America's Health Insurance Plans

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Submitted Electronically

February 11, 2008

Office of Regulations and Interpretations
Employee Benefits Security Administration
Attn: 408(b)(2) Amendment
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW
Washington DC 20210

Re: Notice of Proposed Rulemaking – Reasonable Contract or Arrangement under Section 408(b)(2) – Fee Disclosures

Proposed Class Exemption for Plan Fiduciaries when Plan Service Arrangements Fail to Comply with ERISA Section 408(b)(2)

Dear Sir/Madam:

America's Health Insurance Plans (AHIP) is writing in response to the Notice of Proposed Rulemaking published in the *Federal Register* on December 13, 2007 by the Employee Benefits Security Administration (EBSA) regarding contracts and agreements between service providers and employee benefit plan fiduciaries (the "Proposed Rule"). We also wish to provide comments regarding the Proposed Class Exemption for Plan Fiduciaries (the "Proposed Class Exemption") released the same day by the EBSA.

AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace including health, long-term care, dental, vision, disability, and supplemental coverage. Almost all of AHIP's members provide insurance coverage to or administer benefits on behalf of employee health and welfare benefit plans.[1]

AHIP and its member health insurance plans fully support the principle underlying the Proposed Rule – that employee benefit plan fiduciaries need sufficient information "to make informed decisions about the services, the costs, and the service provider." (72 Fed. Reg. 70988). We are concerned, however, that the Proposed Rule as currently drafted may impose significant

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[1] AHIP's comments apply to all insurance products, including life, health, disability, long-term care, dental, vision, and supplemental sold to employee benefit plans and administrative service provided to such plans by health insurance plans.

administrative burdens on the very plan fiduciaries it is meant to assist, as well as on their service providers. We also believe the Proposed Rule will result in "information overload" that does not lead to meaningful transparency, at the same time it undermines the very flexibility of contracting that is a key to assuring that the needs of plan fiduciaries and beneficiaries are met by the contract and its compensation terms.

The Proposed Rule appears to broadly apply to contracts and agreements that a health insurance plan may have with thousands and in some cases tens of thousands of plan fiduciaries. In addition, the penalties for non-compliance with the Proposed Rule may be severe – termination of the contract on short notice, civil penalties for violation of the prohibited transaction provisions of ERISA, federal tax liability, and disqualification of the service provider.[2] As a result, plan fiduciaries may request massive amounts of information (whether relevant or not) from health insurance plans and those plans will provide information not because it is "useful," but rather to avoid even a possibility (no matter how minor) of violating the law.

As discussed in further detail below, AHIP recommends that the EBSA withdraw the Proposed Rule for additional review. In the event that the rule is not withdrawn, AHIP asks you to consider the recommendations in the attached document to clarify the application of the requirements of the Proposed Rule.

Identifying Deficiencies in Disclosures to Plan Fiduciaries

As an initial observation, the specific concerns that the Proposed Rule is intended to address are not identified. The preamble refers to work done by the ERISA Advisory Council Work Group and concludes that "plan fiduciaries must receive more comprehensive information about the compensation or fees involved in plan administration and investments, including indirect compensation." (72 Fed. Reg. 70990). The concerns raised by the Proposed Rule appear to primarily apply to the financial services industry and not to health and welfare benefit insurance coverage and administrative services provided to health and welfare plans.

While the Work Group reports have identified some concerns regarding disclosures on the annual Form 5500 reports (which the EBSA addressed last year) and communications to plan beneficiaries and participants (which the EBSA has indicated it will address later this year), there is little direct evidence that plan fiduciaries currently do not receive meaningful disclosures that they need to make informed decisions about service providers.[3]

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[2] State insurance regulators may also choose to investigate or take enforcement action relating to health insurance plans (either acting as health or welfare benefit insurance carriers or as third party administrators) if they believe the health insurance plan has acted improperly with respect to coverage or services provided to an employee benefit plan.

[3] The November 2005 *Report of the Working Group on Health and Welfare Benefit Plans' Communications* focused primarily on disclosures made to plan participants and beneficiaries and recommended improvements in Summary

Health insurance plans currently provide plan fiduciaries with a comprehensive laundry list of information allowing them to choose health or welfare benefits or third party administrative services from among myriad offerings. That information includes the following: (1) the scope of insurance coverage that will be provided; (2) details regarding any related services such as claims administration, underwriting, utilization review, disease management, and contracting with provider networks; (3) the premium or other fees that will be paid for the insurance coverage or administrative services; and (4) whether and to what extent the health insurance plan will assume any fiduciary responsibilities (generally in connection with claim determinations). Disclosures are typically provided to the fiduciary at multiple stages of the contracting process: (1) in responses to Requests for Proposals (RFPs) that are developed by the plan fiduciary and its benefit consultants; (2) in the insurance policy or evidence of coverage outlining the scope of benefits; (3) in contracts or agreements for administrative services; and (4) in "post-contract" reporting to or auditing by the fiduciary of performance and financial measures.

