THELEAPFROGGROUP

CAA Compliance: 4 Things Employers Must Do Before Jan 1st
Toolkit for Employers

Table of Contents

Ballard Spahr LLP

Transparency Requirements

Background. It has long been difficult to obtain accurate information about the charges for health care services. Even with federal requirements to be more transparent, many hospitals have resisted disclosing their fees. Health plan vendors that administer provider networks treat the fees that they negotiate with health care providers as proprietary information, often placing contractual limits on access to this information and its disclosure.

New Rule. A set of regulations issued jointly by the U.S. Departments of the Treasury, Labor, and Health and Human Services requires group health plans and insurers to disclose pricing information in three phases:

- In **Phase One**, health plans must publicly post machine-readable files for in-network rates, out-of-network allowed amounts and billed charges, and prescription drug negotiated rates and historical prices. This requirement does not apply to out-of-network services and prescription drugs if there are fewer than 20 claims for the service or item in the 90-day period for which information is gathered. Plans must update the information monthly.
- In **Phase Two**, health plans must make an internet service tool available to plan enrollees that, on request, provides them information relevant to their costs for 500 specified items and services. The information to be provided includes:
  - An estimate of their cost-sharing (deductible, co-payment, co-insurance) liability
  - Their accumulated amounts to date, for example toward satisfaction of a deductible (both individual and family)
  - The in-network rate or out-of-network allowed amount, as applicable
  - Certain information in the event of a bundled arrangement
  - Notice of other relevant information, such as whether any prerequisite applies to coverage for an item or service and whether balance billing could apply.
- **Phase Three** extends Phase Two to all items and services.

For Phases Two and Three, the internet service tool must allow plan enrollees to search for information by certain elements, such as billing codes, descriptive terms, and in-network providers. Enrollees must be able to refine and reorder their search by geography and the amount of cost-sharing responsibility. Plans must make search results available by paper free of charge, but may limit the results to 20 providers per request. The Consolidated Appropriations Act, 2021 (CAA) adds a requirement that certain information be available by telephone

Citations. 26 CFR 54.9815-2715A1, A2, and A3; 29 CFR 2590.715-2715A1, A2, and A3; 45 CFR 147.210, 211, and 212; and 45 CFR 158.221. ERISA section 719; Internal Revenue Code section 9819; and Public Health Services Act section 2799A-4.

Effective Date. Phase One of the transparency regulations applies to plan years beginning on or after January 1, 2022. Phase Two applies to plan years beginning on or after January 1, 2023. Phase Three applies to plan years beginning on or after January 1, 2024. The CAA provisions on the furnishing of information by telephone apply to plan years beginning on or after January 1, 2022.

Enforcement. For health plans that are subject to ERISA, the U.S. Department of Labor and plan participants and beneficiaries may enforce compliance with these rules. Plans not subject to ERISA may be subject to enforcement by the U.S. Department of Health and Human Services (HHS). HHS shares responsibility for enforcement against insurers with state agencies. In addition, the Internal Revenue Service may impose an excise tax of $100 per day per affected individual under section 4980D of the Code for any failure to comply.

The regulatory agencies that enforce the transparency rules have announced that they would delay enforcement of Phase One until July 1, 2022, for plan years that begin before that date. The delay for prescription drugs may be even longer depending on when the agencies issue regulations to coordinate these transparency rules with certain prescription drug reporting rules in the CAA. The agencies also announced that their enforcement of the CAA requirement to make information available, including by telephone, will be delayed until January 1, 2023, to align with the Phase Two effective date. Technically, the delay by the agencies will not preclude individuals or states from seeking to enforce the new rules on or after the effective date, although the agency guidance encourages states to follow suit.

A plan or insurer will not be deemed to violate the rules if the applicable website is temporarily inaccessible or it makes an error or omission in a required disclosure provided that it has acted in good faith and with reasonable diligence to comply and promptly corrects the error or omission.

Plan Considerations. Plan sponsors cannot meet these requirements without the full cooperation of their health plan vendors and need to make appropriate arrangements with those vendors to comply. Sponsors of insured plans may meet the transparency requirements by entering into a written agreement with their insurer to meet the requirements. Sponsors of self-insured plans will be legally responsible for complying with the requirements, but may (and, as a practical matter, must) amend their agreements with applicable plan vendors to make them contractually responsible for compliance. Plans may rely on the information provided by those vendors unless they know or reasonably should know that the information is incomplete or inaccurate. Most often plan sponsors (and insurers and vendors) will want to make the information available through the insurer's or vendor's website. However, they should allow plan enrollees to link to that information from any website that the plan sponsor maintains that provides health plan information.

Ideally, the contract will be effective as of the dates each phase of the rules becomes effective. Vendors may seek to delay compliance until the date of agency enforcement and plan sponsors should consider how to address the interim period.

Recommended Steps. Plan sponsors should consider taking the following actions:

- Enter into written contracts with applicable health plan insurers, third party administrators, and pharmacy benefit managers to provide the required information through their websites, to update the information in accordance with the new regulations, and to allow for a portal from the plan website to the vendor website to facilitate enrollees' access to their own information.
- Establish a portal from the plan website to the vendor's website for such information.
- Determine whether the vendor will comply by the effective date and, if not, what the vendor will do and be responsible for prior to its compliance.

Lawyers at Ballard Spahr are prepared to assist you with questions that you may have. Please contact Edward Leeds or G'Nece Jones.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

G'Nece Jones
Associate, Philadelphia
jonesgn@ballardspahr.com
215.864.8286

Ballard Spahr LLP

A Call to Action: Health Plans Must Respond to New Rules

In the coming months, employers and other group health plan sponsors will need to address a diverse and largely unheralded array of health plan requirements. Collectively, these new rules may constitute the largest set of compliance obligations for health plans since the implementation of the Affordable Care Act. Most of the requirements are set forth in provisions of the Consolidated Appropriations Act, which was signed into law in December 2020, but they also include regulatory guidance published in late 2020 and throughout 2021. The new rules include:

- Requirements to disclose information about network, out-of-network, and prescription drug pricing in a transparent manner
- Requirements to report to the federal government certain information about prescription drug pricing
- "No Surprises" rules that limit how much plan participants must pay in certain situations (such as emergencies) when they receive out-of-network care and that establish a process for determining how much plans must pay in those situations
- An obligation to conduct an analysis that compares non-quantitative limits on coverage for mental health and substance use disorders to similar limits on coverage for medical and surgical expenses
- A prohibition against entering into vendor contracts that inappropriately restrict the disclosure of information about cost and the quality of care
- A requirement to obtain specific information from brokers and consultants when engaging them to provide services for a health plan

Some of these requirements are already in effect. Others will take effect near the end of 2021 or at the start of the next plan year. The rules require action from those who maintain insured plans as well as those who sponsor self-funded arrangements.[1]

---

[1] Certain types of plans—including most dental, vision, employee assistance plans, and individual account plans (such as health flexible spending arrangements and health reimbursement arrangements)—will generally be exempt from the new rules.

