Consolidated Appropriations Act (CAA) No Surprises Act, Transparency and Broker Compensation Disclosure Updates

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Course Summary & Learning Objectives

- **Course Summary:** This course provides an overview of the Consolidated Appropriations Act (CAA) provisions of Title I and Title II, which covers the No Surprises Act and Transparency Provisions of the CAA, as stated in the Interim Final Rule and its applications to plans and issuers, as well as an overview of the CAA's Broker/Consultant Compensation Disclosure requirements (rules pending). We will discuss the background of the No Surprises Act and summarize the elements of the interim final rule. We will also discuss the applications and potential conflicts with self-funded reference-based pricing plans, the notice requirements, and interaction with existing state laws. We will also provide details on the broker/consultant compensation disclosure provisions of the CAA, including the content of agent disclosure, and services included.
- **Learning Objectives:** Attendees in this class can expect to learn the following from this CE course:

- Understanding the generalities of the provisions of CAA in Title I and Title II
- Understanding the basics of balance billings and how the CAA protections will work
- Understanding the basics of the transparency provisions of the CAA
- Understanding what the CAA rules do
- Understanding the implications of state laws related to surprise billing and how they will interrelate
- Understanding the Notice Requirements of the CAA
- Understanding potential conflicts and work-arounds with self-funded reference-based pricing plans
- Be aware of the Independent Dispute Resolution in the rules
- Understanding the requirements of CAA's Broker/Consultant compensation disclosure and when to expect further guidance and rules

Let's Start with the ACA Transparency Rules and the CAA

- **Affordable Care Act (ACA)**:
  - "Transparency in Coverage" Final Rule (TiC), issued November 12, 2020
- **Consolidated Appropriations Act, 2021 (CAA), signed December 27, 2020**, includes:
  - "No Surprises Act" (Title I of Div. BB)
  - "Transparency" (Title II of Div. BB)
- **FAQs Part 49, issued August 20, 2021**: New effective dates for some—but not all—TiC and CAA provisions

ACA: Transparency in Coverage

- **Public Disclosure**: For plan years beginning on/after **January 1, 2022**, plans/issuers (not grandfathered plans) must make public 3 machine-readable files that will include detailed pricing information that will show:
  1) Machine-readable file with in-network provider rates for covered items and services
  2) Machine-readable file with out-of-network allowed amounts and billed charges
  3) Machine-readable file with negotiated rates and historical net prices for covered prescription drugs
- **FAQs Part 49**: New compliance deadlines:
  1) **Delayed until July 1, 2022** (but will also apply to plan years beginning on/after 1/1/22)
  2) **Delayed until July 1, 2022** (but will also apply to plan years beginning on/after 1/1/22)
  3) **Delayed indefinitely**

ACA: Transparency in Coverage

- **On-Line Self-Service Tool**: Plans/issuers (not grandfathered plans) must make available to participants personalized out-of-pocket cost information, and the underlying negotiated rates, for all covered health care items and services, including prescription drugs, through an internet-based self-service tool (and in paper form upon request).
  - List of 500 shoppable items/services must be available for plan years beginning on/after **January 1, 2023**
  - All other items/services must be available for plan years beginning on/after **January 1, 2024**
- **FAQs Part 49**: Deadlines unchanged
- **CAA Price Comparison Tool**: CAA is "largely duplicative" of TiC, but also applies to grandfathered plans and includes a requirement to provide info over the phone; delayed to 1/1/23
- **Action Items**: Fully insured plans must enter into a written agreement with issuer; self-funded plans must either comply or outsource through a written agreement (such as to a TPA or PBM), but remain liable

Deadlines: ACA Transparency in Coverage Final Rule (TiC Final Rule)

