NORTHEAST
BUSINESS GROUP ON HEALTH

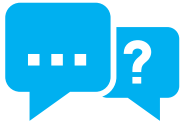
LET'S GET CLEAR ON

Employer Fiduciary Responsibilities

TUESDAY, JULY 11, 2023
12:00 - 1:00PM

Webinar Procedures

All lines will be muted



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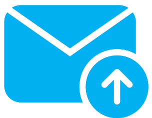

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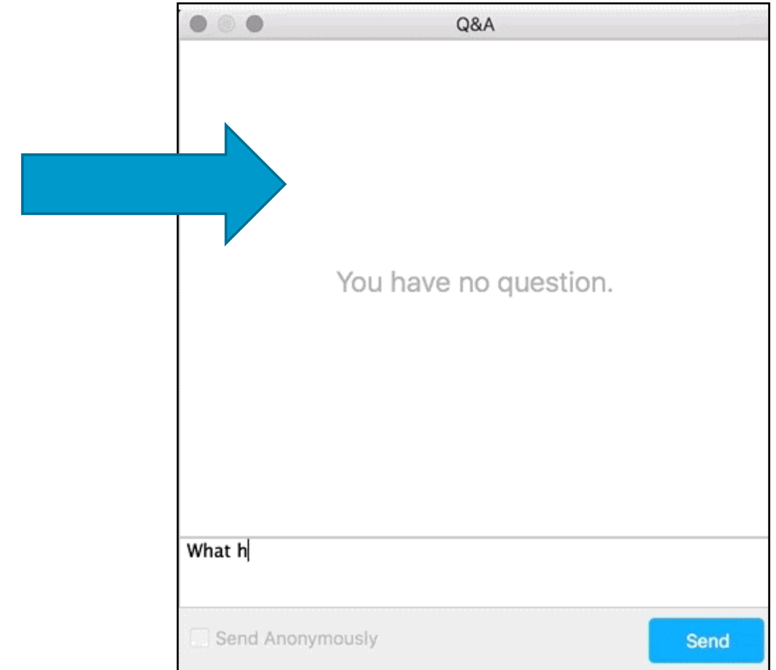

NORTHEAST BUSINESS GROUP ON HEALTH

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Employer Fiduciary Responsibilities for Group Health Plans

NEBGH

July 11, 2023

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What Is ERISA?

Employee Retirement Income Security Act of 1974

Imposes stringent standards on those with discretionary authority over employee benefits plans and plan assets

Imposes very strict rules prohibiting conflicts of interest and insider dealing

Allows plan participants, the Department of Labor ("DOL"), and subsequent fiduciaries to bring suit to enforce ERISA's provisions

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Key Points on Serving as an ERISA Fiduciary

Separate Position. Serving as a health & welfare plan fiduciary is **not** just an additional part of an employee's work responsibilities for the Company. Serving as a health & welfare plan fiduciary is akin to working for a separate employer whose exclusive business is promoting the interests of the plans and participants in the Plans.

High Standard of Conduct. The ERISA fiduciary standards applicable to a health & welfare plan fiduciary are often higher than the standards that apply in normal corporate settings, as a health & welfare plan fiduciary is charged with holding and safeguarding the property of others. The "fiduciary standards" are discussed in more detail below. Corporate standards like the "business judgment rule" generally do not apply.

Knowledge Cannot Be Left at the Door. Under ERISA, plan fiduciaries are not free to disregard knowledge acquired from other sources in exercising their duties and responsibilities.

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Key Points (*Cont'd*)

Interests of Employer/Sponsor Not Relevant. ERISA does not permit fiduciaries to make decisions for plans and plan participants based on what is in the best interests of employers or plan sponsors.

Fiduciaries Have an Affirmative Duty to Avoid Prohibited Transactions. ERISA imposes an affirmative duty on fiduciaries to avoid having plans engage in transactions that benefit persons who have pre-existing plan relationships with the plans, unless the transaction benefits from a statutory or regulatory exemption. This rule is particularly important where the plan sponsor is in the health industry and the plan utilizes the sponsor's services or products.

Fiduciaries May Be Personally Liable to Plan. Fiduciaries may be held personally liable to a plan for plan claims and losses. ERISA prohibits a plan (but not a plan sponsor) from indemnifying a fiduciary.

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ERISA Fiduciaries

Who is an ERISA fiduciary?

Named in plan documents

Functional test

A person is an ERISA fiduciary with respect to a plan to the extent they do any of the following:

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ERISA Fiduciaries (*Cont'd*)

Who is an ERISA fiduciary?

