FLORIDA ALLIANCE FOR HEALTHCARE VALUE

LED BY FLORIDA'S TOP EMPLOYERS SINCE 1984

# All Employer Member Meeting

## Monday, June 5, 2023

# To Ask Questions of the Speaker

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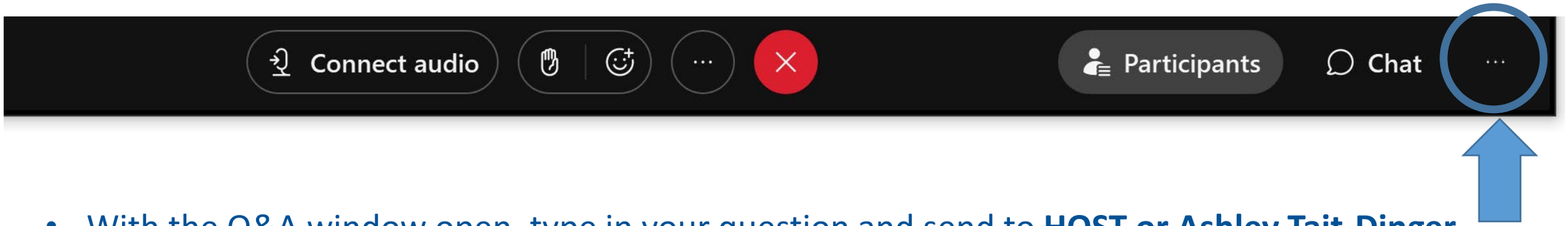
# QUESTIONS?

For most devices, the **Q&A function** can be found by clicking on the ellipsis (the 3 dots) at the bottom of your screen on the far right.




- With the Q&A window open, type in your question and send to **HOST or Ashley Tait-Dinger.**
- There is a 512-character limit for questions.
- If we are unable to address your questions during the online presentation, we will try to have the remaining questions answered following the session and posted with the follow up material.

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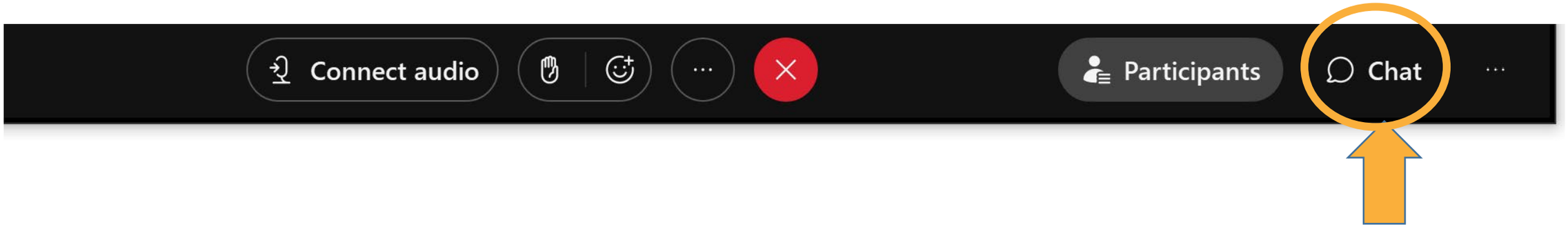
# Technical Issues

We request the **Chat function** be reserved for technical or logistical issues or questions.




- With the chat window open, type in your question and send to **Ashley Tait-Dinger (Host).**
- There is a 512-character limit for questions.
- We will address your issue as quickly as possible

# FL Alliance Initiatives Requiring Employer Claims Data

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**For the RAND Hospital Price Transparency Study or the Cost Savings Analysis -- It's not been easy even with the CAA law!**

- Numerous delays that were essentially unwarranted – data layout, scope, date ranges, files to include (all explicitly stated in the initial request)
- Questioning whether the employer should have access to financial fields (like the prices they paid) – stating that this information is proprietary
- Claiming restrictions under HIPAA that don't exist or have nothing to do with the requests for price data
- Asserting that claims data cannot be used for the purpose of conducting audits

# More excuses!

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- Requesting the indemnification of the health plan or PBM prior to releasing the claims data to the employer or third party
- Requiring the purchase of cybersecurity insurance in astronomical amounts (like $75M) to protect the carrier from liability that has nothing to do with the claims data request
- Health Plan and PBM attorneys stating that we are misinterpreting the CAA and that employers do not have the right to their claims data for any reason.
- Stating that the data cannot be used by third parties despite the fact that all data analytics companies are third parties and do this every day

# Please note!

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- Nothing about conducting a claims analysis to benchmark prices is or should be considered to be confidential!