Mandate	Original Compliance Date	New Compliance Date
Machine-readable file with in-network provider rates for covered items and services	For plan years beginning on/after January 1, 2022	Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22)
Machine-readable file with out-of-network allowed amounts and billed charges	For plan years beginning on/after January 1, 2022	Delayed until July 1, 2022 (but as of that date will also apply to plan years beginning on/after 1/1/22)
Machine-readable file with negotiated rates and historical net prices for covered prescription drugs	For plan years beginning on/after January 1, 2022	Delayed indefinitely
Price comparison tool with initial list of 500 shoppable items/services	For plan years beginning on/after January 1, 2023	Not delayed
Price comparison tool with all other items/services	For plan years beginning on/after January 1, 2024	Not delayed

Deadlines: CAA "No Surprises Act" and "Transparency"

Mandate	Original Compliance Date	New Compliance Date
Price comparison tool	For plan years beginning on/after January 1, 2022	For plan years beginning on/after January 1, 2023
Reporting on Pharmacy Benefits & Drug Costs	December 27, 2021 & June 1, 2022	Delayed indefinitely pending guidance; plans should start preparing to report for 2020 and 2021 by December 27, 2022
ID Cards	For plan years beginning on/after January 1, 2022	Not delayed
Provider Directories	For plan years beginning on/after January 1, 2022	Not delayed
Good Faith Estimates by Providers	For plan years beginning on/after January 1, 2022	Not delayed for uninsured individuals
Advanced Explanation of Benefits (EOB) by Plans/Issuers	For plan years beginning on/after January 1, 2022	Delayed indefinitely pending guidance
Surprise Billing	For plan years beginning on/after January 1, 2022	Not delayed
Continuity of Care	For plan years beginning on/after January 1, 2022	Not delayed
Mental Health Parity	February 10, 2021	Not delayed
Gag Clauses	December 27, 2020	Not delayed
Gag Clauses - Attestation	December 27, 2020	Delayed indefinitely pending guidance
Broker Disclosure	December 27, 2021	Not delayed

A Note about Grandfathered Plans . . .

- **Grandfathered (GR)** health plans are not subject to certain provisions in the ACA (e.g., preventive care, TiC rule, patient protections (choice of provider & emergency services))—this has not changed. However, GR plans are subject to the CAA (FAQ 11). Where this could make a difference:
- **Surprise Billing IFR**:
  - IFR re-states the patient protection rules from the ACA, which will now apply to GR plans (GR Plans: Don't forget to add patient protection notice to plan documents)
  - IFR re-states and rewrites rules on emergency services, which will now apply to GR plans
- **TiC Rules**:
  - Prescription drug reporting requirement in TiC Rule does not apply to GR plans, but similar requirement in CAA does; Departments are delaying enforcement of TiC Rule and working on updated rulemaking to address overlapping requirements
  - Self-service tool requirement in TiC Rule does not apply to GR plans, but similar price comparison tool in CAA does; Departments are delaying enforcement of CAA (but not TiC Rule) and working on updated rulemaking to address overlapping requirements