Employers will not be able to meet these new requirements on their own. They will need the cooperation of their vendors and should be seeking commitments from their insurers, third party administrators, brokers, and others to provide the information and services necessary for compliance. Without this cooperation, health plans could be subject to enforcement actions, monetary penalties, and possible litigation.

The new rules are detailed, and guidance on a number of matters has yet to be issued. However, in a series of separate briefings, we will aim to describe the fundamental requirements of the new rules, one-by-one, and suggest measures that employers may take to bring their plans into compliance. Employers should promptly and carefully consider their own courses of action and seek assistance in complying with the new rules, as appropriate.

Lawyers at Ballard Spahr are working with the new rules and are prepared to assist you with questions that you may have. Please contact Edward Leeds or Brian Pinheiro.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

Brian M. Pinheiro
Partner, Philadelphia
pinheiro@ballardspahr.com
215.864.8511

Ballard Spahr LLP

Continuity of Care

Background. Health plan participants who are undergoing a course of treatment with a particular network provider may face a difficult choice if that provider's participation in the network ends. If they continue treatment with that provider, they may need to absorb significant costs. However, having embarked on a course of treatment, participants may be reluctant to change to a new provider that is in the network. Plans sometimes address these situations, most commonly for in-patient care.

New Rule. If a continuing care patient who participates in a plan is receiving care from a particular health care provider at the time that the provider's participation in a network terminates (or suffers certain similar disruptions), the plan or, if applicable, the insurer must notify the participant and provide the participant with the opportunity to elect transitional care. If the participant elects transitional care, the plan must continue to provide benefits under the same terms and conditions that applied prior to the termination. Such coverage must be offered for 90 days following the date that the notice is provided, but the period will end earlier if the participant ceases to receive care from that provider.

For these purposes, a continuing care patient is a patient who is:

- Undergoing a course of treatment for a serious and complex medical condition,
- Undergoing a course of institutional or in-patient care,
- Scheduled to undergo surgery (and post-operative care),
- Pregnant and undergoing a course of treatment for the pregnancy, or
- Receiving treatment for a terminal illness.

The rules will not apply where a contract is terminated for a failure to meet quality standards or fraud.

Providers are required to accept payments prescribed under these rules.

Citation. ERISA section 718; Internal Revenue Code section 9818; Public Health Services Act sections 2799A-3 and B-8.

Effective Date. Plan years beginning on or after January 1, 2022.

Enforcement. For health plans that are subject to ERISA, the U.S. Department of Labor and plan participants and beneficiaries may enforce compliance with these rules. Plans not subject to ERISA may be subject to enforcement by the U.S. Department of Health and Human Services. Insurers are subject to enforcement by HHS as well as state agencies. In addition, the Internal Revenue Service may impose an excise tax of $100 per day per affected individual under section 4980D of the Code for any failure to comply.

The federal agencies have announced that they do not expect to issue guidance on these requirements before the end of the year. Until such guidance is issued and effective, plans should comply with a good faith, reasonable interpretation of the statutory provisions.

Plan Considerations. Plans must take into account the requirements of these rules with regard to their vendor contracts and benefit design.

Recommended Steps. Plans should consider taking the following actions:

- Arranging with vendors to continue to process and adjudicate claims in these transitional situations as if network rates and other terms and conditions still applied and to provide the required notice.
- Amending their plans to provide for transitional in-network coverage for those who elect to continue on an in-network basis.

Lawyers at Ballard Spahr are working with the new rules and are prepared to assist you with questions that you may have. Please contact Edward Leeds or G'Nece Jones.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

G'Nece Jones
Associate, Philadelphia
jonesgn@ballardspahr.com
215.864.8286

Covered Service Provider Disclosure Information

The Consolidated Appropriations Act of 2021 (CAA) amends ERISA Section 408(b)(2) and requires service providers to disclose specific information to group health plan fiduciaries.

Who is covered by these disclosure requirements?
A Covered Service Provider (CSP) is a service provider that enters into a contract with a group health plan and reasonably expects to receive $1,000 or more in direct or indirect compensation in connection with services provided to the plan.

What information must be disclosed?
All CSP must disclose the following information, in writing, to a responsible plan fiduciary:

- Description of services provided to the plan
- Fiduciary status disclosure (will the services be provided in a fiduciary capacity?)
- Description of all direct compensation
- Description of all indirect compensation
- Description of all transactional compensation
- Description of all termination compensation

Which kinds of plans subject to this disclosure?
The disclosure requirements apply to all ERISA-covered group health plans including:

- Medical / prescription drug plans
- Dental plans
- Vision plans
- Health Flexible Spending Account (FSA) plans
- Health Reimbursement Arrangement (HRA) plans

When is disclosure required?
All CSP must disclose this information in advance of the date the contract is expected to be signed or renewed.

Covered Service Provider
Disclosure Worksheet

As a Covered Service Provider, please complete the following disclosure worksheet and return it to your plan contact as soon as possible.

Covered Service Provider:

Employer / Plan Sponsor:

Description of Services:
(Please note if each service will be provided in a fiduciary capacity)

1.
2.
3.

Description of Direct Compensation:

- May be expressed as amount, formula, per capita charge, or any other reasonable method
- If additional compensation may be earned, also include a good faith estimate and a description of the circumstances under which the additional compensation will be earned

Description of Indirect Compensation:

- Identify the payer of the indirect compensation
- Identify the service(s) provided in association with the indirect compensation
- May be expressed as amount, formula, per capita charge, or any other reasonable method
- If additional compensation may be earned, also include a good faith estimate and a description of the circumstances under which the additional compensation will be earned

Description of Transactional Compensation:
(Compensation based on business placed or retained, ex. commissions, finder's fees)

- Identify the payer of the indirect compensation
- Identify the service(s) provided in association with the indirect compensation
- May be expressed as amount, formula, per capita charge, or any other reasonable method
- If additional compensation may be earned, also include a good faith estimate and a description of the circumstances under which the additional compensation will be earned

Description of Termination Compensation:
(Any compensation associated with termination of the contract)

- Identify the payer of the indirect compensation
- Identify the service(s) provided in association with the termination compensation
- May be expressed as amount, formula, per capita charge, or any other reasonable method
- If additional compensation may be earned, also include a good faith estimate and a description of the circumstances under which the additional compensation will be earned

Ballard Spahr LLP

Health Plan Fiduciaries Must Solicit Information From Brokers and Consultants

Background. Under the prohibited transaction rules of the Employee Retirement Income Security Act of 1974, as amended (ERISA), a plan fiduciary may engage a vendor to furnish services on behalf of a plan only if no more than reasonable compensation is paid for the services. Brokers and consultants to a health plan often receive compensation from sources other than the plan or plan sponsor.