# Speaker

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**Christin Deacon, J.D.**

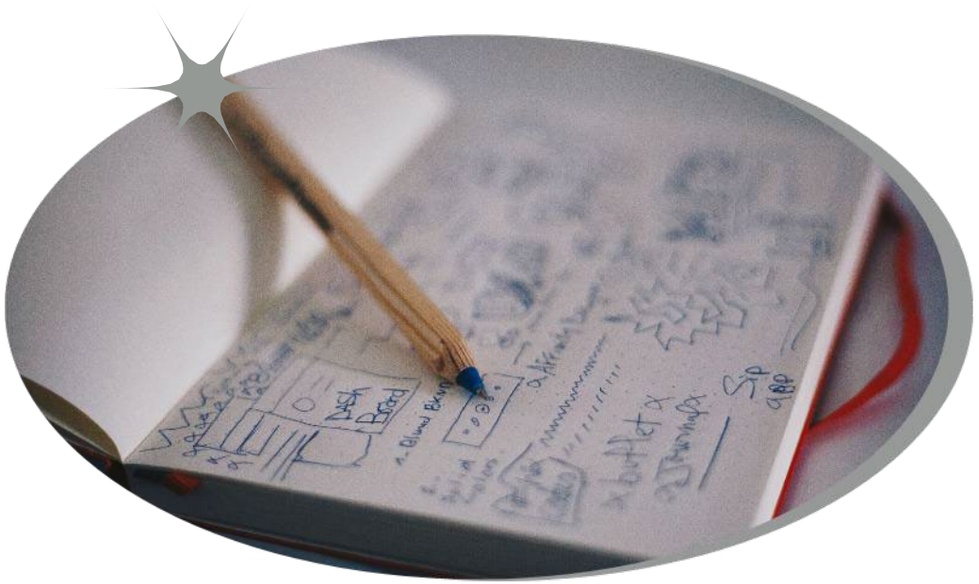
*Founder and Principal*
VerSan Consulting

*Former Director*
Health Benefits Operations and Policy and Planning for the State of New Jersey

VERSAN
Consulting

# EMPLOYER DRIVEN
# HEALTHCARE

# CONTENTS

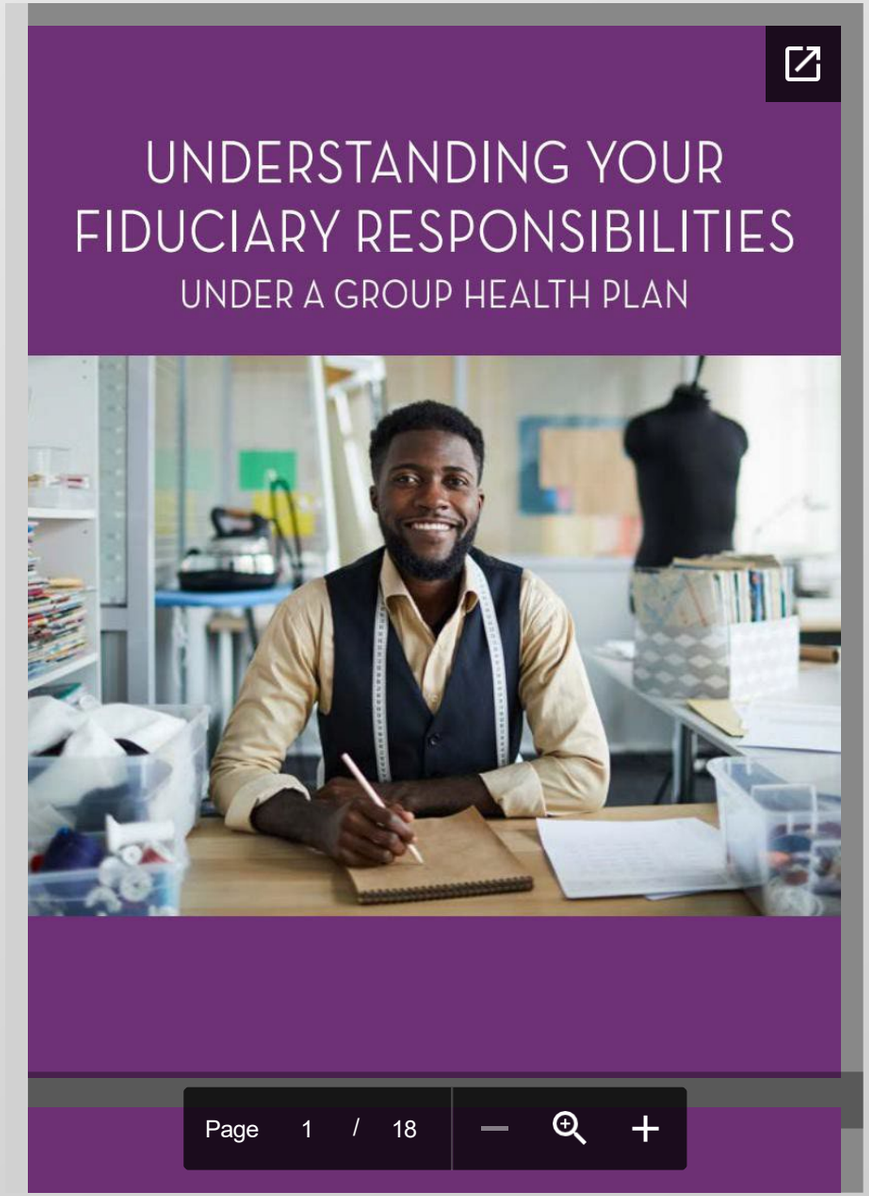


# The Fiduciary Framework

Am I a fiduciary?

What does it mean to be a fiduciary?

How do I execute on fiduciary decisions?