In almost all cases, these contracts are negotiated and entered into on an annual basis, affording the plan fiduciary frequent and ample opportunity to obtain information and decide whether the contract is reasonable and beneficial to plan participants and beneficiaries. Moreover, in many cases health insurance plans provide voluminous information to the health and welfare plan for use in the annual Form 5500 report (including Schedule A "Insurance Information" and Schedule C "Service Provider Information") that is made to the EBSA.[4]

It is axiomatic that rulemaking should be targeted to respond to clearly identified problems in a manner that meets the needs of the intended audience. Health insurance plans and fiduciaries of health and welfare plans already operate in a transparent and competitive marketplace. The EBSA should conduct further investigation and identify any specific problems with or information omissions in the current disclosures made to plan fiduciaries and specifically craft disclosure requirements that are responsive to those concerns.

Providing Real Transparency

A second, but related, issue regarding the Proposed Rule is whether the required disclosures will provide useful information to the plan fiduciary, enabling it to assess the reasonableness of compensation paid, and yet not have an anti-competitive result. It is unclear how the disclosure of additional terms, not normally included in the contract by the plan fiduciary because such

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Plan Descriptions and disclosures of claim determinations. The November 2004 *Report of the Working Group on Plan Fees and Reporting on Form 5500* and the *Report of the Working Group on Health and Welfare Form 5500 Requirements* contain recommendations for changes to the annual report and schedules filed by employee benefit plans as supplemented with information from insurance carriers and service providers.

[4] As noted in the attached recommendations, "fully-insured" health and disability welfare insurance products are also subject to comprehensive regulation and oversight by state insurance and health departments.

information is not deemed material to its particular needs, in any way assists the decision-making process.[5]

One possible unintended consequence of the Proposed Rule is the disclosure of sensitive business information that is not necessary for the fiduciary to determine if the contract with the service provider is reasonable. While such information, by its nature, would vary, it could include disclosures of pharmacy rebates, amounts received from wellness program vendors, and compensation withholds related to risk sharing arrangements with physician groups. Such arrangements are pro-competitive, as they result in lower premiums or other improved contract terms for the plan sponsor.

These concerns are heightened at the bargaining stage, when the health and welfare plan is seeking numerous responses to RFPs, increasing the possibility that the disclosure may spread across the marketplace, rather than being limited just to a particular fiduciary.[6] As a result, the specific agreement details that one plan fiduciary is contemplating would be publicly available making it less likely that the health insurance plan would offer such terms to any fiduciaries in the future. Thus, deals that service providers may be able to offer to some, but not all plans, would be offered to no plans. While this harm may seem counterintuitive, it has been widely recognized.[7]

Any disclosure rule adopted by the EBSA should be carefully tailored to avoid interfering with the highly-competitive marketplace for the sale of health and disability insurance and for the third party administration of benefits that currently exist.[8] As noted by the Federal Trade

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[5] The Federal Trade Commission (FTC) has indicated that requiring disclosure of factors that determine ultimate pricing is "analogous to requirements that firms reveal aspects of their cost structures to customers. There is no theoretical or empirical reason to assume that customers require sellers' underlying cost information for markets to achieve competitive outcomes." FTC, *Letter to New Jersey General Assemblywoman Nellie Pou* (Apr. 17, 2007) (henceforth "*FTC Letter-New Jersey")* at 12.

[6] *See FTC Letter-New Jersey* at 11 (noting that "mandat[ing] the disclosure of proprietary business information without effective protection . . . increases the likelihood of proprietary business information becoming public knowledge.")

[7] For example, in a series of comment letters the FTC has opposed state mandated "transparency" measures because of just this type of harm and has noted that "[p]ublic disclosure of proprietary information can foster tacit collusion or otherwise undercut vigorous competition on . . . pricing." FTC, *Letter to Virginia House of Delegates Member Terry G. Kilgore* (Oct. 2, 2006) at 13; *see also FTC Letter-New Jersey* at 10 (noting that requiring "disclosures [of sensitive financial information] may facilitate collusion, raise price, and harm the patients the bill is supposed to protect"); FTC, *Letter to California Assembly Member Greg Aghazarian* (Sept. 7, 2004) at 2 (noting that requiring such disclosures by pharmacy benefit managers would have the "unintended consequences of limiting competition, thus increasing the cost of pharmaceuticals and ultimately decreasing the number of Americans with insurance coverage for pharmaceuticals.")