New Rule. The Consolidated Appropriations Act, 2021 (CAA) requires the disclosure of information to ensure that brokers and consultants receive no more than reasonable compensation for their services. The rule applies to arrangements with:

- Brokers who provide services for the selection of health insurance products (including dental and vision insurance) and a wide range of other plan administrative services and programs, including third-party administrative services, pharmacy benefit management, stop-loss insurance, wellness programs, employee assistance programs, and recordkeeping; and
- Consultants who provide services that would subject a broker to the new rules or services related to the development and implementation of plan designs.

Compensation includes amounts that the plan or plan sponsor pays the broker or consultant directly and amounts that the broker or consultant receives from other sources in connection with their services provided to the plan. This includes non-monetary compensation with a value of at least $250.

Brokers and consultants must disclose to the plan fiduciary responsible for the relationship a description of their services (including when the broker or consultant will act as a fiduciary, if applicable), a description of all direct and indirect compensation they expect to receive in connection with their services (including certain details about their arrangements with other sources of payment), and certain information about their financial arrangements with affiliates and subcontractors. The rules contain details about these disclosures, particularly with regard to indirect compensation. The plan fiduciary may also require the broker or consultant to provide information that the fiduciary needs to comply with other requirements under ERISA.

This information must be provided reasonably in advance of the date that a contract is executed, extended, or renewed, and the information must be updated within 60 days of any change (absent extraordinary circumstances).

Although couched largely in terms of what the broker or consultant must disclose, the rules will require the plan fiduciary responsible for the relationship to require the broker or consultant to disclose this information. The rules specify actions that the fiduciary must take if it knows of a failure by a broker or consultant to make an appropriate disclosure. As is the case with similar rules applicable to retirement plans, the penalties for compliance failures are on the plan fiduciary, not the broker or consultant.

Citation. ERISA section 408(b)(2).

Effective Date. The new rules will apply to plans as of December 27, 2021. A special transitional rule provides that the rules do not apply to contracts with brokers and consultants executed prior to that date (but see below).

Enforcement. Under ERISA, a prohibited transaction can result in civil penalties of up to 5 percent of the amount involved in the transaction. Penalties can increase to 100 percent of the amount involved in the transaction if appropriate correction is not made within 90 days of notice from the U.S. Department of Labor. In addition, prohibited transactions generally must be unwound, which likely would require the fiduciary to direct the broker or consultant to repay any excess compensation to the plan. A violation of these rules could also be deemed a breach of fiduciary duty, particularly if plan assets are used to pay the broker or consultant. This could result in litigation by plan participants or the U.S. Department of Labor. ERISA also provides for civil penalties for breaches of fiduciary duty equal to 20 percent of the amount recovered.

Plan Considerations. Plan fiduciaries must request and obtain the required information for any new relationship with a broker or consultant. This should include any renewal of a relationship and, we believe, any new matter for which an existing broker or consultant is engaged. Although the new rules technically do not reach contracts executed before the effective date, the new rules establish standards that, in substance, are no less applicable to existing relationships. Thus, fiduciaries would do well to evaluate the reasonableness of compensation that is paid in ongoing broker and consultant relationships to gain assurance that the advice that they are receiving from their brokers and consultants is fully in the interest of their plans and participants and beneficiaries.

Plan fiduciaries will also need to consider how they will make proper use of the information once they receive it. Employers may wish to draw on their experience in responding to fiduciary requirements imposed on them with regard to vendors under their 401(k) and other retirement plans and consider whether it is sensible to delegate responsibility for selecting and monitoring broker and consultant relationships to a particular committee or individual.

Although every regulatory requirement carries with it administrative burdens, plan fiduciaries may view these new requirements as providing them with significantly enhanced leverage to obtain information that will better enable the plan fiduciaries to fulfill their responsibilities with respect to the selection of insurance products, plan vendors, and other matters of great significance to a plan.

Recommended Steps. Plan fiduciaries should consider taking the following actions:

- Identifying the brokers and consultants who are subject to the new rules.
- Identifying and assigning internal responsibility for soliciting and evaluating required information from brokers and consultants.
- Introducing contractual obligations on brokers and consultants to provide the required information (this is particularly urgent for new, renewed, and extended arrangements).

- Setting deadlines for the provision of the required information.
- Developing the means to evaluate the information received, both in terms of completeness and relevance and in terms of the reasonableness of the total compensation that the broker or consultant receives. This may require seeking additional assistance or access to data that allows for benchmarking the information.
- Assessing whether the compensation is, in fact, reasonable and whether the information provided presents any other concerns that need to be investigated or further addressed with the broker or consultant.
- Properly documenting the fiduciary's assessment of the reasonableness of the compensation.
- Considering how the information and evaluation affect the relationship with the applicable broker or consultant.

Lawyers at Ballard Spahr are working with the new rules and are prepared to assist you with questions that you may have. Please contact Edward Leeds or Paige Haughton.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

Paige A. Haughton
Associate, Washington, DC
haughtonp@ballardspahr.com
202.777.6036

Ballard Spahr LLP

Prohibition Against Gag Clauses

Background. Health plan vendors sometimes impose contractual restrictions on the disclosure of data that they consider to be confidential or proprietary, but a number of new rules aim to foster an environment of transparency and require disclosure of pricing and other information that might otherwise be subject to those restrictions.

New Rule. The Consolidated Appropriations Act, 2021 (CAA) prohibits a health plan from entering into an agreement with any health care provider, association or network of providers, third-party administrator, or other service provider offering access to a network that directly or indirectly restricts the plan from:

- Providing provider-specific cost or quality of care information to referring providers, the plan sponsor, plan participants, and others eligible to enroll in the plan.
- Upon request, obtaining electronic access to de-identified claim and encounter data for each plan participant, including:
    - Claim-related financial information in a provider contract
    - Provider information, such as the provider's name and clinical designation
    - Service codes
    - Any other data element in claim or encounter transactions
- Sharing such information with a business associate of the plan.

The plan will need to comply with the privacy provisions in HIPAA, GINA, and ADA in applicable circumstances, and reasonable restrictions may be imposed on the public disclosure of this information.

Health plans will be required to attest annually to their compliance with this requirement.

Citation. ERISA section 724; Internal Revenue Code section 9824; and Public Health Services Act section 2799A-9.

Effective Date. December 27, 2020. Attestations to be collected in 2022.

Enforcement. For health plans that are subject to ERISA, the U.S. Department of Labor and plan participants and beneficiaries may enforce compliance with these rules. Plans not subject to ERISA may be subject to enforcement by the U.S. Department of Health and Human Services. HHS shares responsibility for enforcement against insurers with state agencies. In addition, the Internal Revenue Service may impose an excise tax of $100 per day per affected individual under section 4980D of the Code for any failure to comply.

At this time, the federal agencies have announced that they expect to issue guidance only with regard to the required attestations. Otherwise, plans are expected to comply with a good faith, reasonable interpretation of the statutory provisions.

Plan Considerations. The rule prohibits a plan from entering into an agreement that restricts access to and the disclosure of information in a prohibited manner. Its effective date means that it will apply to agreements entered into after the CAA was enacted on December 27, 2020.