# Understanding the Who and What of Fiduciary Status

- Act in the Sole and Best Interest of Plan and Plan Participants
- Carry Out Duties Prudently
- Follow Plan Documents
- Hold Plan Assets in Trust
- Pay Only Reasonable Plan Expenses

| Principal Fiduciary Duty | Action Required | Examples for Health Plans |
|---|---|---|
| **Act Solely in the Best Interests of Plan Participants and Beneficiaries** | Actions must be for the exclusive purpose of providing benefits.<br><br>You must disclose and avoid all conflicts of interest. | Employer Requires Compensation Disclosure (direct and indirect) from all vendors and has means to discover and enforce conflicts of interest restriction.<br><br>**Example of Breach:** Employer Contracts with Benefits Consultant that Derives Income from Insurance Company as a Result of Employer Business. |
| **Carry out Duties With Prudence** | Exercise skill, care and diligence in responsibilities.<br><br>Document process for all decisions.<br><br>Ensure adequate expertise for plan decisions, or hire competent professional. | Ensure there is a documented process for selection of service provider (TPA, e.g.,) as well as documented process for ongoing monitoring and enforcement of contractual performance and financial guarantees.<br><br>**Example of Breach:** Failure to Conduct Comprehensive Audit of all Third-Party Service Vendors. |
| **Follow Plan Documents** | Plan documents serve as basis for plan operational and management decisions and should not be deviated from. | Medical Necessity Requirement for all covered services is applied by third-party administrator/carrier.<br><br>**Example of Breach:** Failure to audit member eligibility conducted by third-party service provider. |
| **Hold Plan Assets in Trust** | Anything defined as a plan asset must be held in trust. Plan assets include all participant and beneficiary contributions paid to the employer or withheld from employee, as well as rebates, refunds, dividends, and medical loss ratio rebates in most cases. | Clearly identify plan assets held in trust and ensure, through well documented policies and procedures, that only reasonable plan expenses are paid from the trust account.<br><br>**Example of Breach:** Giving third-party administrator/carrier carte blanche authority over account with member premium contributions with no regular and robust accounting or audit oversight to ensure no prohibited transactions or self-dealing. |
| **Ensure That Plan Expenses are Reasonable** | Investigate, analyze, hire and monitor plan service providers for reasonableness of fees.<br><br>**THIS IS THE SINGLE LARGEST AREA OF WEAKNESS FOR HEALTH PLAN FIDUCIARIES | Employer engages in regular analysis of health plan data and financials in order to ensure that healthcare claims are reasonable (i.e., engage in payment integrity, outlier analyses, appropriate benchmarking, etc.).<br><br>Employer regularly engages in evaluation of third-party point solution value to ensure efficacy, engagement, and overall value to health plan members. |

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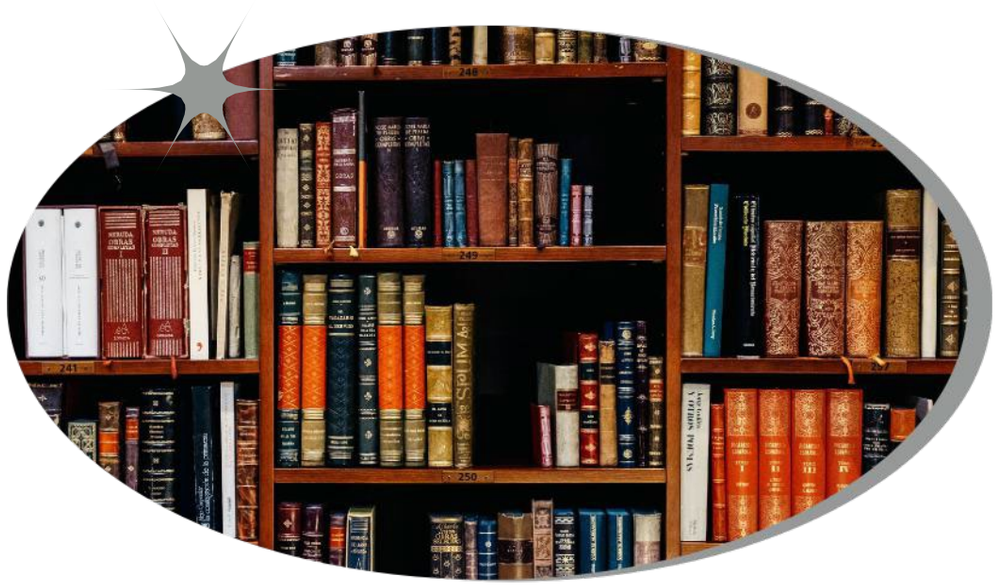
## EXAMPLE OF FIDUCIARY ANALYSIS

Translating the fiduciary framework to everyday decisions and more strategic purchasing decisions is a vital process which must be diligently performed and documented by healthcare fiduciaries.

