SPD meet all regulatory requirements for content?

Health & Welfare Benefits
MONTHLY UPDATE

General Practices

- Review SPD and plan documents for "Firestone language" to obtain an abuse of discretion standard in benefits litigation. Make sure language is applicable to all who are making benefits decisions (e.g. claims administrators).
- Make sure any other delegation of fiduciary responsibility is appropriately documented.
- Ensure the plan has a procedure for handling QMCSOs .
- Identify parties in interest to the plan and take steps to monitor transactions with them. Be familiar with the major exemptions under ERISA that permit transactions with parties in interest (e.g., such as those applicable for affiliated insurance and/or brokers).
- Ensure that required reports are filed timely, such as the Form 5500 and any applicable tax returns (990 or 990T for VEBA), RxDC reporting, gag clause attestation etc.
- Review any required bonding (primarily funded plans).
- Review fiduciary liability insurance.

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Increased litigation in this area (e.g. Johnson & Johnson complaint).
- Give each potential service provider complete and identical information about the plan and the services needed so a meaningful comparison can be made.
- Get information from more than one provider.
- Compare firms/providers based on the same information, such as services offered, experience, costs, etc.
- Obtain information about the firm/provider itself, including its financial condition and its experience with group health plans of similar size and complexity.

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Document the selection and monitoring process, and, when using an internal administrative committee, educate committee members on their roles and responsibilities.
- Read, understand, and keep copies of all service contracts.
- Establish a formal review process and follow it at reasonable intervals to decide whether to continue using the current service providers or look for replacements. Periodic review of:
  - Provider fees;
  - Benefit pricing;
  - Contract rates;
  - §408(b)(2) disclosures;
  - Claims audits for payment accuracy and trends in approval/denial.

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Evaluate information about the quality of the service provider:
  - the identity, experience, and qualifications of professionals who will be providing services;
  - any recent litigation or enforcement action taken against the provider;
  - the provider's experience or performance record;
  - the procedures in place to timely consider and resolve participant questions and complaints;
  - the procedures for participant record confidentiality; and enrollee satisfaction statistics;
  - ensuring that any required licenses, ratings or accreditations are up to date (insurers, brokers, TPAs, health care service providers);
  - liability insurance including cyber.

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- When monitoring service providers, employers should act to ensure the service providers are performing the agreed upon services including:
  - Reviewing the service providers' performance;
  - Reading any reports they provide;
  - Checking actual fees charged (more on fees in a later slide);
  - Asking about policies and practices (such as a third-party administrator's claims processing systems);
  - Ensuring proper maintenance of plan records; and
  - Following up on participant complaints.
- Document the review process

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Special Issues for ASOs/TPAs/PBMs
  - Comparing amounts paid to medical providers and pharmacies.
    - Focus of the J&J complaint as to amounts paid for RX.
    - Look at median contracted rates by CPT code for services used for QPA?
    - Any way to leverage machine readable files or price comparison tools?
    - Can you leverage RxDC reporting and obtain data that way?
    - Comparison of medical provider reimbursement for one network as compared to another can be ***extremely*** difficult as can comparison of prices a plan pays for RX.
    - Funded plans (i.e. a trust) likely means the analysis is more critical.
  - Network depth and quality (especially with focus on mental health and substance use disorders).

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Special Issues for ASOs/TPAs/PBMs (cont.)
  - Access to claims data;
    - Verifying that the plan is paying medical providers the correct amount.
    - What does your services agreement say?
    - How often can you audit? How many claims?
    - What are the restrictions on the audit results and expanding the audit?
    - What is the remedy under the agreement if claims are erroneously paid or paid at the incorrect amount?
    - Employers/plans in current litigation with ASOs/TPAs on allegedly failing to provide claims data as well as erroneous payment of claims.

Health & Welfare Benefits
MONTHLY UPDATE

Selection and Monitoring of Service Providers

- Special Issues for ASOs/TPAs/PBMs (cont.)
  - What assistance will they provide, and will they comply with CAA/MHPAEA requirements (and what will be charged).
    - QTL testing;
    - NQTL comparative analysis;
    - MRF file posting;
    - RxDC reporting,;
    - Taking No Surprises Act (NSA) claims through independent dispute resolution;
    - NSA disclosures;
    - Gag clause;
    - Requirements regarding provider directories and identification cards;
    - Advance explanation of benefits (once required);
    - Price comparison and self-service tools.
    - Continuity of care.

Health & Welfare Benefits
MONTHLY UPDATE

Service Provider Fees

- There has always been a requirement under §408(b)(2) of ERISA that "no more than reasonable compensation" be paid to a service provider to fall within the prohibited transaction exemptoin.
- For brokers and consultants, the CAA incorporated into §408(b)(2) a ***very*** detailed list of required disclosures for both direct and indirect compensation
  - If a service provider claims that they are not covered under the CAA as a broker or consultant, have they put that in writing and provided a rationale?
  - If disclosures have been provided, have they been reviewed by plan fiduciaries to determine reasonableness?
- When comparing estimates from prospective service providers, ask which services the estimated fees cover and which they do not. Take into account "bundled" service arrangement versus separate charges for individual services.

Health & Welfare Benefits
MONTHLY UPDATE

Service Provider Fees

- Compare all services to be provided with the total cost for each provider.
- Consider whether the estimate includes services that were not requested or are not wanted.
- If not covered under the CAA's ERISA §408(b)(2) disclosures, ask prospective providers whether they receive any third-party compensation, such as finder's fees, commissions, or revenue sharing. Establish a process to regularly monitor plan fees for reasonableness.
- Look at payments to subcontractors and any related parties.
- Consider conducting an RFP every few years (or use a consultant) to benchmark fees, compare available pricing options and service providers, and evaluate negotiated pricing for products and services accessed through the service provider.
- No contract with a service provider is reasonable unless it provides for "termination by the plan without penalty to the plan on reasonably short notice under the circumstances to prevent the plan from becoming locked into an arrangement that has become disadvantageous."

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MONTHLY UPDATE

Service Provider Fees

- Special issues for ASOs/TPAs/PBMs.
  - Fees based on "shared savings". For example, a fee based on 25% of the difference between billed charges and what was allowed for an out of network provider. Fees as a percentage of any class action recovery on behalf of the plan. Fees as a percentage of subrogation or reimbursement.
    - Not prohibited but ask for estimates and ongoing reports.
  - What is the fee for engaging in the IDR process.
  - For PBMs look at:
    - Spread pricing (charging the plan a higher price for medications than what they pay to pharmacies and keeping the difference).
    - Manufacturer's rebates. How are they defined and how keeps them.
    - Proprietary specialty pharmacies.

Health & Welfare Benefits
MONTHLY UPDATE

Claims and Appeals Process

- Understand who is handling claims and appeals and that it is appropriately documented for each benefit/plan. Likely different for different benefits (e.g. group health plan, dental, vision, FSAs, severance etc.) If there is a PBM apart from the group health plan are there claims and appeal procedures.
- If there is a separate claims administrator, do they handle each level of claim and appeal?
  - Procedures for external review and IROs.
- Is there a compliant written claims and appeals procedure for each benefit/plan (e.g. EAP or on-site clinic)? Consider a "back up" written procedure.
- Are all claims' administrators adhering to the timelines for responding to claims and appeals? Special accelerated timelines for group health plans in comparison to retirement plans.
- Do adverse benefit determinations contain all required information (including any contractual statue of limitations?

46