The law does not specifically address agreements executed before that date. However, in view of the transparency requirements that are coming, employers may find it sensible to seek compliance with the new requirements from all applicable health plan vendors. The new rule could serve as a basis for contractual terms that provide affirmatively for the greater sharing of information. Guidance on the attestations is expected and may offer insight into the regulators' view of existing contracts, as well as contract renewals and amendments.

Recommended Steps. Plan sponsors should consider taking the following actions:

- Identifying contracts that include restrictions on access to and the disclosure of provider-specific information (as proprietary, confidential, or otherwise).
- Modifying those contracts entered into on or after December 27, 2020, to eliminate or override those restrictions.
- Addressing those restrictions in new contracts and potentially in contracts that were entered into before these anti-gag rules were enacted.
- Attending to guidance on attestations and submitting timely attestations in 2022.

Lawyers at Ballard Spahr are working with the new rules and are prepared to assist you with questions that you may have. Please contact Edward Leeds or G'Nece Jones.

Contacts

Edward I. Leeds
Counsel, Philadelphia
leeds@ballardspahr.com
215.864.8419

G'Nece Jones
Associate, Philadelphia
jonesgn@ballardspahr.com
215.864.8286

OneVision

An Independent Fiduciary Company

Fiduciary CORE™

Comparison of Reasonable Expenses

Services & Costs Analysis

Limited Scope Report: Medical Only

Benchmarking

Requirements

Legislation passed in December 2020 requires employers that offer health & welfare benefits to operate their plans as fiduciaries. Among other things they are required to pay no more than "reasonable" fees for services.

Determining "reasonableness" requires identifying the services received, compensation earned, and comparing them to services and compensation for comparable plans. This process is commonly called benchmarking.

Affected Plans

These new requirements affect ERISA-covered "group health plans" including:

- Medical plans
- Prescription drug plans
- Dental plans
- Vision plans
- Flexible Spending Account plans (medical)
- Health Reimbursement Arrangement plans

Covered Service Providers

Vendors are required to provide detailed disclosures of services and compensation if they reasonably expect to earn $1,000 or more in direct and/or indirect compensation for brokerage or consulting services regarding:

- Selection of insurance products
- Recordkeeping services
- Medical management vendors
- Benefits administration
- Stop-Loss insurance
- Pharmacy benefits management (PBM)
- Employee assistance programs (EAP)
- Third party administration (TPA)
- And more

OneVision

Fiduciary Process

OneVision endorses the fiduciary process developed by the Center for Board Certified Fiduciaries. This five-step cycle codifies a prudent process for plan management. Legislation establishes the Plan Sponsor as a fiduciary under ERISA, PHSA and IRS tax code. A fiduciary must:

- Act solely in the interest of plan participants and their beneficiaries, with the exclusive purpose of providing benefits
- Carry out their duties prudently
- Follow the plan documents (unless inconsistent with legislation)
- Hold any plan assets in trust
- Pay only reasonable plan expenses

CENTER FOR BOARD CERTIFIED FIDUCIARIES
PURPOSE · PASSION · PROCESS

OneVision

National & Regional Trends

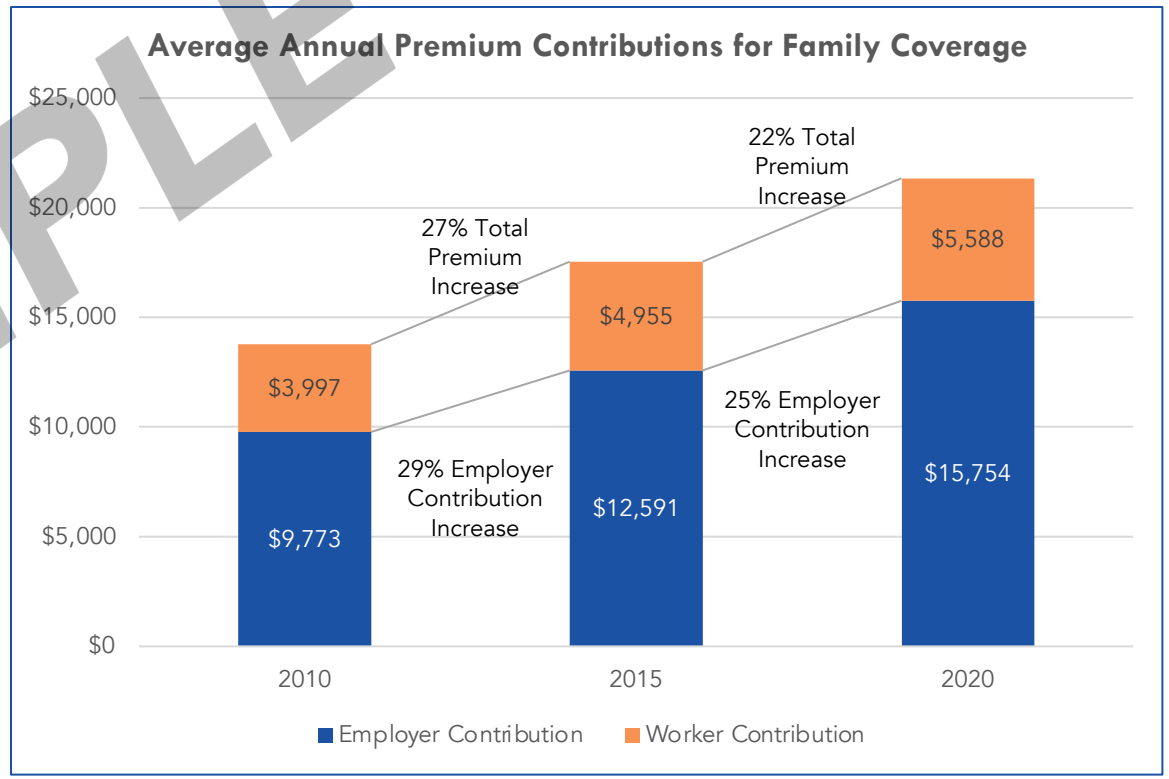
Fiduciary CORE™

OneVision

National Trends

The data used for this report was generated from multiple large scale national surveys, and OneVision's proprietary database.

- The average premium for family health coverage has increased 22% over the last five years and 55% over the last ten years.
- On average, covered workers contribute 17% of the premium for single coverage and 27% of the premium for family coverage. Compared to covered workers in large firms, covered workers in small firms on average contribute a higher percentage of the premium for family coverage (35% vs. 24%).