Surprise Billing - Overview

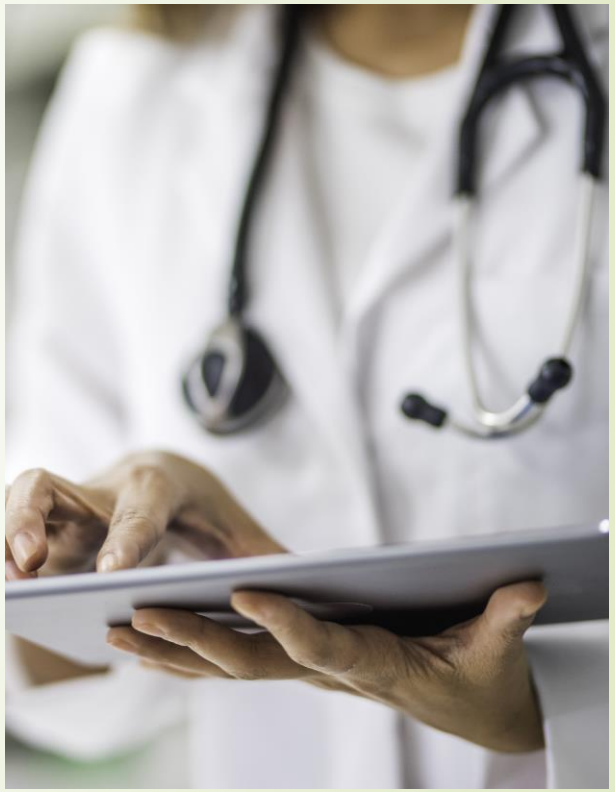
- **"Interim Final Rules with Request for Comments" (IFR) pertaining to "Requirements Related to Surprise Billing; Part I":**
  - Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without prior authorization
  - Bans high out-of-network cost sharing for emergency and non-emergency services. Patient cost sharing (such as coinsurance or deductible) cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network rates
  - Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances
  - Bans other out-of-network charges without advance notice. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before the provider can bill at the higher out-of-network rate
- **Action Items**: Prepare notices and amend plan terms, as necessary
- **State Rules**: Continue to apply

CAA's No Surprises Act – Background

- Most health plans, whether group, individual, Marketplace or Medicare plans, offer a network of providers and facilities (PPO or EPO network) that agree to accept payment of an established, contracted rate.
- Non-network providers generally charge higher amounts as there is no contracted pre-established rate.
- In many cases, those out-of-network providers may balance-bill the patient for the difference between the billed charge and the amount the health plan or insurance has paid, unless prohibited by state law.
- Balance bills can happen in both emergency and non-emergency care.

No Surprises Act- Background

- In emergency, patient goes to nearest emergency room. Even if ER happens to be a contracted PPO facility, not all of the providers working inside the ER may be contracted under network. This often results in balance billing (charging the difference between the billed amount and the amount the plan pays).
- "Forced Providers." - Common examples: ER Physicians, Anesthesiologists, Pathology/Lab/Xray, Rehabilitative Care, Physical Therapy, Neonatology, Surgeon, Assistant Surgeon.
- Patients should be trained to ask them "who pays you?"
- See it often in Air Ambulance billings.
- **In most cases, surprise medical bills usually DO NOT count toward your deductibles or OOP Maximums.**
- Interim Final Rules apply to group health plans and health insurance issuers offering group or individual coverage, including GF health plans, effective January 1, 2022.
- Does not apply to retiree-only plans, excepted benefits, short term limited duration plans, HRAs, FSAs, or HSAs.



No Surprises Act - Intention

- Intent is to protect consumers from the types of balance-billing or surprise billing practices described.
- Focuses on billing practices in certain non-network situations by limiting the amount of the bill to the amount that would have been payable under a network arrangement.
- Bipartisan bill.
- May not fully protect self-funded plans when they use financing methods like RBP.

Summary of the Interim Final Rule (IFR), Part 1

- As Discussed Briefly (more details):
  - Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without prior authorization
  - Bans high out-of-network cost sharing for emergency and non-emergency services. Patient cost sharing (such as coinsurance or deductible) cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network rates
    - Limits cost-sharing as if the total billed amount for services are equal to the "recognized amount." Commonly: UCR amount.
    - Amount must be calculated based on one of the following amounts:
      - Amount determined by an applicable All Payer Model Agreement (section 1115A of Social Security Act)
      - An amount determined under a specific state law
      - If neither apply, the lesser amount of either the billed charge or the "qualifying payment amount" (more later)
  - Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances
  - Bans other out-of-network charges without advance notice. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before the provider can bill at the higher out-of-network rate

Employer/Plan Sponsor Concerns

- No Surprises Act should be good news to employers and their plan participants worried about surprise bills.
- Employers and/or their brokers should educate employees on new rules during open enrollment or other means
- Ancillary services "forced providers" good news since they were targets for balance billing in the past.
- Employers and their brokers should review plan documents to be sure they are consistent with the interim final rules.
- Employers or their brokers should discuss with their TPAs about changes to administrative services agreements, cost increases, and implementation is extremely important.

