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Hearing on
The Possible Extension of
Section 408(b)(2) Fee Disclosure Regulation
to Welfare Benefit Plans

Conducted by:
The Employee Benefit Security Administration
U.S. Department of Labor

**Application of 408b-2 Disclosure Requirements to Health and Welfare Plans**

Good morning!

My name is Randy DeFrehn, and I am the Executive Director of The National Coordinating Committee for Multiemployer Plans (the "NCCMP"). Multiemployer plans are a product of the collective bargaining process where at least one labor organization and two or more employers provide health, pension and other permitted employee benefits for the "sole and exclusive benefit" of the collectively bargained employees, their families and dependents.. Multiemployer plans are required under the Labor Management Relations Act to hold their assets in trust funds which are the joint and equal responsibility of the labor organizations and employers which sponsor them. Approximately 26 million Americans – active and retired workers, their families and survivors - receive their health benefits coverage from the roughly 3,000 multiemployer health benefit plans as beneficiaries of these trust funds. The NCCMP is an advocacy organization, in fact, the only such organization, established for the exclusive purpose of representing the interests of these beneficiaries, the plans, and their sponsoring organizations.

We appreciate the opportunity to present testimony and answer questions at today's EBSA hearing on issues related to fee disclosure to health plans under Section 408(b)(2) of ERISA. As we noted in our comments on the proposed regulations, the issue of transparency of service provider's fees is a significant one for all plan sponsors. We note that Title I of ERISA requires certain annual reporting requirements applicable to employee benefit plans and their vendors; however, we believe that in many cases the disclosure requirements are too removed from the decision making process. Therefore, we wish to highlight two key areas – compensation of pharmacy benefit managers, and transparency in commissions and incentive compensation arrangements paid to independent insurance brokerages - where additional disclosure would enable plan sponsors to make more informed decisions regarding the prospective costs of administering employee benefit programs in advance of entering into such arrangements.

Pharmacy Benefit Managers (PBM's):

There has been significant media attention placed on the interplay between PBMs and drug manufactures. Many self-insured multiemployer funds enter into direct relationships with PBMs to oversee the dispensing of, and drug utilization management of the participants' prescription needs. Although a number of service providers provide prescription drug management services , it is an area that is dominated by a few very large entities whose compensation arrangements are anything but transparent.

Several of the previous speakers (such as Mr. Balto) and panels have gone into great detail regarding the problems with conflicts of interest and the potential for overstepping ethical boundaries involving "self-dealing." Rather than restating those concerns, we will focus on how these practices can prevent plan sponsors (boards of trustees for multiemployer plans) from fulfilling their fiduciary responsibility of assuring that the fees paid for such benefits are "reasonable."

The financial relationships between drug manufacturers and the PBMs have a profound impact on the underlying economics of PBM pricing and the direct cost paid by Plan Sponsors and the plan participants. However, there is very little disclosure of those relationships. Drug manufactures routinely offer rebates to PBMs as well as directly to providers in order to incent

them to dispense or prescribe certain drugs. The specific financial details of these arrangements are closely guarded secrets by both the PBM and manufacturers. PBMs willingly enter into these rebate arrangements seeking enhanced financial terms based on the dispensing volume and efficacy of a manufacturer's drug versus competing drugs .

Plan fiduciaries would be well served if PBM's were required to disclose all instances in which they receive payments from, drug manufacturers, retail pharmacy providers and, data managers. The disclosure need not require detailed financial accounting. However, (remembering the "sole and exclusive benefit" obligation of plan fiduciaries) the disclosures need to be sufficient to allow plan sponsors to assess whether, and to what extent, the deals offered by the PBM's are in the best interest of Plan participants, rather than simply furthering the financial interests of the PBM. For most purposes, a plan sponsor's bargaining position (on behalf of plan participants) is strengthened by simply understanding the extent of the PBM's financial involvement with each of the above entities as well as the mechanics for how each program results in revenue to the PBM; and how that revenue is used: either to reduce pricing with the Plan through revenue sharing; or retained by the PBM.

PBMs provide revenue sharing arrangements with plan sponsors to lower cost and drive participant behavior. However, because PBMs do not fully disclose the underlying terms it remains uncertain to the plan sponsor whether the revenue sharing arrangements, which may appear financially attractive, are primarily intended to steer plan participants to more cost effective treatments, or treatments which benefit the PBM and their drug manufacturer partners.

The primary use of this disclosed information would be for plan sponsors to gauge the willingness of the PBM to partner with the plans rather than the manufacturers to control costs. For instance, requiring a listing of the programs (formulary, generic switching, etc.) in which a PBM is engaged in with specific manufacturer, and for which a PBM receives payments is very useful information during a PBM selection process as well as monitoring the effectiveness of a PBMs performance. For example, a plan sponsor looking to maximize generic drug utilization will be able to determine if a PBM was effectively managing and improving generic utilization, or if the PBM was disproportionately steering plan participants to drugs that resulted in a financial advantage to the PBM.