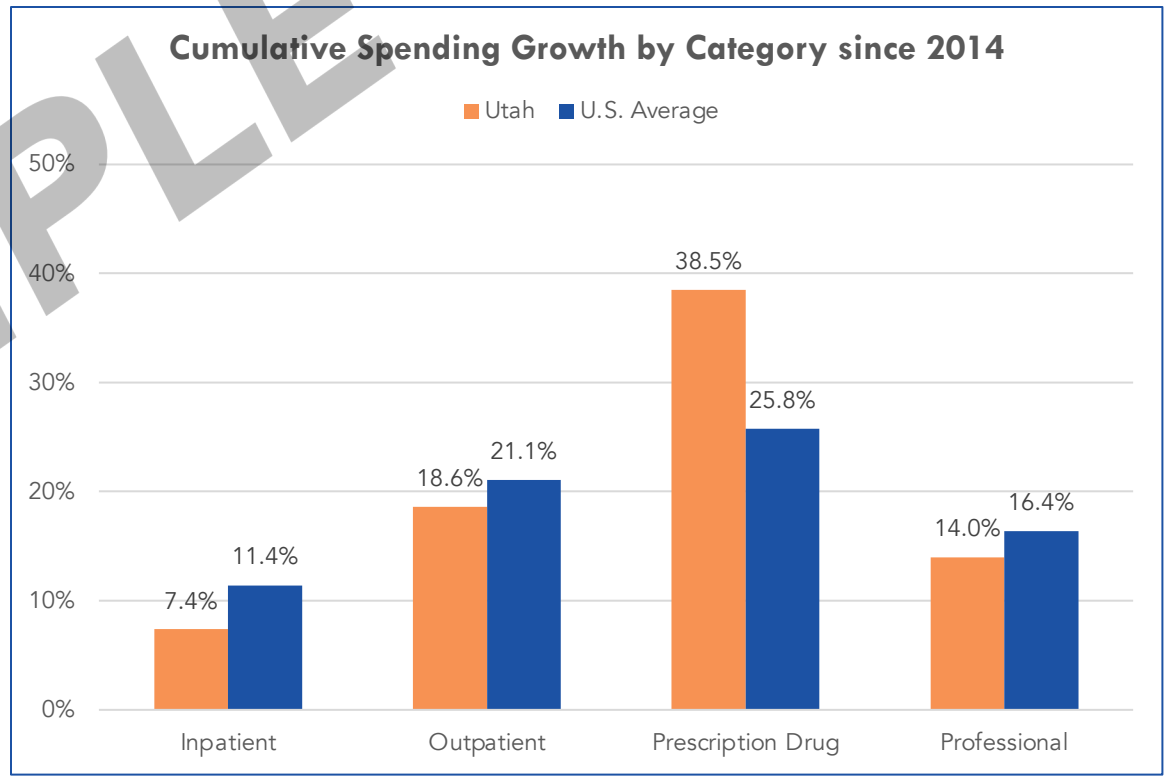


OneVision

Regional Trends

The data used for this report was generated from multiple large scale national surveys, and OneVision's proprietary database.

- Between 2014-2018 health care spending in Utah increased across four major categories: inpatient care, outpatient care, prescription drug spending, and professional services.
- Nationally, prescription drug spending had the highest growth at 25.8%, while inpatient spending experienced the lowest growth at 11.4%.
- The increase in prescription drug spending in Utah outpaced the national growth rate by 12.7%.



OneVision

Standard Services & Fees

Fiduciary CORE™

OneVision

Plan Profile

The data used for this report was generated from multiple large scale national surveys, and OneVision's proprietary database.

	ACME Corp.	Benchmark Group (312 employers)
Location	Salt Lake City, UT	Rocky Mountains & South-West (AZ, CO, ID, NM, NV, UT, WY)
Employees	1,117	750 – 1,500
Benefits Offered		
Medical	Self funded: 933 participants	Self funded & Fully insured
Rx	Bundled w/ Medical	Bundled & Unbundled
Dental	Self Funded: 837 participants	Self funded & Fully insured
Vision	Fully Insured: 685 participants	Self funded & Fully insured
FSA (medical)	Offered: 912 participants	Offered
HRA	Not offered	NA

Standard Services & Fees

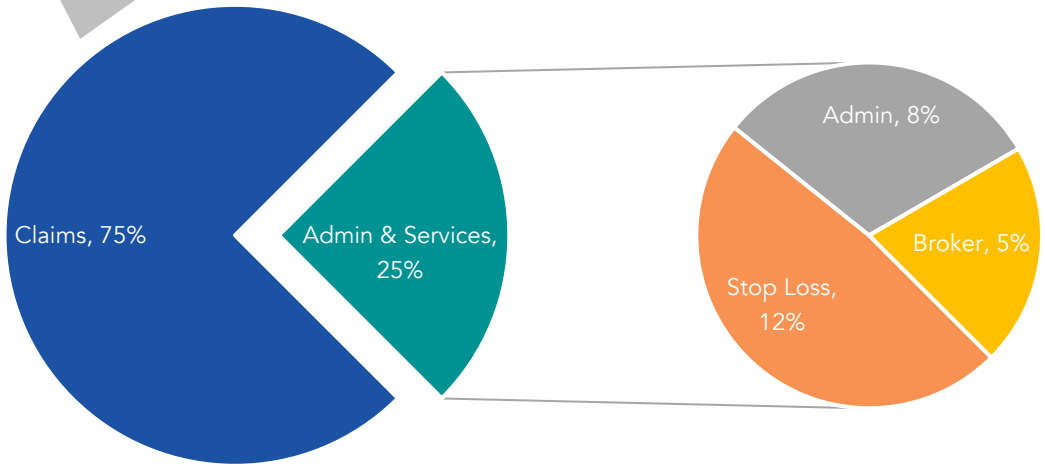
Don't consider fees in a vacuum. They are one part of a much bigger picture, including the extent and quality of services received from providers. Premium services often come with premium prices.

Self-Funded Plan Costs by Category

Total health plan costs can be grouped into four large categories: Claims costs, Stop Loss premiums, Administrative costs, and Broker fees. Within the benchmark group, their relative share of total plan costs follows.

Claims costs account for the majority of expenditures, paying providers and reimbursing participants for services provided and received.

Stop loss premiums, Administrative services provided by the carrier / network or a Third-Party Administrator (TPA), and Broker's fees constitute the remainder.