Administrative Concerns

- The No Surprises Act throws confusion into the claims payment industry by requiring that coverage be provided without limiting what constitutes an emergency medical condition, solely on the basis of diagnosis codes, such as the ICD-10 codes.
- *The federal departments appear to have expressed their disapproval of claims practices which do not look at all of the facts and circumstances, relying solely on the diagnosis codes to determine if a claim is eligible for payment. Many plans and claims administrative practices will automatically deny an emergency claim, for example, based on a pre-determined list of final diagnosis codes without regards to the actual symptoms being presented to them at the time of care. It is often only following claim denial that a plan or claims administrator will review all of the facts, and generally upon a formal (but sometimes informal) appeal.*

Emergency Medical Condition

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to:
  - 1) place their health in serious jeopardy
  - 2) seriously impair bodily functions, or
  - 3) cause serious disfunction to a bodily organ or part
- Plans must ultimately determine whether the standard was met by *reviewing presenting symptoms, without imposing any type of time limit between onset and presentation for emergency care.*
- May require Plan Amendments.
- TPA's claims procedure manual and processes must also be updated
  - Revised claims procedures should also include, as necessary, updated record keeping requirements that will enable the plan to prove that it is has satisfied the new legal standard in each case. The emphasis placed on the prudent layperson standard in the preamble to the regulations implies that this issue may be a priority for the Departments. (86 Fed. Reg. 36872, 36879-36880).

Surprise Billing IFR & CAA Rules Place Many New Obligations on Plans and Issuers

- Employers with fully insured plans should communicate with their carriers to ensure the carriers' intent to comply on time.
- Employers with self-funded plans have more work to do.
  - Changes created by the CAA will probably require changes to plan documents, ID cards, provider directories, and more
  - May also require changes to the terms of TPA contracts and claims processing manuals
  - Employers should be prepared to discuss with their TPA who will be responsible for implementing each relevant section of the CAA, and the timeframe for implementation
  - Do changes need to be made to the written contract with the TPA, including adjustments in cost, scope of services, indemnification, and other key clauses?
  - Who will be responsible for each item required? Create a checklist and assign who is responsible for each requirement and communicate with all.

Will These Changes Increase Costs?

- If you can't control costs with straight ICD-10 codes, how do you contain cost?
  - Higher ER copays or coinsurance
  - Raising deductibles, or additional deductibles for ER services
  - Educate your employees on more cost-effective steps prior to walking into an emergency room;
    - Using Urgent Care Centers instead of high-cost emergency rooms,
    - For many services that are not life-threatening, implementing new or encouraging plan participants to use Telehealth options
    - Administrative expenses also likely to increase

Qualifying Payment Amount - QPA

- QPA - The median of the in-network (or contracted) rate in a geographic area (becomes complex for RBP plans – will discuss later).
- Also applies in other portions of the law, including the base-line factor that an arbiter may consider when they determine the final amount to be paid under the new federally-established independent dispute resolution process.
- Under the No Surprises Act, when a self-funded plan and an out-of-network provider cannot agree on a rate, they must go through an independent dispute resolution process (IDR).
- A median contract rate should be determined by taking into account every group health plan offered by the self-insured plan sponsor. The IFR allows for administrative simplicity for self-funded plans to permit the TPA who processes their claims to determine the QPA for the plan sponsor by calculating the median contract rate based on all of the plans that it processes and administers claims for.
- The IFR states that the contracted rates between providers and the network provider for the health plan would be treated as the self-insured plan's contracted rates for purposes of calculating the QPA.