# Legal and Statutory Updates



- Transparency in Coverage
- Hospital Transparency
- Consolidated Appropriations Act 2020 & 2021
- ERISA Fiduciary Updates

# Consolidated Appropriations Act Updates

Section 201 - Data Ownership, Access and Removal of Gag Clauses

Section 202 - Broker and Compensation Disclosure

Section 204 - RxDC Data Submission

**"SEC. 9824. INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.** 26 USC 9824.

"(a) INCREASING PRICE AND QUALITY TRANSPARENCY FOR PLAN SPONSORS AND CONSUMERS.—

"(1) IN GENERAL.—A group health plan may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan from—

"(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries of the plan;

"(B) electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis—

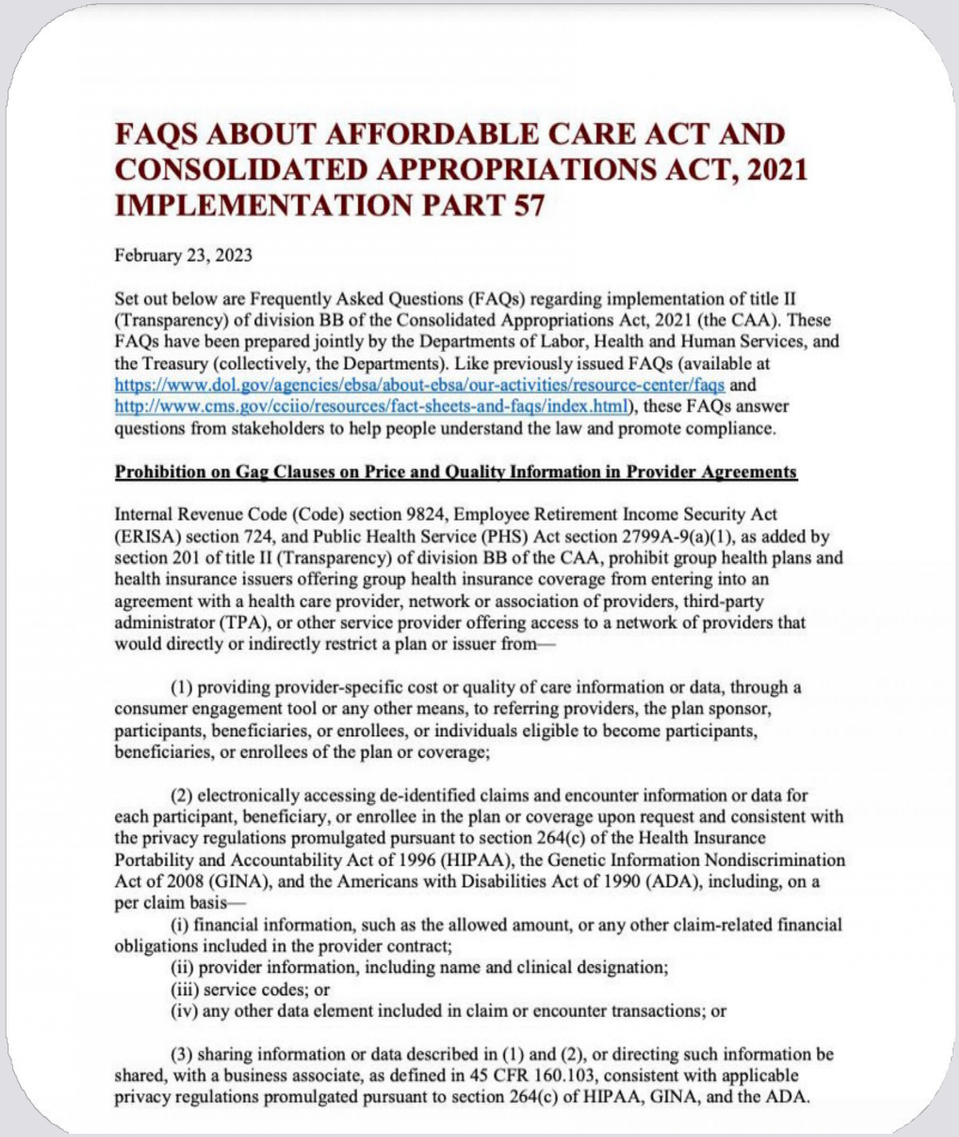
"(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

"(ii) provider information, including name and clinical designation;

"(iii) service codes; or

"(iv) any other data element included in claim or encounter transactions; or

"(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated



**FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 57**

February 23, 2023

Set out below are Frequently Asked Questions (FAQs) regarding implementation of title II (Transparency) of division BB of the Consolidated Appropriations Act, 2021 (the CAA). These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs and http://www.cms.gov/cciio/resources/fact-sheets-and-faqs/index.html), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

**Prohibition on Gag Clauses on Price and Quality Information in Provider Agreements**

Internal Revenue Code (Code) section 9824, Employee Retirement Income Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9(a)(1), as added by section 201 of title II (Transparency) of division BB of the CAA, prohibit group health plans and health insurance issuers offering group health insurance coverage from entering into an agreement with a health care provider, network or association of providers, third-party administrator (TPA), or other service provider offering access to a network of providers that would directly or indirectly restrict a plan or issuer from—

(1) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage;

(2) electronically accessing de-identified claims and encounter information or data for each participant, beneficiary, or enrollee in the plan or coverage upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Americans with Disabilities Act of 1990 (ADA), including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