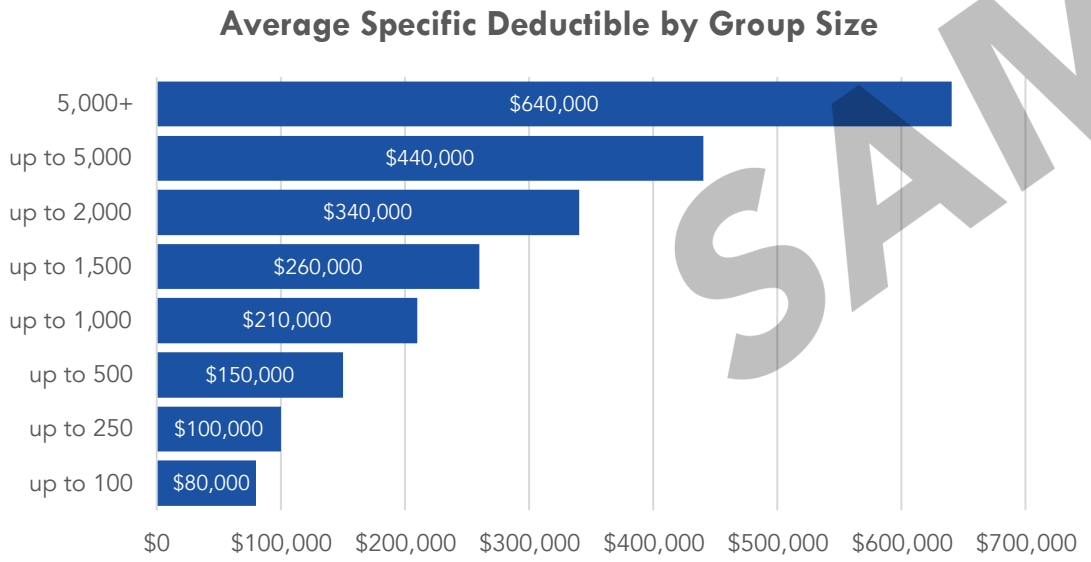


OneVision

Stop Loss Services & Fees

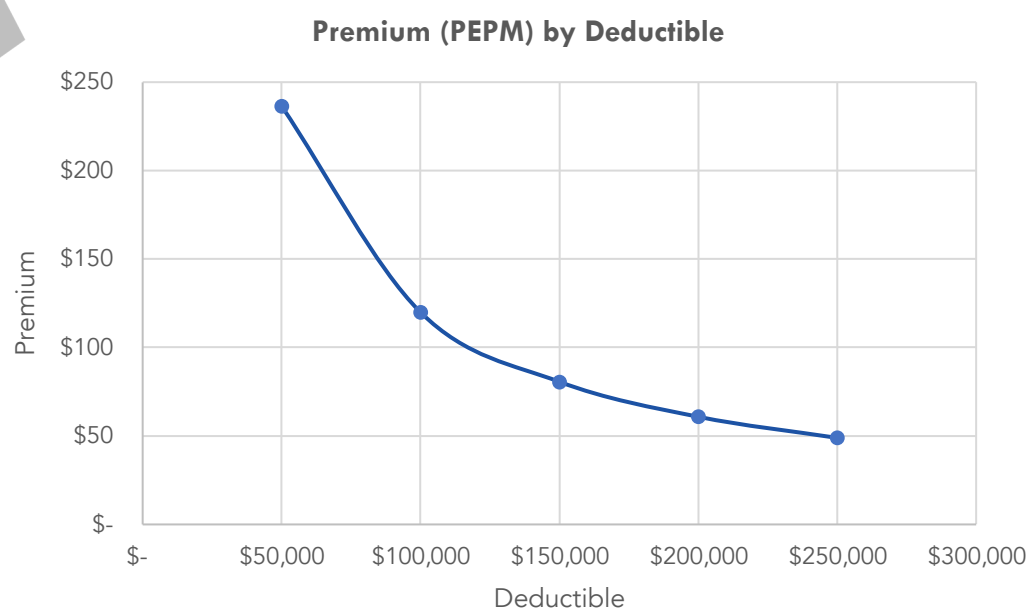
Stop Loss Coverage

Stop loss insurance provides coverage against catastrophic losses, either from an individual claimant (Specific coverage) or across the covered population (Aggregate coverage). Generally, larger companies choose a larger Specific deductible.



Stop Loss Premiums

Premiums are dependent upon multiple factors and inversely proportional to deductibles.



OneVision

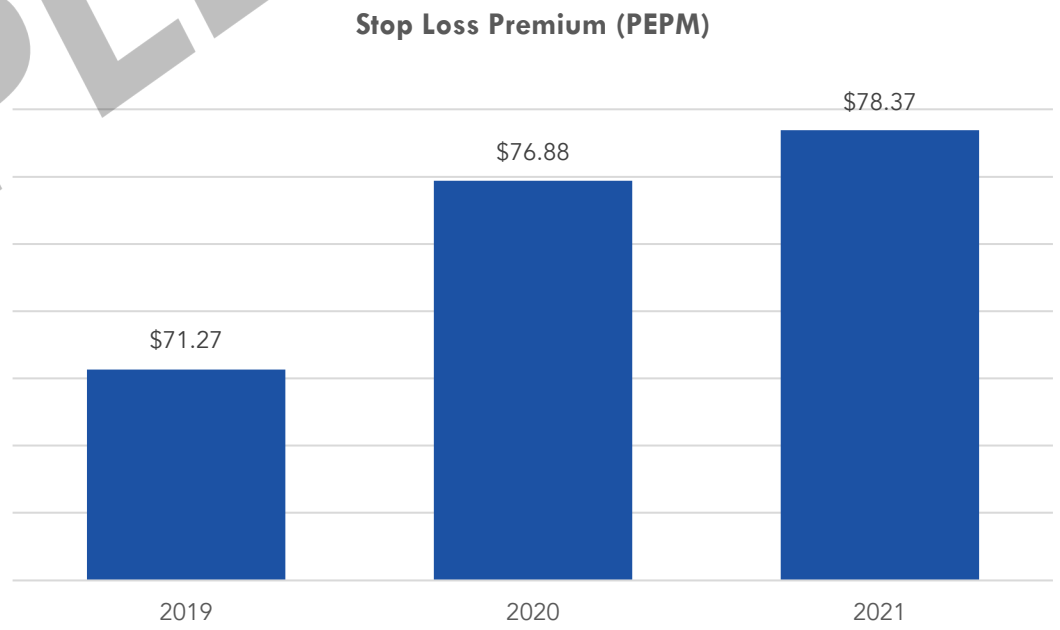
Stop Loss Services & Fees

Stop Loss Premium Trends

Nationally, the average Specific stop loss premium PEPM grew 7.9% from 2019-2020 and grew an additional 1.9% from 2020-2021.

Due to leveraged risk, lower specific deductibles are expected to experience a more significant increase on an annual basis than higher deductibles. To help reduce future increases, employers can take proactive measures such as increasing the specific deductible each year.

A modification to the specific deductible, the aggregating specific is a form of risk retention used to offset premium costs for stop-loss coverage. After the Specific Deductible is reached for an individual, the employer pays an additional deductible across all Specific claims prior to stop-loss coverage stepping in.



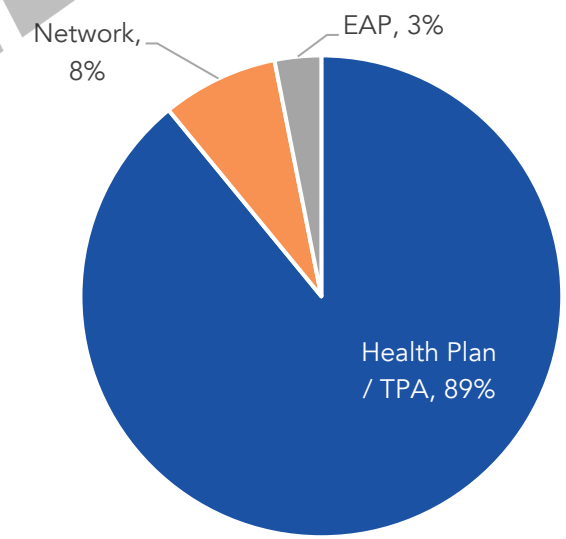
OneVision

Administration Services

Total Admin Costs by Category

Health plan administrations costs can be divided into three large categories: Third Party Administrator (TPA) fees, Network charges, and Employee Assistance Program (EAP). Within the benchmark group, their share of total admin costs follows.