Cost of Administration with No Surprises Act

- TPAs will find the No Surprises Act quite complicated, and expensive to administer.
- TPAs will need to set up their claims payment systems to administer the QPA.
- Most self-funded health plan sponsors will rely on their TPAs to assist them with all of the No Surprises Act requirements, and it will likely be the norm for TPAs to assist self-insured plans with the Model Notice that is required.
- The No Surprises Act will be costly to administer for TPAs.
  - They will need to determine the QPA
  - Changes will need to be made in understanding the implications of the ER services determination – and taking the extra steps up front to examine more documentation and understand symptoms, rather than initially denying a claim up front, and all of that will cost more; in claims adjudication training, in system adjustments, and more.
  - QPA's independent dispute resolution process will have large learning curve
  - *What this means to self-funded employers is that they should expect their claims fees to increase due to the No Surprises Act.*

Determining QPA

- The geographic regions used to determine the contracted rates will follow the metropolitan statistical areas (MSA) used by both Medicare and the U.S. Census.
- The IFR includes the “rule of three” expansion, meaning that if a plan cannot identify three rates to determine a median rate within an MSA, then the plan is permitted to increase the size of the MSA to include the state as a single region.
- TPAs often will not have the databases needed to determine the QPA, and will likely have to rely on their Business Associates, such as PPO networks or RBP vendors.
- The IFR issued clear guidelines for steps to be taken in order to determine the appropriate rate, using primarily databases. This piece ties in directly with the Transparency rules, which were in part also addressed in the IFRs.
- One important provision that was included in the IFR addressed self-insurance industry concerns related to the possibility of conflicts of interest while using databases. The IFR states that the organization maintaining the database cannot be affiliated with, controlled by, or owned by any health insurance issuer, provider, or healthcare facility.

Independent Dispute Resolution (IDR) Process

- If a payer, such as a carrier or health plan, cannot resolve a payment settlement with a provider, then the payer and provider must resolve the payment dispute using methods of negotiation and arbitration.
- The No Surprises Act requires payers to send an initial payment or denial of payment of a claim no longer than 30 days after a claim is submitted. After the 30-day period, either party may begin negotiations on a claim. If the parties involved cannot agree on payment terms during the 30-day period, then they will move to an Independent Dispute Resolution (IDR) process. This process may be initiated within 4 days of the 30-day period (for a 34-day window).
- Each entity will offer a final payment amount and then the arbiter will use a variety of factors to determine the final amount, including geographic areas, service codes, etc. The intent is to make it fair to both parties.
  - Must be a reasonable amount submitted initially. Can't be $30 for a large surgery bill.
- Under the IDR process, they are not allowed to use lower payment rates such as Medicare or Medicaid.
- The IDR does not impact the consumer or plan participant. The dispute is between the provider and the health plan. The provider has no recourse against the consumer, and therefore, it is not an adverse benefit determination.

No Surprises Act Impact on Self-Funded Health Plans Using Referenced-Based Pricing

- The No Surprises Act's limitation on balance billing for services provided in an "in-network" facility by an out-of-network provider is likely to be quite problematic for self-funded plans that use Reference-Based Pricing as their financing method, in place of a PPO network.
- Because there is no network, and all claims are generally paid at a reference-based rate (most commonly a percentage above known Medicare Rates, such as 150% or 200% of Medicare), such self-funded health plans and their RBP vendors will need to discuss how they intend to deal with the No Surprises legislation, sooner rather than later.
- At times, have refused payment entirely from RBP plans, and instead, have opted for immediate balance billing to all plan participants. In response to these provider actions, certain RBP vendors are struggling to produce solutions that will limit disruption to employer and employees while attempting to retain as much of the savings that RBP Plans have been known for.
  - RBP plans generally pay claims at a stated percentage above Medicare (such as 140%, 150%, 200%, etc.), while PPO contracts, although a great savings over non-contracted provider rates, generally result in (if compared to Medicare, which of course their rates are not based on) costs ranging from 300% to 900% of Medicare rates. Sadly, I've seen many initial bills from hospitals coming in at over 1,000% of Medicare rates when no network is in place.