[8] Indeed, major metropolitan areas have many competing health insurance offerings, including multiple health maintenance organizations (HMOs) and preferred provider organizations (PPOs). *See, e.g.,* Health

Commission and the U.S. Department of Justice, "[v]igorous competition . . . is more likely to arrive at an optimal level of transparency than regulation of those terms."[9] We respectfully suggest that, in the insurance and administrative services markets subject to the proposed rule, competition is doing just that.

Improving Plan Fiduciary Education

In considering how best to inform plan fiduciaries, the EBSA should consider if there are other, more effective and less intrusive ways to achieve the intended results of the Proposed Regulation. Over the past few years, the EBSA has engaged in increased educational activities and seminars for plan fiduciaries.

The agency has also created new publications and educational materials to inform plan fiduciaries of their responsibilities and the importance of service provider contracting. In addition, the Form 5500 annual reporting requirements have been revised to more clearly inform plan fiduciaries and the EBSA regarding fees and compensation paid in connection with employee benefit plans. The EBSA should determine if these educational efforts are effective and if additional initiatives would better inform plan fiduciaries.

Conclusion

Health and welfare benefit plan fiduciaries and health insurance plans operate in a transparent and highly competitive market for health and welfare benefit insurance and third party administrative services. Such a competitive market is likely to reach an optimal level of disclosure as health insurance plans and fiduciaries negotiate insurance coverage, administrative services, and other aspects of their agreements. Further, many plan fiduciaries are guided by very sophisticated consultants, who are also well equipped to ensure that the fiduciaries receive the information they need to enter into contracts that are "reasonable" and beneficial to plan beneficiaries and participants.

AHIP and its members appreciate the work done by the ERISA Advisory Council and the EBSA to make sure that employee benefit plan fiduciaries, beneficiaries, and participants have all of the information necessary to make meaningful decisions. We agree that transparency is an important protection for employee benefit plans. We are concerned, however, that the Proposed Rule may not lead to meaningful disclosures and will instead, result in increased administrative burdens. AHIP therefore recommends that the EBSA take the following steps:

Leaders/InterStudy, *The Competitive Edge: Part III: Managed Care Regional Market Analysis* (2007) at 108-117 (reflecting large numbers of HMOs and PPOs in metropolitan statistical areas).

[9] FTC and United States Department of Justice, *Improving Health Care: A Dose of Competition* (2004), Chapter 7 at 17.

- The Proposed Rule should be withdrawn.
- The EBSA should work with plan sponsors, insurance carriers, and plan sponsors and fiduciaries to identify "gaps" in disclosures that negatively impact the ability of plan fiduciaries to make informed decisions.
- The EBSA should carefully consider potential regulatory responses to address these gaps including fiduciary education, additional changes to the Form 5500 reporting requirements, and possible additional service provider contract requirements.

As noted, if the EBSA believes the Proposed Rule should be finalized, we have attached a number of specific recommendations for revisions that we believe will clarify the intent and scope of the requirements.

We appreciate the EBSA's attention to this very important matter. If you have any questions, please feel free to contact me at (202) 778-3255 or twilder@ahip.org.

Sincerely,

Thomas J. Wilder
Senior Regulatory Counsel

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AMERICA'S HEALTH INSURANCE PLANS

Comments in Response to Proposed Requirements for Contracts or Arrangements with ERISA Plan Fiduciaries and Proposed Class Exemption

February 11, 2008

America's Health Insurance Plans (AHIP) is responding to a Proposed Rule published on December 13, 2007 in the *Federal Register* regarding "reasonable" contracts or arrangements between service providers and fiduciaries of employee benefit plans (79 Fed. Reg. 70988 *et seq*.). These requirements are being promulgated by the Department of Labor, Employee Benefits Security Administration (EBSA) pursuant to Section 408(b) of the Employee Retirement Income Security Act of 1974 (ERISA). In addition, AHIP is commenting on a Proposed Class Exemption for plan fiduciaries in situations where the contract or arrangement with the service provider does not meet the requirements of the Proposed Rule (72 Fed. Reg. 70893 *et seq*.).