- Fiduciaries include:
  - Plan sponsors
  - HR administrators
  - Health and welfare plan committee
  - Professionals who give advice related to the plan
  - Those responsible for selecting who sits on the plan committee

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Settlor Functions

Some decisions concerning an ERISA plan are settlor rather than fiduciary decisions

Fiduciary duties do not apply to settlor functions

Be careful, even where a particular decision is a settlor function, the mechanics of carrying the decision out may be a fiduciary function

Settlor functions generally involve business decisions external to the plan such as

- Whether to offer an ERISA plan
- Whether to amend the terms of the plan
- What level of benefits should be offered
- Whether to terminate the plan

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Why Does It Matter Who Is An ERISA Fiduciary?

"A fiduciary's duties under ERISA are 'the highest known to law.'" *Reich v. Valley Nat'l Bank*, 837 F. Supp. 1259, 1273 (S.D.N.Y. 1993) citing *Donovan v. Bierwirth*, 680 F.2d 263, 272 n.8 (2d Cir. 1982)

ERISA fiduciaries can be held personally liable to reimburse the plan for any losses it suffers due to a breach of fiduciary duty

Fiduciaries can be held liable for failing to prevent ERISA violations of their co-fiduciaries

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General Fiduciary Duties Under ERISA

Prudence: Reasonable person standard

Loyalty: Act for the exclusive benefit of participants and beneficiaries

Adhere to Documents: Act in accordance with documents and instruments governing the plan, to the extent such documents comply with ERISA

Compliance: Avoid prohibited transactions and follow various ERISA compliance requirements

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Consolidated Appropriations Act of 2021

Fee Disclosure Requirements

- The CAA set forth new compensation disclosure requirements applicable to certain service providers who enter into contracts or arrangements to provide “brokerage” or “consulting” services to group health plans subject to ERISA
  - DOL has stated that one is subject to the disclosure requirements if the services are brokerage or consulting, even if they do not identify or are not licensed as a broker or consultant
  - Applies to group health plans (insured and self-insured, large and small, HRAs and health FSAs) and excepted benefits such as dental and vision plans
- Covered service providers must disclose in writing the direct and indirect compensation that is expected to be received in connection with a contract or arrangement between the covered service provider and the plan and other details about the services relationship
- Fee disclosure requirements are intended to help plan fiduciaries recognize and prevent potential conflicts of interest that can arise when plan service providers are compensated from third parties
- Disclosures on Form 5500 (Schedule C) – trust-funded group health plans

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Consolidated Appropriations Act of 2021 (cont'd)

Fee Disclosure Requirements

- Applies to broker and consultant contracts entered into, extended or renewed on or after December 27, 2021
- Contracts with service providers who do not disclose required information will be deemed unreasonable and constitute a prohibited transaction
  - Plan fiduciaries required to ensure that service providers to the plan are only receiving "reasonable" fees
- Fiduciary litigation risk
- Action steps for group health plan sponsors subject to ERISA
  - Request and receive required compensation disclosures prior to signing contracts, renewals, or extensions with covered service providers
  - Scrutinize fee information, specifically indirect compensation in determining whether the fees are reasonable, specifically if plan assets are used to pay service providers
  - Document process and analysis
  - Potentially consider creation of a benefits committee

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Mental Health Parity & Addiction Equity Act (MHPAEA)

- The MHPAEA prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.
- Fundamentally a consumer protection anti-discrimination statute
- MHPAEA and its implementing regulations and sub-regulatory guidance effectuate this anti-discrimination requirement through a complex series of tests.
- Consolidated Appropriations Act of 2021 requires group health plans to make available to regulators and/or participants a comparative analysis of the design and application of non-quantitative treatment limits
  - Anything that has effect of limiting a beneficiary's access to services can be an NQTL (ex: prior authorization)
  - Factors, sources, and evidentiary standards used to apply NQTLs to MH/SUD benefits **must be comparable and no more stringent** relative to M/S benefits, both "as written" and "in operation"

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Mental Health Parity & Addiction Equity Act (MHPAEA)

Plans must disclose the comparative analysis and related information to the DOL upon request

- Participants and beneficiaries may also request this information under general ERISA disclosure rules

Creates new authority for DOL to enforce parity with regard to insurance issuers

Increased enforcement action by the DOL with a large number of open investigations

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Mental Health Parity & Addiction Equity Act (MHPAEA)

Best Practices for Compliance Programs

- Conduct a preliminary parity risk assessment
  - Analyze existing parity documentation for key NQTL types, quantitative testing for financial requirements, and definitions for conditions and classifications
- Develop formal policies and processes that govern parity compliance
  - Designate key personnel responsible for ongoing compliance and governance
  - Annual reviews of the 5-step NQTL analyses and operations measures data
  - Update programmatic P&Ps, committee reporting templates, and other related documents as needed to maintain alignment with NQTL analyses
  - Internal communication plan for provider and member complaints, issues identified by regulators, and new guidance and enforcement
  - Regular collaboration with TPA
- Train all relevant personnel on parity requirements
  - Train on key parity requirements and documentation (NQTLs and QTL/FRs)
  - Explain ongoing personnel roles in maintaining parity compliance
- Monitor TPA parity activities; conduct a regular review of parity documentation, particularly NQTLs
- Monitor federal and state guidance and enforcement and private litigation