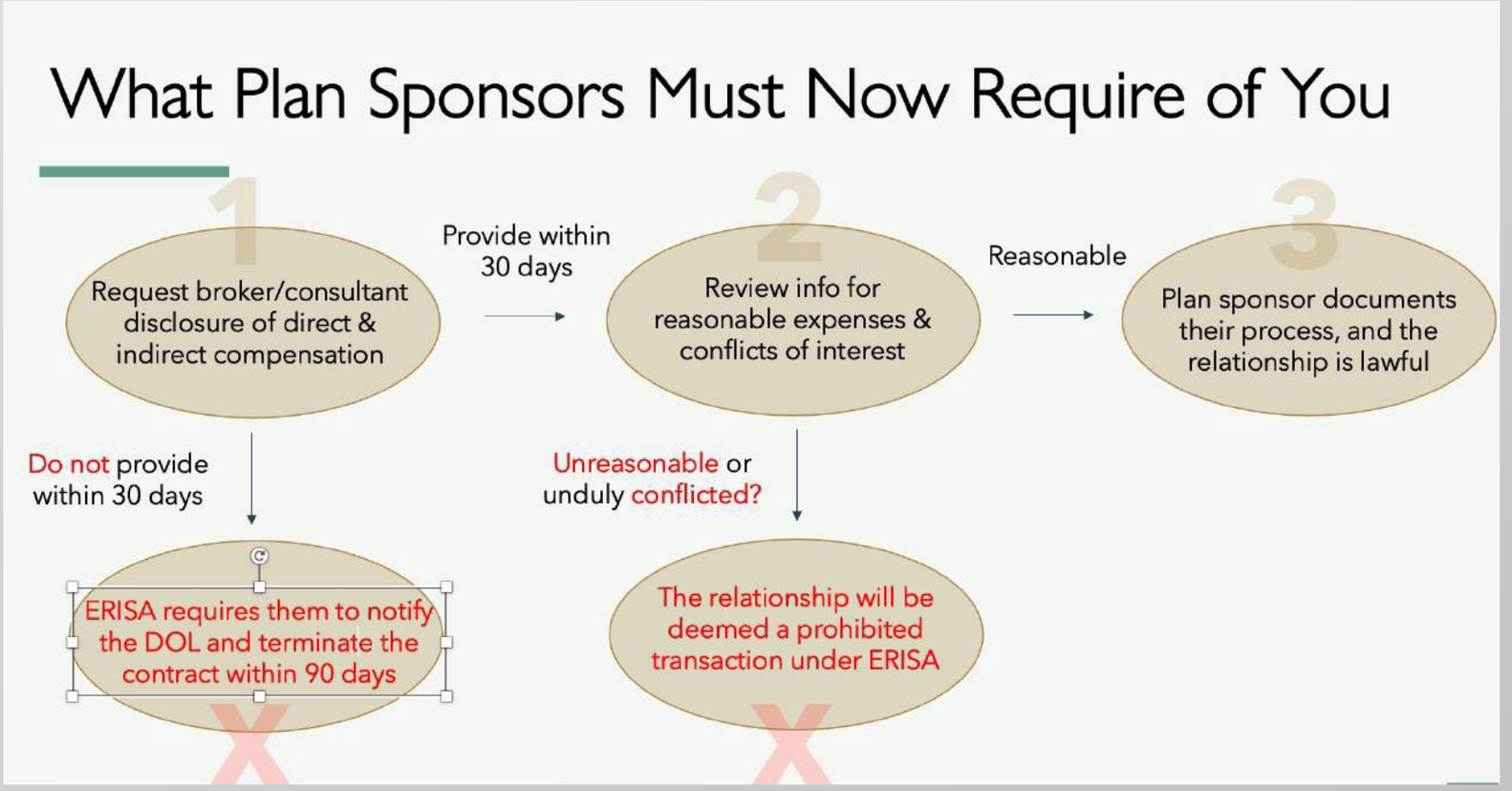
(3) sharing information or data described in (1) and (2), or directing such information be shared, with a business associate, as defined in 45 CFR 160.103, consistent with applicable privacy regulations promulgated pursuant to section 264(c) of HIPAA, GINA, and the ADA.

"if a contract between a TPA and a plan provides that the plan sponsor's access to provider-specific cost and quality of care information is only at the discretion of the TPA, that contractual provision would be considered a prohibited gag clause."

"if a contract between a TPA and a group health plan states that the plan will pay providers at rates designated as "Point of Service Rates," but the TPA considers those rates to be proprietary ...[any] language prohibiting disclosure would be considered a prohibited gag clause..."

- §202 of the CAA amends ERISA at 408(b)(2)(B)

> *[Effective December 27, 2021,] the new disclosure requirements . . . apply to persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans who reasonably expect to receive $1,000 or more in direct or indirect compensation in connection with providing those services.*