As noted in our cover letter, AHIP believes the Proposed Rule and Proposed Class Exemption may: (1) pose significant burdens on plan fiduciaries and service providers and (2) lead to "information overload" that does not provide meaningful transparency. As a result, AHIP suggests that it be withdrawn for further review. If the EBSA chooses to proceed with rulemaking, we have a number of specific suggestions for revisions and clarifications to the requirements.[1]

Scope of the Proposed Rule

A. Application of the Rule to "Fully-Insured" Health and Welfare Benefit Coverage

The Proposed Rule is intended to apply to certain contracts or agreements between employee benefit plan fiduciaries and service providers. Service providers are broadly defined to include any entity "who provides or may provide any one or more of the following services to the plan pursuant to the contract or arrangement: banking, consulting, custodial, insurance, investment advisory (plan or participant), investment management, recordkeeping, securities or other investment brokerage, or third party administration . . . ." (29 CFR §2550.408b-2 (c)(1)(i)(B)). As a result, health insurance plans arguably may be required to comply with the Proposed Rule in situations where they provide health or welfare benefit insurance coverage to "fully-insured" health and welfare benefit plans.

Health insurance plans that sell fully-insured benefits to a health and welfare plan are arguably not "parties in interest" and therefore should not be considered service providers

[1] AHIP's comments apply to all insurance products, including life, health, disability, long-term care, dental, vision, and supplemental sold to employee benefit plans and administrative service provided to such plans by health insurance plans.

for purposes of the Proposed Rule. This position is consistent with the statement in the preamble to the Proposed Rule that "the investment of plan assets or the purchase of insurance is not, in and of itself, compensation to a service provider for purposes of this regulation." (72 Fed. Reg. 70900).

Exempting fully-insured benefits from the Proposed Rule is also in harmony with the new instructions for the Form 5500 annual report Schedule C (Service Provider Contracts) which state that "(t)he investment of plan assets and payment of premiums for insurance contracts, however, are not in and of themselves payments for services rendered to the plan for purposes of Schedule C reporting and the investment and payment of premiums themselves are not reportable compensation for purposes of Part I." (72 Fed. Reg. 64825, November 16, 2007) Unfortunately, it is not entirely clear from the wording of the Proposed Regulation whether fully-insured insurance products (which would by their nature include claim payment and other services) are considered "[insurance] services to the plan pursuant to the contract or arrangement . . . ." (29 CFR §2550.408b-2 (c)(1)(i)(B)).

We believe that additional disclosure requirements are not needed in the context of "fully-insured" health or welfare benefit insurance products that are sold to health and welfare plans. Such coverage is extensively regulated by state insurance departments and, in some cases for health maintenance organizations, by state health agencies. Many state insurance laws mandate that health and disability insurance premiums and policy forms be approved by the state regulators. Moreover, in many states both the premium rates and policy forms must be "pre-approved" before they are used.

In addition, the group insurance market is highly competitive for most employers. For many small employers, the rates charged by health insurance plans are strictly regulated by state law. Such price competition assures plan fiduciaries that they will get true value in their health coverage at a reasonable price. In almost all cases, the premium covers all of the services that are provided under the contract. Because of this competitive and regulated environment AHIP believes it is more appropriate to direct the Proposed Rule to health insurance plan service providers that are offering services to plan fiduciaries that "self-fund" their benefits and not include fully-insured coverage if the premium is the only cost paid by the fiduciary.[2]

AHIP recommends that the EBSA clarify that the Proposed Rule does not apply to the purchase of health or welfare benefit insurance by a plan fiduciary.

B. Application of the Rule to Certain Types of Health and Welfare Plans

The Proposed Rule attempts to construct "one size fits all" disclosure requirements for health and welfare benefit plans that vary significantly in size and sophistication. The types of disclosures needed by a small employer (which may rely on a part-time human

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[2] We recognize there may be situations where a health insurance plan provides insurance coverage and also offers administrative services to the plan fiduciary for a separate fee or compensation pursuant to a written contract or agreement. In such cases those administrative services and fees may need to be disclosed.

resources representative) are different from those that might be needed by a large, multi-state employer that has a professional benefits staff and relies on the advice of independent benefits consultants. In addition, certain types of health and welfare plans, such as "top-hat" plans that cover a select group of key executives, may have entirely different information requirements.

The EBSA should consider whether the disclosure requirements may differ depending on the type or size of plan. It should also consider the separate, but related, question regarding the extent to which disclosures required by Schedules A and C of the Form 5500 Annual Report provide the information needed by plan fiduciaries.[3]

AHIP recommends that the EBSA revise the Proposed Rule to more closely tailor the disclosure requirements based on the size of the plan and the resources available to the plan fiduciary to use the disclosures in a meaningful manner. We suggest that the EBSA work with plan fiduciaries, benefit consultants, and service providers to determine what disclosures are most appropriate depending on the type and size of the plan.