No Surprises Act RBP Strategies/Options

- **One-off facility agreements**, creating a networked facility, or single case agreements, which is negotiated often-times prior to the participant entering the facility for service.
  - An example is a known procedure or surgery, such as a knee replacement, hip replacement or other procedure. In these cases, some RBP vendors have opted to offer pre-payment to the facility, to encourage them to accept the patient at the RBP rate. There is concern, however, that such pre-negotiated rates could be perceived as a contracted rate, and may set precedents. One of the administrative concerns of this type of solution is the burden that would likely result from pre-negotiations, as well as a possible delay in service while negotiations are in the works.
- Another work-around may **be direct provider contracts**, but those may likely be limited to certain services only, and if providers result in providing additional services, they could opt to balance-bill for those additional services, which may or may not be prohibited under the No Surprises Act, depending on the type of service.
- It is assumed by most in the self-insured industry that work with RBP plans that **the level of payment for RBP plans may end up increasing to a higher percentage,** to still provide savings over PPO plans, but not at the wide difference we are seeing currently. Many of us are expecting payment levels to raise from the 140%-200% rate to perhaps raise to something more like perhaps 200% to 250% for normal facility payments, to cut back on the provider pushback and possible refusal to accept patients under RBP plans.
- TPAs and Self-Funded Employers (and likely their brokers) will need to have serious discussions with RBP vendors to see how they are approaching the No Surprises Act and what their plan is for “work-arounds.”

CAA Broker/agent compensation rules

- **The Consolidated Appropriations Act of 2021 (CAA) includes significant broker compensation disclosure requirements, effective one year from enactment, or December 27, 2021.**
- This disclosure provision modifies ERISA to add a disclosure requirement of both direct or indirect compensation by brokers or consultants, if they enter into a contract or arrangement with a group health plan, or reasonably expect broker services or consulting compensation to equal $1,000 or more per year (group health plan insurance commissions would likely count toward the $1,000 threshold in all cases).
- Compensation includes anything of monetary value, but does not include non-monetary compensation valued at $250 or less, in aggregate, during the contract term.
- The broker and consultant disclosure requirements include health plans, which would include excepted benefits like stand-alone dental and vision, health FSAs, EAPs, and HRAs.

Overview of disclosure rules

- Disclosure is required under Section 408(b)(2) of ERISA and is very similar to retirement plan disclosures that have been required since 2012.
- The broker/consultant must provide in advance of the contract date to the employer/plan sponsor all expected compensation, and communicate any changes no later than 60 days from the date the broker is aware of the change, or upon written request.
- Brokers/consultants will be required to provide a disclosure notice to each client.
- Some rules were released on September 16, 2021, but only for Individual and Short-Term Limited Duration Plans. We expect more rules to be released by October, 2021.

Background and History of Agent Disclosures and Prohibited Transactions

- CDI Bulletin NO 80-6 (April 1, 1980)
  - An agent may not charge fees not authorized by insurer
  - Brokers who are appointed agents are agents of the insurer
  - Life Agents (and accident and health agents) may not generally charge fees for fully insured plans/plan sponsors
    - "There are life insurance agents who provide advisory services such as estate planning, employee benefit plans, investment counseling, etc., which might not be directly related to the solicitation of life insurance. Sometimes, fees are charged for these services which are paid by the client. Frequently, however, the life insurance agent's recommendations include insurance which that agent actually places. In such cases, this office has consistently taken the position that the primary objective in the services provided is the sale of insurance and that, therefore, a separate charge for those services is unlawful."