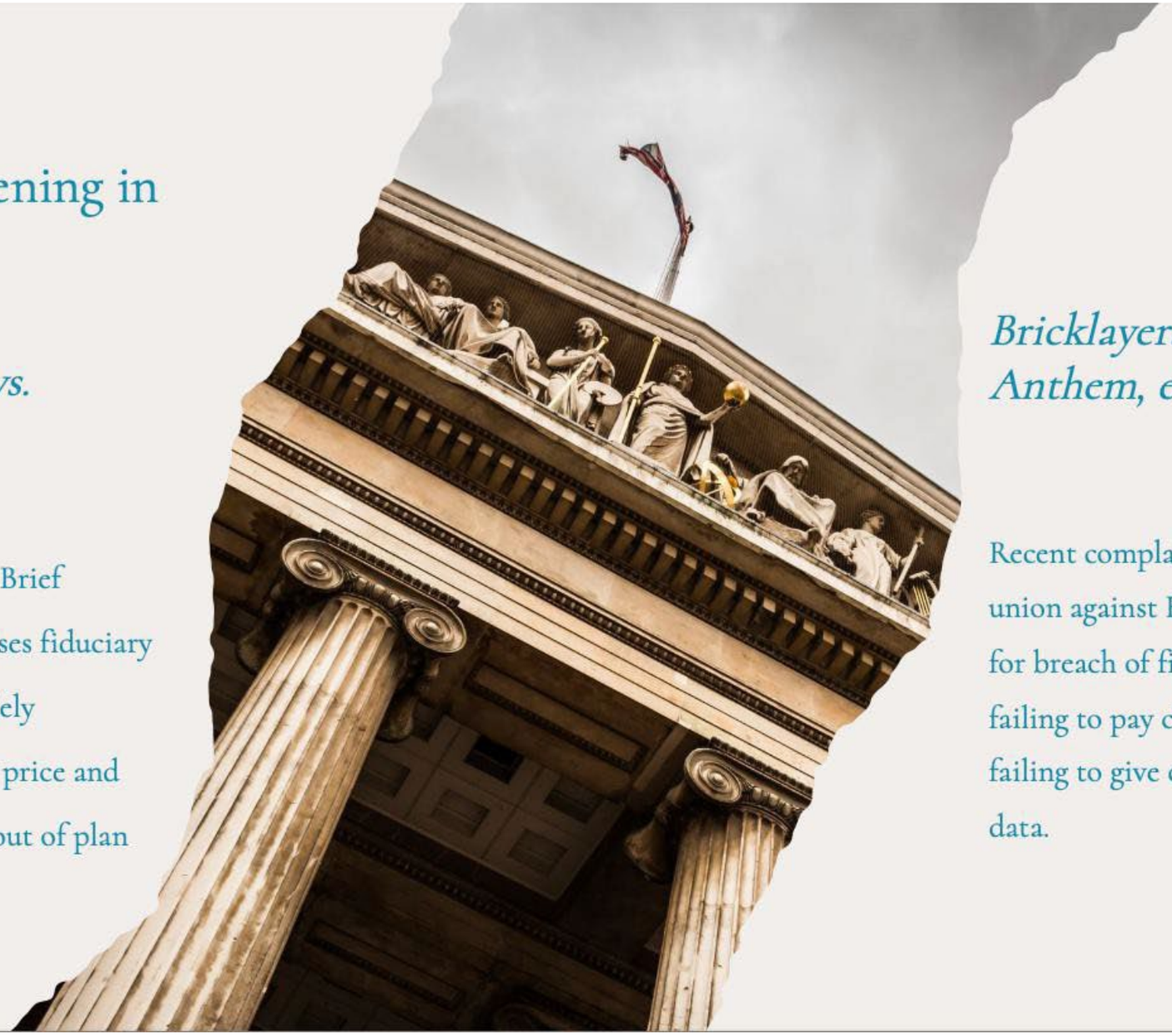

The reporting requirements include information intended to identify the significant drivers of increases in prescription drug and healthcare costs; increase understanding of how prescription drug rebates impact premiums and out-of-pocket costs; and improve prescription drug pricing transparency.

- Premium and Life Years
- Spending by Category
- Top 50 Most Frequent Brand Drugs
- Top 50 Most Costly Drugs
- Top 50 Drugs by Spending Increase
- Rx Totals
- Rx Rebates by Therapeutic Class
- Rx Rebates for the Top 25 Drugs

# What's Happening in the Courts?

## *Mass Laborers' vs. BCBS of Mass*

DOL Filed an Amicus Brief Asserting BCBS exercises fiduciary roles when they are solely responsible for setting price and when they pay claims out of plan assets.