Disclosure of Fees and Compensation

A. Disclosures in Connection with Premiums Paid for Fully-Insured Health and Welfare Benefit Coverage

Health insurance plan contracts disclose the premium charged for health and welfare benefit insurance coverage, any additional fees for administrative services, the benefits that will be provided, and the type of services (such as claims administration, care coordination, coordination of benefits, and subrogation) that are included. In general, the premium is the total charge to the plan fiduciary for the insurance coverage and the health insurance plan bears the risk. For example, if the health insurance plan underestimates its cost for providing medical care or other welfare benefits, the health insurance plan is not permitted to recover any additional compensation from the plan fiduciary. If the EBSA intends to apply the Proposed Rule to fully-insured coverage, it would be helpful to clarify that the service provider must only disclose the total premium charged to the plan and provide a general description of the services that are included in the premium.

The EBSA should also take into account the extensive oversight required by state insurance regulators (and health department in the case of some health maintenance organization laws). As noted, many states require approval of policy forms and, in such cases, state approval of a policy form or other documentation of coverage should meet the disclosure requirements of the Proposed Rule.

AHIP recommends that if the EBSA applies the disclosure rule to fully-insured insurance products, that it revise the rule to clarify that health insurance plans must disclose the premium amount and provide a general description of the insurance coverage and services that will be provided. The rule should also be clarified to provide that a state

[3] We strongly suggest the Proposed Rule not duplicate information that is already disclosed to plan fiduciaries and the EBSA in connection with the annual Form 5500 requirements.

approval of a policy form or other documentation of coverage is sufficient to meet the disclosure requirements.

B. Disclosure of Payments Made from Plan Assets

We believe the Proposed Rule is intended to require the disclosure of payments made from plan assets and does not apply to situations where the plan sponsor may separately compensate a service provider for additional services. For example, many employers contract for disease management and health risk assessment services from a health insurance plan in addition to the insurance coverage offered to plan beneficiaries and participants. In some situations, the employer pays for the disease management or other services separately (i.e., not from plan assets).

According to the new instructions for the Form 5500 report, "(p)ayments made by the plan sponsor, which are not reimbursed by the plan, are not subject to Schedule C reporting requirements even if the sponsor is paying for services rendered to the plan." (72 Fed. Reg. 64825). Presumably, the plan fiduciary will be aware of compensation or fees paid by the plan sponsor for ancillary services such as disease management programs. The EBSA should clarify that the disclosure of fees and compensation by a service provider applies to situations where service provider is aware that the payment is made from assets of the plan and not separately by the plan sponsor.

AHIP recommends that the Proposed Rule be amended to make clear that service providers are not required to disclose the receipt of fees or other compensation unless the service provider is aware that such fees or compensation is paid or reimbursed from assets of the plan.

C. Disclosure of Fees and Compensation not Allocated to a Specific Contract or Agreement

The requirement to disclose fees and compensation is very broadly defined:

> "Compensation or fees" include money or any other thing of monetary value (for example, gifts, awards, and trips) received, or to be received, directly from the plan or plan sponsor or indirectly (i.e., from any source other than the plan, the plan sponsor, or the service provider) by the service provider or its affiliate in connection with the services to be provided pursuant to the contract or arrangement or because of the service provider's or affiliate's position with the plan.

29 CFR §2550.408b-2 (c)(1)(iii)(A)(1). As a result of this broad definition, service providers may end up disclosing nearly all compensation and fees or other "things of monetary value" that are directly or indirectly related to the contract or agreement. This potentially broad application raises a number of issues and questions.

For example, do the following need to be disclosed?

- Health insurance plans are required by state law and financial reporting rules of the National Association of Insurance Commissioners to set aside reserves to meet future claim obligations and other expenses associated with fully-insured health and welfare benefit products. In some cases, interest will accrue on these reserve funds.

- Some health insurance plan contracts with provider networks utilize "withholds" which are funds that may be paid to or held back from the provider based on meeting or failing to meet certain performance or quality assurance standards.

- Health insurance plans may recover amounts based on subrogation or fraud recoveries. In many cases, these recoveries are allocated to the overall health or welfare benefit insurance plan budget and not directed to any specific contract or agreement with a plan fiduciary.

- A health insurance plan may receive compensation from a third-party vendor for advertising services to its members (for example, an advertisement for health club membership at a reduced price that is included in a newsletter).