Federal Form 5500, Schedule A Disclosures

- Under ERISA, insurers and HMOs must provide information needed to complete a Schedule A for fully insured benefits(not ASO arrangements)
- Schedule A reports the total fees and commissions paid per the insurance contract, and reports who received the fees sand commissions, as well as the purpose
- What is included in the amount reported?
  - Sales and base commissions and all other monetary and non-monetary forms of compensation, including persistency and profitability bonuses, service and consulting fees, finders' fees, awards and prizes

Form 5500 Schedule C

- Under ERISA, service providers must provide data on fees and other compensation which is reported on the Schedule C (many welfare plans are exempt – small welfare plan exception, Technical Release 92-01)
- Reporting required if the service provider received, directly or indirectly, $5,000 or more in reportable compensation in connection with services rendered (unless reported on Schedule A)
- Must report money and other things of value, such as gifts, awards, trips
- Includes direct and indirect compensation

Prohibited Transactions Under ERISA

- ERISA Section 406(1)(C) provides that a fiduciary may not cause a plan to engage in a transaction if he knows that the transaction constitutes a furnishing of goods, services, or facilities between the plan and a party of interest.
- Parties in interest includes a person providing services to a plan
- Exemptions if 3 conditions are met:
  - Service is necessary for the establishment or maintenance of the plan
  - Service is furnished under a contract or arrangement that is reasonable
  - No more than reasonable compensation is paid for the service

CAA Amendment to ERISA Section 408(b)(2)

- CAA enacted December, 2020
- Amended ERISA creating new requirements for establishing when a contract between a group health plan and a service provider is considered reasonable
- No contract or arrangement for services provided to a covered plan by a covered service provider (CSP) is considered reasonable unless specific disclosures are made
  - New rule applies to contracts or arrangements entered into, extended or renewed on or after December 27, 2021
  - A Covered Plan means a group health plan, as defined by ERISA
  - A Covered Service Provider is a provider that enters into a contract or arrangement with a covered plan and reasonably expects to make $1,000 or more, adjusted for inflation
    - Direct or indirect compensation

Disclosure to Plan Fiduciary

- Disclosures related to Direct Compensation must include:
  - A description of the services to be provided to the plan
  - A statement that the CSP, affiliate, or subcontractor will provide services to the covered plan as a fiduciary, and
  - A description of all direct compensation (aggregate or by service) that the SCP, affiliate or subcontractor expects to receive in connection with the services provided to the plan
- Disclosures related to Indirect Compensation must include:
  - Compensation from a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan, not including compensation received by an employee from an employer on account of work performed by the employee
  - Description of arrangement between the payer, CSP, affiliate, or subcontractor pursuant to which indirect compensation is paid
  - ID of services for which the indirect compensation will be received and
  - ID of the payer of the indirect compensation

Content of disclosure

- In general, **the CAA Broker compensation disclosure notice must include:**

  - A description of services (what are you doing for your client?)
  - A statement indicating if the broker/consultant plans to offer fiduciary services to the plan, if applicable (yes or no – in most cases, this should be NO for most brokers)
  - All direct compensation, in the aggregate, or by service
  - All indirect compensation, including vendor incentive payments, a description of the arrangement under which the compensation is paid, the payer name, and any services for which compensation will be received
  - Any transactional-based compensation, for example, commissions, finder's fees for services and the payers and recipients of the compensation
  - A description of any compensation expected with regard to the contract's termination

- Note that bonuses and overrides, etc. were not clearly specified in the bill text. The coming regulations/rules/guidance should give us more clarity on this.

Services included

- In general, the **services you provide to your clients must be included in your disclosure notice**. Examples of services include, but are not limited to:

- Development or implementation of plan design, insurance or insurance selection
- Recordkeeping services
- Medical Management vendor
- Benefits Administration (including dental and vision)*
- Stop-loss insurance placement or recommendations
- PBM services
- Wellness program services
- Transparency tools and vendors
- Group purchasing organization preferred vendor panels
- Disease management vendors or products
- Compliance services
- EAP Programs
- Third Party Administration (TPA) services *

What about consulting services?

Consulting services are nearly identical to the brokerage services, but do not need to involve the actual broker services.

At this time, it is unclear whether "consulting" just involves brokers serving in a consulting capacity (for example, consulting for a self-insured employer in a self-funded health plan), or other service providers who "consult" such as TPA consulting on plan design or implementation.