When leveraging a bundled service provider, all of these services may be covered by the Health Plan itself for a single fee. Unbundling the services may offer additional transparency and more competitive pricing.



OneVision

Administration Services

Unbundled: TPA Services

Across all Third-Party Administrators (TPA) servicing the benchmark group, the following services were included in their core offering.

- Claims administration / processing
- Medical management
- Customer service
- ID card production
- Eligibility determination
- 125 plan testing
- Document production – SPD, SBC
- Advanced Explanation of Benefits (EOB)*

* New requirement under CAA

Unbundled: Other Admin Services

The following additional administrative services are often provided by the Carrier or Network:

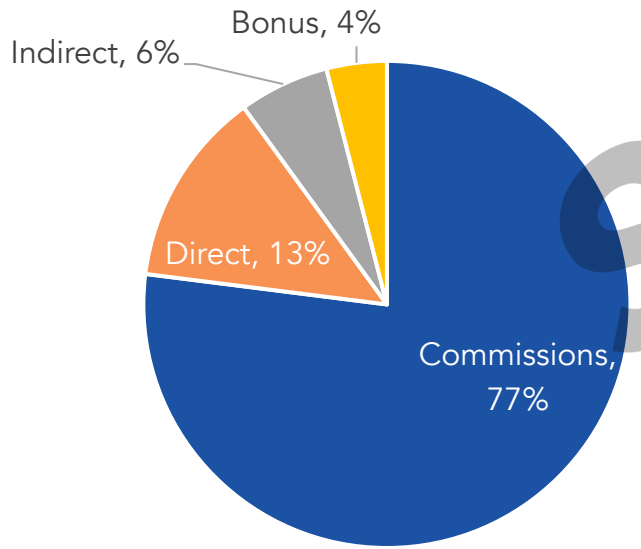
- Network access, contracting & negotiation
- Employee Assistance Program (EAP)
- Virtual care
- Disease management
- Internet portal access
  - In-network provider identification
  - Digital EOB
  - Medical pricing transparency tool
- Tool set (mobile app, health tracker, etc.)
- Compliance & communications
- Medicare eligibility
- Customer service
- Advanced Explanation of Benefits (EOB)*

* New requirement under CAA

Broker Services & Fees

Broker Compensation by Category

Broker compensation can be described by four categories: Commissions, Direct compensation, Indirect compensation and Bonuses. Within the benchmark group, brokers received compensation via multiple revenue streams, and total compensation is broken down as:



Broker Compensation Structure

Commissions are structured as a percentage of premium. This can be established as a flat rate or graded by volume or time.

Direct compensation is governed by a contract between the broker / consultant and the plan sponsor. This is the most intuitive and transparent form of broker compensation.

Indirect compensation is often based upon the performance of a particular plan. Medical loss ratio, headcount growth, premium growth and overall profitability are all factors that could affect the calculation.

Bonus compensation is calculated based on the volume of business a brokerage does with a particular carrier. New business generated and existing business retained at renewal will factor into bonus qualification.

OneVision

Broker Services & Fees

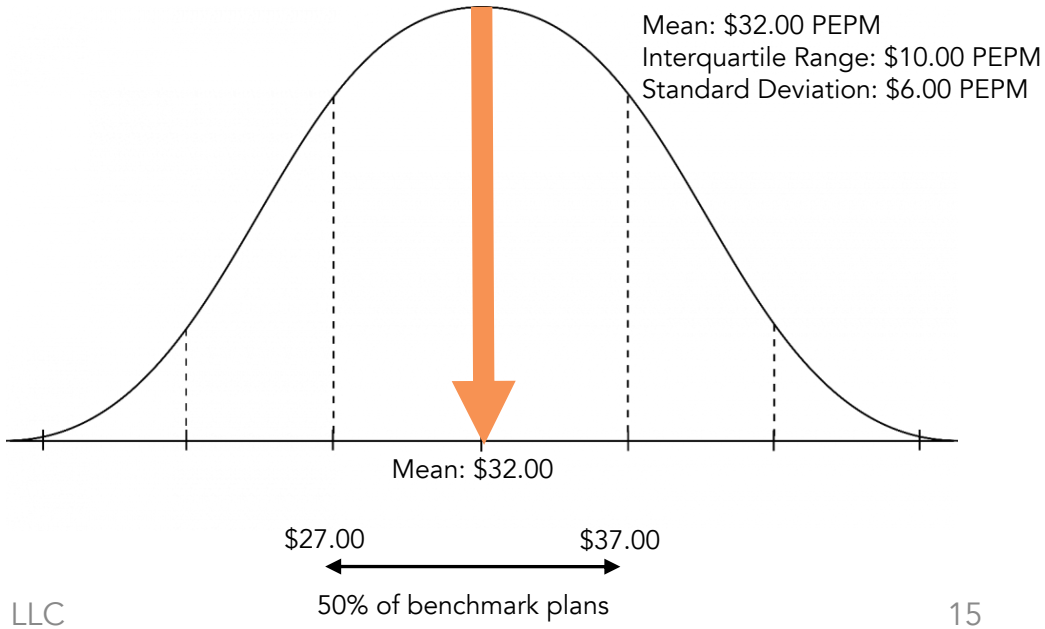
Broker / Consultant Services

Across all brokerages associated with the benchmark group, the following services were included in their core offering.

- Strategic planning
- Plan design
- Participant Communication / Education
- Vendor management
- Contract negotiation
- Compliance (ACA)
- Reporting
- Underwriting & Actuarial services
- HR consulting services
- Online enrollment
- Data analytics
- Risk management services
- Population health analysis
- Ready to sign 5500 form

Broker Compensation

Within the benchmark group, the average total broker compensation is $32.00 PEPM. The middle 50% of plans generated total broker compensation between $27.00 - $37.00 PEPM.



OneVision

Value Indicators

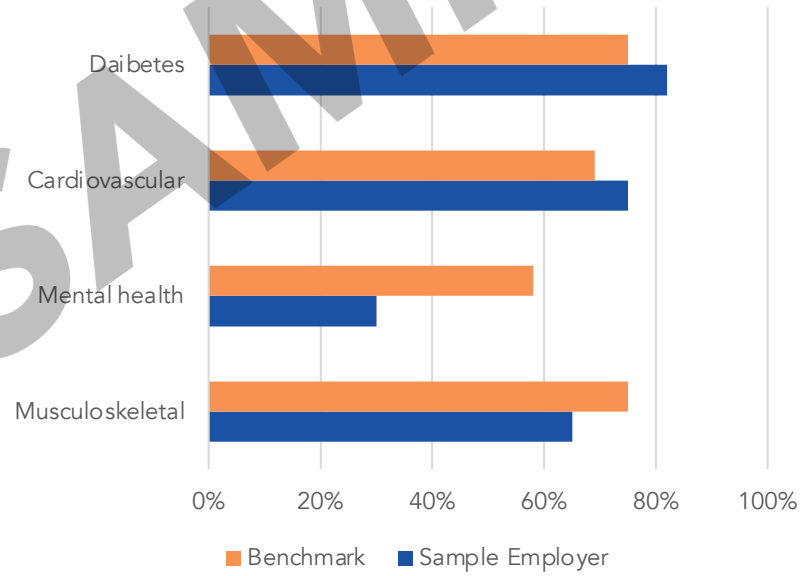
There are multiple ways to measure the value of your plan. Below are three indicators to consider. Together they can offer insight into how healthy your population is, whether they are getting the preventative care they need, and if they are getting that care at high quality facilities.