We believe that fees and compensation received by a service provider that are allocated across the line of business do not need to be reported. Such fees or compensation do not directly affect the amount that the plan fiduciary must pay for services; instead, the only impact would be on future insurance premiums or administrative services fees.

AHIP recommends that the Proposed Rule be revised to make clear that fees or compensation paid to or received by a service provider, subcontractor or affiliate that are not directly allocated to a specific contract or agreement do not have to be disclosed. We suggest that Section 2550.408b-2 (c)(iii)(A)(1) be amended as follows (new language is underlined, deleted language is indicated by a ~~strikethrough~~):

> *(1) "Compensation or fees" include money or any other thing of monetary value (for example, gifts, awards, and trips) received, or to be received, directly from the plan or plan sponsor or indirectly (i.e., from any source other than the plan, the plan sponsor, or the service provider) by the service provider or its affiliate ~~in connection with~~ that is directly allocated to the services to be provided pursuant to the contract or arrangement or because of the service provider's or affiliate's position with the plan.*

D. Disclosure of Fees and Compensation in Connection with Bundled Services

The Proposed Rule requires service providers to disclose all fees and compensation, "received, directly or indirectly, by the service provider, any affiliate or subcontractor of such service provider, or any other party in connection with the bundled services." (29 CFR §2550.408-b (c)(1)(iii)(A)(3)). According to the preamble to the proposed rule, the disclosures are not intended to "double count" any compensation. For example, "an

employee's salary or a bonus that is paid to an employee from the general assets of his or her employer (i.e., the service provider) would not need to be separately disclosed, even if the employee is paid in connection with services to an employee benefit plan." (72 Fed. Reg. 70990).

The wording of the Proposed Rule, however, may be broadly read to require a service provider to disclose all payments made <u>by the service provider</u> to any affiliate, subcontractor, or other party in connection with the contract or agreement. For example, is the service provider obligated to disclose payments to an affiliated health care provider for disease management or utilization review services in connection with health coverage provided to a health and welfare benefit plan? Such payments do not affect the charges assessed to the plan fiduciary but under a broad reading of the Proposed Rule could be considered as payments "received, directly or indirectly . . . . in connection with the bundled services." (72 Fed. Reg. 70990). Disclosure of such compensation or fees is not relevant to the cost paid by the plan fiduciary to a service provider.

Another example would be compensation paid by a health insurance plan to an insurance broker in connection with the purchase or renewal of health and welfare benefit plan coverage. Is the service provider obligated to disclose the amount of compensation attributable to insurance broker separately? Such compensation is typically charged to and disclosed as part of the premium.

A second issue arises with respect to indirect payments that a service provider's subcontractor may receive. A service provider may have multiple subcontractors and in most cases the service provider will not be aware if a subcontractor is receiving any fees or compensation that might arguably be "in connection with" the bundled services. A broad interpretation of the Proposed Rule will require service providers to routinely query all subcontractors to see if they are receiving, or are considering receiving, any compensation or fees with respect to any contracts that the service provider may have with employee benefit plans. It is difficult, if not impossible, to expect a service provider to police all of the contracts or arrangements that its subcontractors may have with other entities.

Finally, the reporting of fees or payments made, directly or indirectly, to "any other party" should be deleted from the rule. It is not clear how service providers will be expected to know all of the potential parties, not under its control, that may possibly be involved with insurance benefits or administrative services provided to an employee benefit plan.

We believe that the Proposed Rule should be revised to make clear that a service provider does not have to disclose payments that the service provider makes to an affiliate, subcontractor or any other party in connection with bundled services. We also believe a service provider should not be required to disclose any fees or compensation that a subcontractor "or any other party" may receive. Disclosure of such compensation or fees is not relevant to the cost paid by a plan fiduciary to a service provider.

AHIP recommends that the Proposed Rule be revised to make clear that a service provider does not have to "double count" payments by disclosing compensation or fees paid by the service provider to other parties in connection with bundled services. In addition, the service provider should not be required to report indirect payments made to a subcontractor. We suggest that Section 2550.408-b(c)(1)(iii)(A)(3) be amended as follows (new language is underlined, deleted language is indicated by a ~~strikethrough~~):
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> *The service provider must disclose all services and the aggregate compensation or fees to be received, directly or indirectly, by the service provider~~,~~ or any affiliate ~~or subcontractor~~ of such service provider~~, or any other party~~ in connection with the bundle of services except for compensation or fees paid by the service provider to any affiliate, subcontractor, or any other party.*

E. Disclosure of Indirect Compensation

The Proposed Rule requires the disclosure by service providers of "indirect" compensation (i.e., from any source other than the plan, the plan sponsor or the service provider) "in connection with the services to be provided pursuant to the contract or arrangement or because of the service provider's or affiliate's position with the plan." (29 CFR 2550.408b-2 (c)(1)(iii)(A)(1)). This provision may be broadly read to include fees or compensation paid to the service provider that are not dependent on the contract with the health and welfare plan or on the size of the plan (i.e., the number of beneficiaries or participants).