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Cybersecurity Obligations

Plan fiduciaries have a duty to mitigate a plan's cybersecurity risks

Plan fiduciaries must prudently select service providers with strong cybersecurity practices and monitor the service providers

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No Surprises Act and Transparency in Coverage

- Part of the Consolidated Appropriations Act, signed into law on December 27, 2020
- Effective January 1, 2022
- Addresses balance billing plan participants, transparency in health care and additional patient protections
- Applies to group health plans
  - Does not apply to excepted benefits, short-term, limited duration insurance, health reimbursement arrangements or other account-based group health plans

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Prohibition on Gag Clauses

- Gag clauses are prohibited from being included in agreements between providers and group health plans (or insurers) that restrict the plan or insurer from:
  - Disclosing provider-specific cost or quality-of-care information or data to plan sponsors, referring providers, or eligible individuals; or
  - Electronically accessing de-identified claims information (in accordance with HIPAA, GINA and the ADEA); and
  - Sharing this information with a business associate
- FAQs released on February 23, 2023 by the Departments of Labor, Health and Human Services and the Treasury require health plans and health insurance issuers to submit their first attestation of compliance with the CAA's prohibition of gag clauses by December 31, 2023
  - Must be submitted annually
- Self-insured plans required to complete the attestation
  - Can enter into a written agreement with the TPA where the TPA will provide the attestation on the plan's behalf
  - Still required to ensure timely attestation occurs
- Employers should ensure contracts with TPAs and other providers do not violate the prohibition on gag clauses

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Machine Readable Data Files

- Machine readable data files requirements became effective July 1, 2022
- Plan sponsors and insurers are required to make available online (and update monthly) three machine readable data files with the following information:
  - In-network negotiated rates for covered items and services
  - Out-of-network amounts allowed and associated billed charges for covered items and services
  - Prescription drug pricing information (delayed until further rulemaking)
- Self-funded plans should coordinate with TPAs regarding obtaining links to machine readable files and post links on its public website

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Price Comparison Tool

- For plan years beginning January 1, 2023, plans must offer price comparison guidance by phone and make a price comparison tool available online that allows a participant to compare cost-sharing with respect to 500 “shoppable” services identified specified by CMS
  - Effective January 1, 2024, plans must provide the same comparison tool **for ALL items and services**
- Fully insured plans should confirm that health issuer will comply with comparison tool requirement
  - Update agreements to reflect responsibility
- Self-funded plans should discuss with TPAs (and other service providers) to confirm the TPA will be in compliance by deadline
  - Revise agreements to clearly outline obligations
  - Continue to monitor TPA’s compliance with this requirement since self-funded plans are ultimately responsible for compliance with the requirements

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ERISA Group Health Plan Litigation

New wave of fiduciary litigation?

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Tax Treatment of Supplemental Benefits

- Under Internal Revenue Code Section 213(d), generally medical care expenses are tax deductible
  - Medical care expenses includes the costs of diagnosis, cure, mitigation, treatment or prevention of disease and for the purpose of affecting any part of the function of the body
  - Includes transportation primarily for and essential to medical care
- Legal advice memorandum from the Office of Chief Counsel, discussed the tax treatment of an employer-funded, fixed indemnity insurance policy, an insurance policy that pays individuals a specified amount of cash for the occurrence of health-related events
  - Payments made are made under such policies, where premiums are being paid on a pre-tax basis, must be included in the employee's gross income and subject to tax if the employee has no unreimbursed medical expenses related to the payments
    - Employee pays $1200 in monthly premiums using pre-tax dollars and the policy pays $1,000 per month if the employee engages in certain health or wellness activities, which may include wellness counseling, nutrition counseling, preventing care or vaccinations.
    - Because payments are made whether the employee has any unreimbursed medical expenses or triggered even if the employee engaged in activities at no cost, the IRS considered the payments to be provided in connection with employment and considered as wages
- Providing taxable benefits, such as travel expenses that exceed the tax thresholds, must be included in gross income
- Biden administration cracks down on "short-term limited-duration insurance" plans with proposed rule
  - Will limit the length of the contract period and coverage period, and prohibit "stacking"
  - Aims to clarify tax treatment of certain benefit payments in fixed amounts received under accident and health plans that are paid without regard to the amount of medical expenses incurred

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Best Practices for Effective Plan Governance

Effective Flow of Information

Timely and relevant information is distributed among decision makers and service providers

Written Plan Policies

Written policies regarding how the plan is to be administered

Review plan design and determine if in best interest of plan participants

Ensure compliance with various disclosure requirements

Including new covered service provider fee disclosure rules and MHPAEA comparative analysis requirements

Fiduciary Liability Insurance/Indemnification

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Best Practices for Effective Plan Governance (*Cont'd*)

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