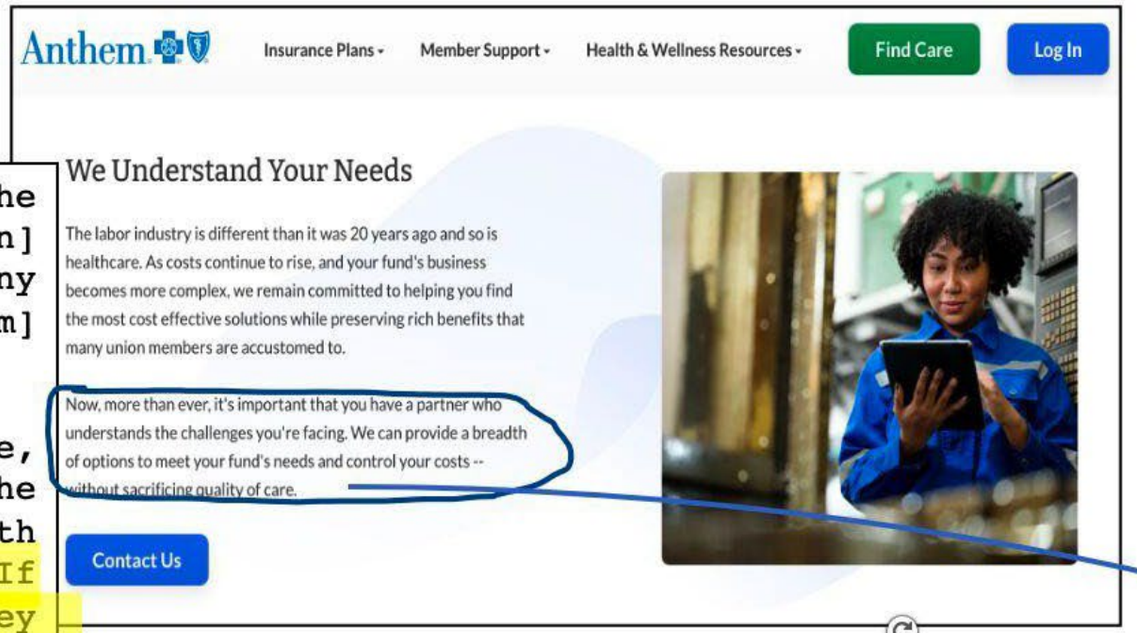
## *Bricklayers, et al. vs. Anthem, et al*

Recent complaint filed by labor union against Elevance/Anthem for breach of fiduciary duty by failing to pay claims correctly and failing to give client access to data.

*Bricklayers vs. Elevance f/k/a Anthem Health*

"To start, Section 724 [the CAA Gag Clause Prohibition] does not impose any obligations on [Anthem] whatsoever…

By its plain language, Section 724 applies to [the Client] as the group health plan, not [Anthem]. If [Clients] believe that they need to renegotiate their contracts to meet their obligations under Section 724, they are free to do so…."




**Anthem's legal position against their clients is quite different from their sales pitch on their website.**

**The quote to the left is an excerpt from their Motion to Dismiss a complaint filed by several clients against Anthem/Elevance after their refusal to deliver the Client's own data to the Client, despite the express language of CAA Section 724 that prohibits gag clauses in TPA contracts.**

**On the other hand, Anthem's Labor/Trust webpage says that "[n]ow, more than ever, its important that you have a partner that understands the challenges you're facing…"**

# How to Turn Legal Obligations into Opportunities & Risk into Reward

Data Ownership and Leverage

Purchase Healthcare Smarter

Continue to Monitor Performance of Purchase

Radical Focus on Transparency and Accountability

# EXAMPLE ONE

1

## Administrative Services Agreement Analysis

| [redacted] Contract Provision | Acting Solely in Interest of Plan (Exclusive Benefit Rule) | Carry out duties prudently | Follow Plan Documents | Hold Plan Assets in Trust | Pay Only Reasonable Plan Expenses |
|---|---|---|---|---|---|
| Restrictive Language on Proprietary Information (Rates Provider Contract Rates, Price, etc.) | No – no ability to determine whether [redacted] is following exclusive benefit rule without restricted data | No – lack of data limits ability to engaged in prudent and informed decision making | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | No- lack of data and financial transparency precludes [redacted] ability to assess reasonableness |
| Ownership interests in providers, solutions, etc. | No – undisclosed financial interests of [redacted] in providers precludes [redacted] from monitoring conflicts | No – undisclosed financial interest limits ability to engage in prudent purchasing | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | Neutral |
| Audit Restriction Provisions | No – limited ability to monitor exclusive benefit rule | No – no audit discretion limits prudent purchasing | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | No- lack of data and financial transparency precludes [redacted] ability to assess reasonableness |
| Discretionary authority to determine ALL reimbursement | No – failure to ensure plan assets utilized only for plan beneficiaries | Neutral | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | No- lack of data and financial transparency precludes [redacted] ability to assess reasonableness |
| Medical Rebate Retention | No – conflict of interest in undisclosed provider and Rx arrangements | Neutral | Neutral | Neutral | No- Reasonableness of Rx and Medical Rx [redacted] hould be determined net of rebate |
| Recovery Discretion | No – no ability to recover plan assets when appropriate | Neutral | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | No- discretion over recovery amounts precludes [redacted] assessment and reasonableness of plan exp. |
| Interplan Arrangements | No – plan assets leveraged for benefit of other non-[redacted] health plans | No – undisclosed Interplan discretion limits prudent purchasing and oversight | Neutral | No – lack of data and financial transparency precludes confirmation that assets are held in trust | No – lack of data and financial transparency precludes [redacted] assessment of reasonableness on Interplan financial TRXs. |

[redacted] or [redacted] affiliate **may have financial interest in Network Providers** through direct ownership, partnership, joint venture, or other arrangement.

[redacted] may share in the Network Provider's profits or other revenue, and **all revenue is retained by** [redacted].

[redacted] reimburses Provider on a percentage of charges, fixed payment, global fee, single case rate, or other reimbursement methodology **whether amount is more or less than Provider's billed charges.**

[redacted] may receive remuneration for **"selling" employer's plan data** to other parties for use in research, monitoring, benchmarking, and industry analysis.