Some health insurance plans may aggregate de-identified health information based on claims payment and other administrative operations. Such information may then be sold to third parties -- for example, to determine appropriate benchmarks or quality indicators based on employer size or industry cohort. The aggregation and sale of such information is arguably "connected to" the plan but is not based on the specific contract or agreement with the plan fiduciary. In other words, the price paid by the plan fiduciary and the administrative services provided by the service provider do not change based on the sale of such information.

AHIP believes the Proposed Rule should be changed to clarify that a service provider does not have to report compensation or fees received by the service provider, subcontractor or affiliate if such compensation or fees is not dependent on the contract or based on the size of the plan.

AHIP recommends that the Proposed Rule be clarified to provide that indirect compensation does not include any compensation or fees received by a service provider or affiliate that is not dependent on the contract or based on the size of the plan. Section 2550.408b-2 (c)(1)(iii)(A)(1) should be amended as follows (new language is underlined):

> *(1) "Compensation or fees" include money or any other thing of monetary value (for example, gifts, awards, and trips) received, or to be received, directly from the plan or plan sponsor or indirectly (i.e., from any source other than the plan, the plan sponsor, or the service provider) by the service provider or its affiliate in connection with the services to be provided pursuant to the contract or arrangement or because of the service provider's or affiliate's position with the plan. <u>Such compensation or fees does not include amounts received by the service provider or affiliate that are not dependent on the contract or based on the size of the plan.</u>*

Disclosure of Conflicts of Interest

A. Defining Conduct that is a "Conflict of Interest"

The Proposed Rule requires service providers to disclose "any material financial, referral, or other relationship or arrangement with . . . . any other entity that creates or may create a conflict of interest for the service provider in performing services pursuant to the contract or arrangement . . . ." (29 CFR §2550.408-b (c)(1)(iii)(D)). The term "conflict of interest" is not defined in the Proposed Rule and, as a result, service providers and plan fiduciaries will not have a clear understanding of the types of conduct that must be disclosed (especially for relationships or agreements that "may create" a conflict). Because of the potential penalties that may be incurred, it is important to clearly define when such relationships may exist in order to avoid "over-reporting" of all potential conflicts, whether real or not.

AHIP believes it is important to clearly define the term "conflict of interest" so service providers will know what must be disclosed. We suggest that a "conflict" exists if the relationship or arrangement materially and negatively affects the fees or compensation paid or the service provided pursuant to the contract or agreement between the service provider and the plan fiduciary.

AHIP recommends that the Proposed Rule include a definition of the term "conflict of interest" such that a conflict exists if the relationship or arrangement materially and negatively affects the fees or compensation paid by or the administrative services provided to the plan fiduciary..

B. Potential "Conflicts" Involving the Plan Sponsor

There may be situations where a service provider and a plan fiduciary are providing services to each other. For example, a health insurance plan may offer health insurance coverage or administrative services to a hospital that is part of the health insurance plan's network. While we do not believe such a relationship creates a conflict of interest, the wording of the Proposed Rule could be broadly interpreted to require the health insurance plan to notify the plan fiduciary of a relationship of which it is already aware (i.e., the fact that the sponsor of the plan is providing services to the service provider).

AHIP believes health insurance plans as service providers should not be required to report to the plan fiduciary any relationship with the sponsor of the plan. The plan fiduciary is already aware of such relationships and can evaluate any potential conflicts of interest.

AHIP recommends that the proposed rule be revised to make clear that the service provider does not have to report any relationships with the sponsor of the welfare plan. Section 2550.408-b(2) (c)(1)(iii)(D) of the Proposed Rule should be amended as follows (added language is underlined):

> *(D) Whether the service provider (or an affiliate) has any material financial, referral, or other relationship or arrangement with a money manager, broker, or other client of the service provider, other service provider to the plan, or any other entity (except for the sponsor of the plan) that creates or may create a conflict of interest for the service provider in performing services pursuant to the contract or arrangement and, if so, a description of such relationship or arrangement.*

Timing of Required Disclosures

A. Disclosures by Service Providers that "May Provide" Services

According to the Proposed Rule, a service provider that "may provide services" is required to make disclosures. This requirement, although well intended, may unintentionally burden plan fiduciaries during the contract negotiation stage.