We assume that further guidance will be coming soon.

Administrative services

- Be aware that a number of administrative services require an administrator's license in many states (including California)
- In many cases, providing administrative services that would be covered under that license as a broker could be considered prohibited transactions under ERISA
- In California, the Department of Insurance issued a bulletin some time ago that basically states that for insured products, if you're getting a commission, you cannot also take a fee, unless you are doing other services (see earlier slide)
- Check with your legal counsel to determine what you can and cannot charge fees for (self-funded plans with ERISA jurisdiction are separate and fees and stop loss commissions are acceptable and common)

Direct and indirect compensation

Direct compensation is defined as compensation from the plan itself, through plan assets.

Amounts paid by the plan sponsor/employer would not be considered plan assets, but participant contributions are always plan assets.

Indirect compensation is generally amounts received from anyone other than the plan or the employer/plan sponsor.

For example, if a consultant receives compensation from an insurance carrier, an industry vendor, or TPA not in the form of commissions.

HHS Reporting

- Insurers will report direct and indirect compensation on Schedules A and C of Form 5500
- GA Compensation from the insurer is not reported for the GA's "management of an agency performance of administrative functions for the insurer."

Sept 16, 2021 Rules on Disclosure Requirements for Individual and Short-Term Policies

- New rules were released on Sept 16, 2021, but they only addressed requirements for individual and short-term limited duration plans.
- https://www.federalregister.gov/documents/2021/09/16/2021-19797/requirements-related-to-air-ambulance-services-agent-and-broker-disclosures-and-provider-enforcement
- Disclosure needs to be made only to the POLICYHOLDER, not all dependents and beneficiaries.
- Individual plans must provide commission schedules, which appears to be the commission levels (likely percentages)
- Other provisions basically similar to what is presented here.

Burden or blessing?

Many brokers are in panic mode about the disclosure requirements, seeing them as a burden and risk

I actually think they are a blessing, as it allows a broker to show their true value for the services performed

The more services you perform, once laid out in disclosures, may help distinguish the better broker/consultant to the employer

Where do you begin?

Recommended that brokers/consultants begin now to identify all group health plans where broker or consulting services are provided, to determine all sources of direct and indirect compensation, and determine all compensation that meets the $1,000 threshold.

Then begin to design your disclosure notice and determine the best way to produce this to your clients.

For most, particularly large agencies, this would be easier if automated, so that timely disclosures can be provided at the end of the year.

Don’t be afraid to ask for help from consultants or attorneys to get you started.

Resources

No Surprises Act

- Interim Final Rule and Comment Period: CMS: https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf
- Federal Register: https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i
- CMS Fact Sheets: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period
- https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing

CAA Broker Compensation Disclosure Rules

- New rules were released on Sept 16, 2021, but they only addressed requirements for individual and short-term limited duration plans.
- https://www.federalregister.gov/documents/2021/09/16/2021-19797/requirements-related-to-air-ambulance-services-agent-and-broker-disclosures-and-provider-enforcement
- Stay tuned for more updates! Expected by October, 2021
- I will be preparing an on-demand CE class as soon as the rules are released to assist agents in working through the disclosure requirements. Click on the Agent CE icon on the class offering page. CAHU Member discount will be available; use discount code CAHU2021AgentCE10. This discount code is good for $10 off any class offered (classes are added regularly).
- https://advancedbenefitconsulting.com/empowered-education-center/
- I will also be preparing Model Notices once the rules are released. NAHU will also be providing model notices.
- I'm sure I'll also be writing an article for The Statement on this topic as soon as new rules are released.

Questions?

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- The information provided during this program does not constitute legal advice. In addition, this program only provides a summary of certain complex and always evolving laws and regulations. Attendees should consult their legal counsel for guidance on the application and implementation of the many federal and state laws that impact employee benefit plans and the workplace, including the topics discussed during this program.