[redacted] shall determine which recoveries it will pursue and **is not liable** for any amounts it does not successfully recover.

[redacted] **retains drug rebates** for pharmaceuticals reimbursed through the medical benefit as payment for administrative services.

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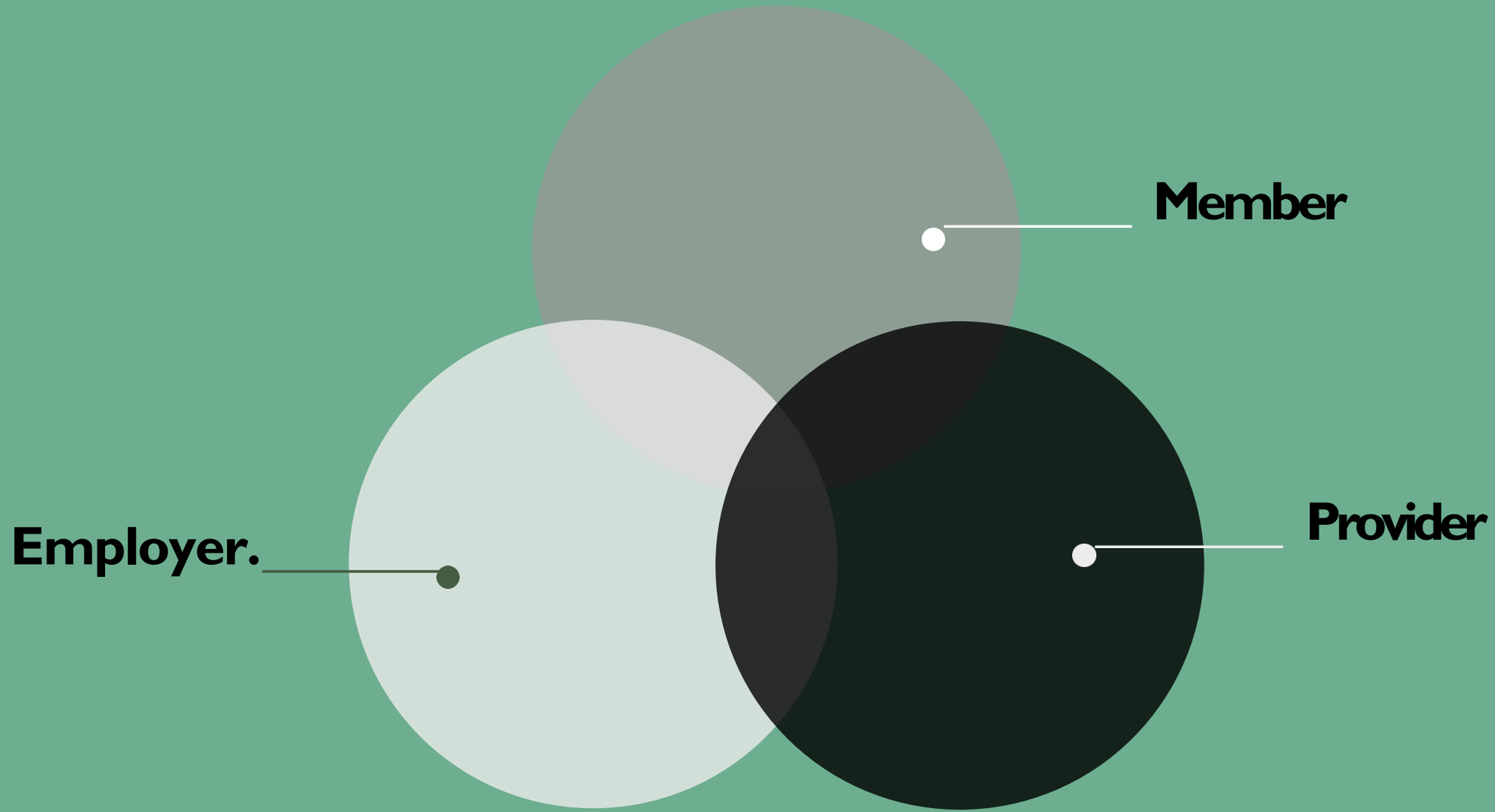
# EXAMPLE TWO

## Use Data and Transparency Data to Drive Better Healthcare Purchasing Strategy

# Realignment of Incentives



- Evaluate Price on Unit Cost
- Tie Performance Guarantees to Unit Price Trend
- Evaluate Quality of Network, not just size
- Prioritize Primary Care Directly to Engage in Supply Chain Management (reduce variability in cost and quality)

# Identify Allies

High Quality Providers Are Ready to Direct Contract, Primary Care Partners, Accountable Tech Enablement

Employee Champions, Labor, and Trusted Water Cooler Leaders

Organizational Leadership - C-Suite, Procurement Experts, Fellow Purchasers

# Prepare for Foes

Legacy Carriers

Low Value Provider Organizations

Conflicted Consultants and Brokers

Internal Politics of Change Management

# Questions and Discussion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Consulting

# Questions??

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If you have a question, please feel free to unmute your audio line and turn on your camera

- OR -

You may use the **Q&A function at the bottom of your screen on the far right** to submit your question to:

**Ashley Tait-Dinger (host)**