Relative Risk Score

A risk score is assigned to each covered individual based upon an actuarial analysis. A "relative risk score" is measured in standard deviations from the average score across the benchmark group. A positive number indicates a higher-than-average risk.

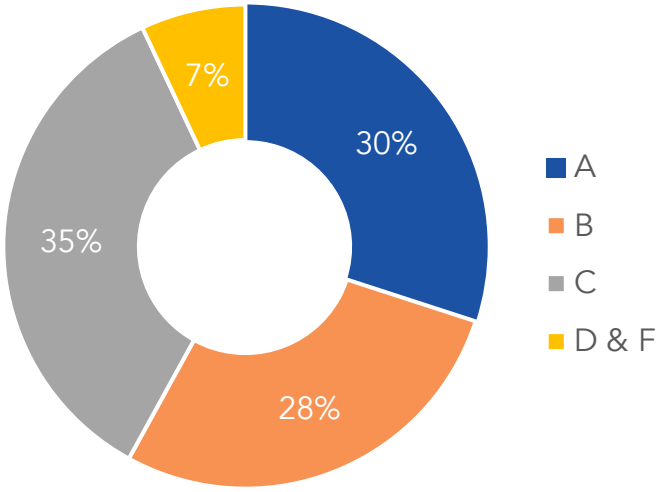
Care Gap Measurement

Care gap measurements identify areas in a health plan where participants are not getting the preventative care they should. This non-compliance can produce negative impacts over time.



Point of Care

The facilities your employees choose for in-patient and out-patient procedures can directly affect health outcomes. Poorly graded facilities are prone to complications and additional costs. Nationally, procedures are completed at facilities with the following ratings:



OneVision

Sources & Disclaimer

- Consolidated Appropriations Act, 2021
- KFF. 2021. 2020 Employer Health Benefits Survey. [online] Available at: <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/> [Accessed 18 October 2021].
- Health Care Cost Institute. 2021. 2019 Health Care Cost and Utilization Report. [online] Available at: <https://healthcostinstitute.org/interactive/2018-health-care-cost-and-utilization-report> [Accessed 18 October 2021].
- Stealth Partner Group. 2021. State of the Market, First - Second Quarter 2021. [online] Available at: <https://www.amwins.com/resources-insights/article/stop-loss-market-update> [Accessed 20 October 2021].
- Marsh & McLennan Agency. 2019. 2019 Upper Midwest Stop-Loss Survey. [online] Available at: <https://mma.marshmma.com/2019StopLoss> [Accessed 22 October 2021]
- The Leapfrog Group. 2021. Lives & Dollars Lost Calculator. [online] Available at: <https://www.leapfroggroup.org/employers-purchasers/lives-dollars-lost-calculator> [Accessed 18 October 2021].

OneVision makes no representations or warranties about the accuracy or suitability of any information provided (such as handouts, presentation documents and recordings); all such content is provided to users on an "as is" basis. The information contained in these reports and related materials is not intended to constitute legal advice or the rendering of legal, consulting, or other professional services of any kind. Users of these materials should not in any manner rely upon or construe the information or resource materials in these materials as legal, or other professional advice and should not act or fail to act based upon the information in these materials without seeking the services of a competent legal or other professional.

TILT

DID YOU KNOW?

The Consolidated Appropriations Act (CAA) Identifies the Health Plan Sponsor as a Fiduciary

The CAA, passed in December of 2020, lays out extensive rules and responsibilities that plan sponsors, as Fiduciaries, must both familiarize themselves and comply with.

The goal of the CAA is to improve transparency by:

1. Removing Gag Clauses From Service Provider Contracts
2. Establishing Reporting Requirements for Pharmacy and Prescription Drug Prices
3. Requiring disclosure of Direct and Indirect Compensation from All Service Providers
4. Requiring Parity in Substance Abuse and Mental Health Benefits

The CAA will provide you with more transparency and access to your health care data so you can:

- ✓ Create significant savings for the plan and your participants
- ✓ Improve health outcomes for your participants
- ✓ Understand who you're paying and what you're getting
- ✓ Demonstrate parity in substance abuse & mental health coverage

Potential risks:

- ✓ Government action for non-compliance
- ✓ Class Action Lawsuits

It's critical that plan sponsors act with urgency and establish a Fiduciary procurement process, just like you do with your retirement plan!

How TILT can help:

- ✓ Educate you and your team about CAA and its implications for your organization
- ✓ Develop a Fiduciary procurement process and provide the tools you will need for compliance
- ✓ Implement and monitor your adherence to the process

> ***"The CAA is good for plan sponsors and their participants. When those two things are aligned, something magical happens"***
>
> **Hugh O'Toole, CEO at Innovu**

If you are looking for further information or would like to discuss CAA in more detail, please contact Jamie Greenleaf at jgreenleaf@tiltthebalance.com

CAA Compliance: 4 Things Employers Must Do Before Jan 1st
Toolkit for Employers

VIIII. Additional Resources: *The Panelists*

Leah Binder
CEO and President
The Leapfrog Group
1775 K Street NW, Suite 400
Washington, DC 20006
www.leapfroggroup.org
202-292-6713

James Gelfand
Executive Vice President
ERIC, The ERISA Industry Committee
701 8th Street NW, Suite 610
Washington, DC 20001
http://www.eric.org
202-789-1400

Jamie Greenleaf, Jamie Greenleaf
Managing Director/Founder
TILT
jgreenleaf@tiltthebalance.com
800-401-4830

Michael Thompson
President and CEO
National Alliance of Healthcare Purchaser Coalitions
1015 18th Street, NW, Suite 730 Washington, DC 20036
202.775.9300 ext. 200
mthompson@nationalalliancehealth.org

Additional Employer and Payer Engagement, Education & Data Products:

Jill Berger, Director
Employer & Payor Engagement
The Leapfrog Group
1775 K. Street, NW, Suite 400
Washington, DC 20006
jberger@leapfrog-group.org
(202) 292-6713

Beth Sprole
Vice President Data Products and Marketing
The Leapfrog Group
1775 K. Street, NW, Suite 400
Washington, DC 20006
bsprole@leapfrog-group.org
(202) 292-6713