There is also a lack of transparency in PBM owned mail order dispensing programs. PBM's routinely quote mail order dispensing fees of $0.00 per Rx. Looking at other situations in which the 408(b)(2) rules apply, this is analogous to a 401(k) provider saying that recordkeeping is "free." This fee is clearly not representative of the cost associated with dispensing any drug via a mail order facility. Understanding the base cost of dispensing from a mail order facility along with who is absorbing that expense, via transparency and disclosure of mail order dispensing fees, would enable more informed plan sponsor decision making, and allow plan sponsors to more effectively address plan design considerations such as directing members to mail order versus retail pharmacies via communications and copayment differentials.

Commissions

The second area in which the NCCMP (among others) believes that greater transparency should be required is the payment of commissions and incentive based "contingent" compensation arrangements to independent insurance producers (as opposed to captive agents for carriers who write business exclusively for that single insurer). Under the current ERISA reporting and

disclosure requirements, commissions are subject to disclosure through retrospective reporting to plan sponsors. However, the current requirements do not provide the level of transparency needed for plan representatives to make informed decisions in advance of awarding the business. I would also note that the importance of improved disclosure of insurance commissions will be highlighted in the upcoming discussions of the proposed Patient Protection and Affordable Care Act's minimum loss ratio regulations.

As noted by Cynthia Borrelli, Esq., in a 2008 article published in the Federation of Regulatory Counsel Journal *(FORC Journal: Vol. 19 Edition 4 - Winter 2008)*, incentive based and contingent commissions have been controversial since at least 2004. They have been the subject of legal actions and investigations regarding kickbacks, price fixing and bid-rigging. AIG paid $125 million in settlements with nine states and the District of Columbia over such allegations.

It will come as no surprise, then, that many favor requiring all insurance producers, brokers and consultants to disclose, in advance, the basis of any percentage commission based on premium volume that will be paid to the insurance producer, broker or consultant at the time a sale is completed with an insurance carrier.

A second form of compensation considered common in the marketplace is a "contingent commission." Contingent commissions may be paid in addition to flat percentage commissions and typically are based on profit, volume, retention and/or business growth. Contingent commissions, often loosely referred to as "bonus commissions," are not payable on a per-risk basis, but are allocated based on the performance of the entire portfolio of business placed with a particular insurer by a specific producer  a type of "loyalty program" which benefits the insurer and the broker, but not the customer. . The contingent commission schedule is often known to producers at the beginning of a given period of time (usually one year); however contingent commissions actually earned are calculated some time after business is placed and loss experience is observed and measured. It is in the best interest of plan participants and plan sponsors to understand the degree to which an insurance producer, broker or consultant derives income from contingent commissions.

Some insurers also pay so-called "supplemental commissions." These commissions are similar to contingent commissions in that an incentive structure based on profit, volume, retention and/or business growth is generally put in place at the beginning of a given year. However, under a supplemental system, rather than paying additional cash commissions at the end of the year, the incentive structure is used to reflect the flat percentage commission for the following year.

The National Association of Insurance Commissioners (NAIC) has adopted model rules relating to an insurance producer or its affiliate receiving any compensation for the placement of insurance or representing the customer regarding the placement of an insurance contract. In general the model rules prevent the producer or its affiliate from accepting or receiving any compensation from an insurer or other third party for placement of insurance unless, prior to purchase: the producer has both disclosed the amount of compensation to be received for that placement or, if unknown at the time, the specific method for calculating the compensation (and, if possible, a reasonable estimate of the amount); and obtained the customer's documented acknowledgment that such compensation will be paid to the producer or affiliate.

According to the NAIC less than one-third of the states appear to have adopted the NAIC Model Act as proposed, despite the fact that many critics consider that these standards too weak and fail

"to address the key defects in the current system. Even these standards, however, provide a floor upon which to build.

As states are inconsistent with respect to when disclosure of contingent commission and broker compensation arrangements is required, additional protection of plan sponsors is needed at the federal level. Because the size and structure of the contingent commissions that insurers offer to intermediaries and producers can vary significantly they can lead to abuses, such as improper "steering" of clients to insurers that allegedly fail to provide coverage as beneficial as that covered by competitors. While the defenders of contingent commissions assert that competition in the marketplace can adequately address any such conflicts, the evidence suggests that conflicts of interest created by contingent commissions, supplemental and flat percentage commissions, require that mandating advance disclosure of the prospective payments is in the best interest of plan participants.

We appreciate the opportunity to offer our perspective on these issues and welcome your questions.