D1 HEALTHCARE™ BERGER|MONTAGUE

The Consolidated Appropriations Act of 2021 ("CAA"): Key Compliance Issues

1. REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION

- Requires health plan fiduciaries to remove all contractual provisions in contracts providing access to a health care provider or a network or association of providers that directly or indirectly restrict the plan from sharing provider-specific cost & quality of care information with sponsor, participants, others or from electronically accessing de-identified claims and encounter information or data, on a per claim basis, for each plan participant/beneficiary, upon request and consistent with applicable privacy regulations, & sharing that info with plan business associates.
- The contracts requiring removal of gag clauses include Administrative Service Agreements (ASAs), Pharmacy Benefit Management ("PBM") Agreements & any direct contracts with providers.
- Employer/plan sponsor must file attestation of compliance annually on CMS website.

PURPOSE: paves the way to getting plan claims data and utilizing it to make sound fiduciary decisions. Ensure claims are being paid properly & in accordance with plan documents; recover overpayments.

2. DISCLOSURE OF DIRECT AND INDIRECT COMPENSATION

- Requires health plan fiduciaries to obtain disclosures of all direct and indirect compensation from covered service providers who are expected to make more than $1,000 in a plan year.
- If no disclosure is received, the contract is a prohibited transaction; plan is obligated to terminate contracts for future services.
- Only applicable to ERISA-covered plans, but best practice for <u>all</u> employer-sponsored health plans.

PURPOSE: To provide the responsible plan fiduciary with sufficient information to **assess the reasonableness of the compensation** to be received **and potential conflicts of interest** that may exist as a result of covered service provider receiving indirect compensation from sources other than the plan.

3. STRENGTHENING PARITY IN MENTAL HEALTH ("MH") AND SUBSTANCE USE DISORDER ("SUD") BENEFITS

- Requires health plan fiduciaries to ensure there are no separate treatment limitations and cost sharing requirements that apply only to MH/SUD benefits.
- NQTL Comparative Analysis Report must compare 6 classifications of benefits: Inpatient in-network, Inpatient Out of Network, Outpatient IN, Outpatient OON, Emergency Care & Drugs.
- NQTL Report is a plan doc; must be available upon request of participant, beneficiary, gov agency.

PURPOSE: Increase parity between medical/surgical benefits and MH/SUD benefits.

4. REPORTING ON PHARMACY BENEFITS & DRUG COSTS

- Requires health plan fiduciaries to report annually on premiums and rebates, total healthcare spend, top 50 drug brands most frequently dispensed, amount spent on top 50 prescription drugs.
- All reporting goes to CMS; data will be aggregated and publicly reported.

PURPOSE: Identify major drivers of increases in prescription drug & health care spending, understand how rebates impact premiums &out-of-pocket costs and increase prescription drug price transparency.