Health Care Transparency

The Consolidated Appropriations Act, 2021 (CAA), which was signed into law on Dec. 27, 2020, makes a number of changes to increase transparency in health care. These provisions affect employers, group health plan sponsors, health benefits brokers and health insurance issuers. General information is provided below.

Removal of Gag Clauses

The law bans gag clauses in contracts between providers and health insurance plans that prevent:

- Enrollees, plan sponsors or referring providers from seeing **cost or quality of care** information or data on providers.
- Plan sponsors from accessing **de-identified claims data** that could be shared, under Health Insurance Portability and Accountability Act (HIPAA) business associate agreements, with third parties for plan administration and quality improvement purposes.

Group health plans or issuers must annually submit an attestation of compliance with these requirements. The ban on gag clauses is effective on the CAA's enactment date of **Dec. 27, 2020**.

Disclosure of Broker Compensation

The CAA creates new requirements for brokers and consultants to disclose to ERISA-covered group health plan sponsors any **direct or indirect** compensation they may receive for referral of services. Similar disclosure to enrollees in the individual market or enrollees purchasing short-term limited duration insurance is required for referral of coverage. These new disclosure requirements generally apply to contracts entered into, extended or renewed on **Dec. 27, 2021**.

Current Disclosure Requirements

The Employee Retirement Income Security Act of 1974 (ERISA) requires plan fiduciaries to, among other things, ensure that arrangements with their service providers are "reasonable" and that only "reasonable" compensation is paid for services. In order to meet these obligations, plan fiduciaries must be able to obtain sufficient information to enable them to make informed decisions about an employee benefit plan's services, the costs of such services and the service providers.

A 2012 final rule requires covered service providers (CSPs) to provide plan fiduciaries with information they need to assess reasonableness of total compensation, both direct and indirect, received by the CSP, its affiliates and/or its subcontractors. However, this rule only applies to ERISA-covered defined benefit and defined contribution pension plans and **does not apply** to employee welfare benefit plans.

New Disclosure Requirements

The CAA creates similar disclosure requirements for CSPs in order for a contract between an ERISA-covered group health plan and a CSP to be considered reasonable. For this purpose, the term "covered service provider" means one that enters into a contract with the plan and reasonably expects $1,000 or more in compensation (direct or indirect) to be received in connection with providing one or more of the services listed below—regardless of whether the services will be performed or compensation will be received by the CSP, an affiliate or a subcontractor.

Specifically, disclosure is required for:

- **Brokerage services** provided to a covered plan with respect to the selection of insurance products (including vision and dental), recordkeeping services, medical management vendors, 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** 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.

Content Requirements

A CSP must disclose to a plan fiduciary, in writing, the following:

- A description of the services to be provided to the plan pursuant to the contract.
- If applicable, a statement that the CSP, an affiliate or a subcontractor will or expects to provide services pursuant to the contract directly to the plan as a fiduciary.
- A description of all direct compensation, either in aggregate or by service, that the CSP, an affiliate or a subcontractor reasonably expects to receive in connection with the services.
- A description of indirect compensation that the CSP, an affiliate or a subcontractor reasonably expects to receive in connection with the services.
- A description of the arrangement between the payer and the CSP, an affiliate or a subcontractor (as applicable) pursuant to which such indirect compensation is paid.
- Identification of the services for which the indirect compensation will be received, if applicable;
- Identification of the payer of the indirect compensation.
- If compensation is set on a transaction basis (such as commissions, finder's fees or other similar incentive compensation based on business placed or retained), a description of the services for which such compensation will be paid and identification of the payers and recipients.
- A description of any compensation the CSP, an affiliate or a subcontractor reasonably expects to receive in connection with termination of the contract, and how any prepaid amounts will be calculated and refunded upon termination.
- A description of the manner in which the compensation will be received.

Timing Requirements

Disclosure must be made no later than the date that is **reasonably in advance of the date on which the contract is entered into, and extended or renewed**. If there any change to the required information, the CSP must inform the plan fiduciary as soon as practicable, but generally no later than 60 days from the date on which the CSP is informed of the change. Lastly, upon written request of the plan fiduciary, the CSP must disclose any other information relating to compensation received in connection with the contract.

Plan Fiduciary Requirements

If the CSP fails to provide the required information above, the plan fiduciary may be required to notify the Department of Labor and terminate the contract.

Reporting on Pharmacy Benefits and Drug Costs

The CAA requires group health plans to report information on plan medical costs and prescription drug spending to the Secretaries of HHS, Labor and the Treasury. Specifically, plans must report the following:

- The beginning and end dates of the plan year.
- The number of enrollees.
- Each state in which the plan is offered.
- The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan, and the total number of paid claims for each drug.
- The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan for each drug.
- The 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year, and for each drug, the change in amounts expended by the plan in each plan year.
- Total spending on health care services by the group health plan, broken down by the type of costs, the average monthly premium paid by employers (as applicable) and by enrollees, and any impact on premiums by rebates, fees and any other remuneration paid by drug manufacturers to the plan.
- Any reduction in premiums and out-of-pocket costs associated with rebates, fees or other remuneration.

No confidential information or trade secrets can be included in the report. The reporting requirement is effective **Dec. 27, 2021**, and no later than **June 1** of each year thereafter.