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Plan Sponsor Right to Access Claims Data

Pursuant to federal law, including the Employee Retirement Income Security Act of 1974 (ERISA), Plan Sponsorsi not only have a legal right but a duty to access plan data, including medical and pharmacy claim data. Because carriers and providers have sought to deem certain types of claims and pricing data proprietary or otherwise exempt from disclosure to Plan Sponsors, the federal government has recently focused on transparency initiatives, including under the Consolidated Appropriations Act, 2021 (CAA) and pending laws and regulations. Below we have summarized Transcarent's view of a Plan Sponsor's right to access claims data. This view is informed by our experience and advocacy work; it does not constitute or substitute for legal advice.

FIDUCIARY DUTY

FEDERAL FRAMEWORK

ERISA requires that those persons or entities who exercise discretionary control or authority over plan management or plan assets or anyone with discretionary authority or responsibility for the administration of a plan, including the Plan Sponsor, are subject to fiduciary responsibilities.

This includes running the plan in the interest of participants, acting prudently, following the terms of plan documents, and avoiding conflicts of interest (i.e., not engaging in "prohibited transactions" that would benefit parties related to the plan, such as other fiduciaries, services providers or the Plan Sponsor).[ii]

Both the CAA and recent court challenges focus on ERISA fiduciary issues.[iii]

CONCLUSION

Even where a Plan Sponsor engages a TPA for plan administration, the Plan Sponsor must have access to claims information, including financial information such as allowed amount and paid amount, to ensure that the TPA is following the terms of the plan documents and for proper plan administration and supervision. Among other things, the Plan Sponsor must have sufficient information to confirm that the TPA is not charging the group health plan fees are not reasonable, which would have "prohibited transaction" implications under ERISA.

Note that the contract between the group health plan and the TPA may (likely will) include provisions acknowledging the delegation but not abdication of fiduciary duties as well as audit and oversight provisions.

AUDIT RIGHTS

FEDERAL FRAMEWORK

Under ERISA, an annual audit of a group health plan's annual report (the Form 5500 Annual Return/Report of Employee Benefit Plan) must be conducted by an "independent qualified public accountant."[x]

The auditor must examine such books are records as may be necessary to conduct the audit. If some or all of the information necessary for compliance is maintained by a third party, it must be transmitted within 120 days of the end of the plan year.

CONCLUSION

Because group health plans have annual independent audit obligations, Plan Sponsors must have access to books and records maintained by the TPA.

RIGHT OF ACCESS

FEDERAL FRAMEWORK

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered entities (including group health plans) must provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. A business associate may maintain the information on behalf of a covered entity regardless of where the PHI originated (e.g., whether the covered entity, a provider, the member, etc.).[viii]

A group health plan is a "covered entity," whereas its TPA is a business associate.[ix]

A "designated record set" is as a group of records maintained by or for a covered entity that comprises, among other things, the "[e]nrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a (group) health plan."

CONCLUSION

The HIPAA Right of Access requirements apply to Plan Sponsors, not to TPAs. As a result, Plan Sponsors must have access to designated records sets, including payment and claims adjudication information, upon request.

When a Plan Sponsor delegates designated record set support (e.g., for fulfillment of Right of Access requests) to its TPA, the TPA is merely maintaining the information on behalf of the group health plan, regardless of the origin of the PHI. In other words, claims information originating with the TPA is maintained for the group health plan. As a result, TPAs may not refuse to provide claims data to the Plan Sponsor. Any claim by a TPA that such data is proprietary, by virtue of its format or otherwise, must likewise fail as the TPA does not have an independent right to use the PHI for proprietary purposes.

GAG CLAUSE PROHIBITION

FEDERAL FRAMEWORK

Under the CAA, group health plans[iv] (and health insurance issuers offering group health coverage) are prohibited 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 providing provider-specific cost or quality of care information (including, on a per claim basis, financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract; provider information, including name and clinical designation; service codes; and any other data element included in claim or encounter transactions), accessing de-identified (as to the plan participant, beneficiary, or enrollee) information or data, or sharing such information with a business associate.[v] This is referred to as the Gag Clause Prohibition.[vi]

Implementation is subject to a good faith reasonableness standard until such time as further guidance is issued.[vii]

CONCLUSION

TPAs may not take the position that their agreements with providers prohibit them from sharing cost or quality information with a Plan Sponsor.

Such an interpretation would not be reasonable in light of the plain language of the Gag Clause Prohibition nor would it constitute a good faith interpretation.

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[i] "Plan Sponsor" has the meaning ascribed to it at 29 USC § 1002(16)(B).
[ii] See 29 U.S. Code § 1104.
[iii] Summary of Court Challenges available upon request.
[iv] "Group health plan" has the meaning ascribed to it at 29 USC § 1191b(a)(1).
[v] The first Gag Clause Prohibition Compliance Attestation (GCPCA) is due by December 31, 2023, covering the period beginning December 27, 2020 (or the effective date of the applicable group health plan or health insurance coverage, if later) through the date of attestation; subsequent annual GCPCAs are due by December 31 of each year and cover the period since the last GCPCA was submitted.
[vi] A "gag clause" is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party.
[vii] See "FAQS ABOUT AFFORDABLE CARE ACT AND CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION PART 57" (February 23, 2023) available at https://www.cms.gov/files/document/aca-part-57.pdf.
[viii] See 45 CFR § 164.524. See also Department of Health and Human Services (HHS) Guidance Materials, "Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524," available at https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html.
[ix] See HHS FAQ 356 available at https://www.hhs.gov/hipaa/for-professionals/faq/356/is-an-entity-acting-as-a-third-party-administrator-to-a-group-health-plan-a-covered-entity/index.html. See also 45 CFR § 160.103.
[x] See 29 USC § 1023(a)(3)(A).