In many cases, plan fiduciaries issue requests for proposals (RFPs) with detailed requirements and specifications for services that will be provided to the plan. The service providers responding to the RFP may not have all of the information that is required to be disclosed by the Proposed Rule (for example, the service provider may be in the process of arranging for services from affiliates) or the required disclosure may not be relevant to the particular RFP (for example, a statement that all required disclosures have been provided prior to finalizing the contract or agreement is not needed if ultimately the service provider does not get the contract). As a result, the plan fiduciary may receive extensive disclosures from multiple service provider bidders that are neither relevant to the RFP nor useful information needed to choose a service provider.

The purpose of the Proposed Rule is to make sure that the plan fiduciary has all necessary information before the contract or agreement is completed. This purpose is met by the provision of the Proposed Rule requiring all necessary disclosures to be made, "before the contract or agreement was entered into (or extended or renewed) . . . ." (29 CFR 2550.408b-2 (c)(1)(iii)).

We suggest that any possible confusion be removed from the Proposed Rule by deleting the requirement for service providers "who may provide" services to disclose information as long as all required disclosures are made before the contract is finalized. This change will remove potential administrative burdens from the contracting process.

AHIP recommends that the EBSA revise the Proposed Rule to delete the reference to service providers who "may provide" services. In addition, the Proposed Rule should make clear that service providers who are providing services must meet the applicable disclosure requirements prior to entering into the contract with the plan fiduciary.

B. Disclosures of Material Changes to the Contract or Agreement

Service providers must disclose any "material changes" to the terms of the contract or agreement "not later than 30 days from the date on which the service provider acquires knowledge of the material change." 29 CFR 2550.408-b(2) (c)(1)(iv). Although not defined in the Proposed Rule, the preamble states that a "material change" is one "that would be viewed by a reasonable plan fiduciary as significantly altering the 'total mix' of information made available to the fiduciary, or significantly affecting a reasonable plan fiduciary's decision to hire or retain the service provider . . . ." (72 Fed. Reg. 70992).

The definition of "material change" is vague and confusing and will result in service providers disclosing any and all potential changes to the contract or agreement to avoid even the appearance of violating the disclosure requirements. We suggest that a definition of a "material change" be included in the Proposed Rule that requires notification of the plan fiduciary if the change either: (a) increases the compensation or fees required to be paid pursuant to the contract or agreement or (b) materially reduces or alters the services provided pursuant to the contract or agreement.

In addition, the 30 day time frame to notify the plan fiduciary may be problematic, especially in situations where the material change may ultimately not impact the service provider's decision to modify the contract. For example, a service provider may be informed that an affiliate's fees will increase and pursuant to the contract or agreement the provider has the right to pass along such increases. The service provider may ultimately determine that it will not increase its fees to the plan fiduciary or will not increase the fees commensurate with the new price charged by the affiliate. Service providers should be required to notify the plan fiduciary only in the case of an actual material change to the contract or agreement.

AHIP recommends the Proposed Rule be amended to include a definition of a "material change" in a contract or agreement that must be made to the plan fiduciary. We suggest that notification be made if (a) the compensation or fees required to be paid by the plan fiduciary increase or (b) the services provided to the plan fiduciary are reduced or altered. In addition, AHIP recommends that the service provider be required to notify the plan fiduciary within 90 days after the date the service provider has determined that it will materially modify the contract or agreement (rather than within 30 days of the date it "becomes aware" of a potential modification).

Disclosures in Separate Documents and Electronic Disclosures

The preamble notes that "written disclosures may be provided in separate documents from separate sources and may be provided in electronic format . . . . " (72 Fed. Reg. 70990). We strongly support the ability of service providers to reference multiple sources of information; however, this provision is not included in the Proposed Rule. In addition, it would be helpful to clarify that such disclosures may be made to a fiduciary by referencing a website where it can access the required information.

AHIP recommends that the Proposed Rule be clarified to state that written disclosures may be provided in separate documents from separate sources and may be provided in an electronic format including a website. Section 2550.408b-2 (c)(ii) should be revised as follows (added language is <u>underlined</u>):

> *(ii) The terms of the contract or arrangement shall be in writing. <u>Written disclosures may be provided in separate documents from separate sources and may be provided in an electronic format including by reference to a website where the fiduciary may access the information.</u>*

Effective Date of the Proposed Rule and Proposed Class Exemption

Both the Proposed Rule and Proposed Class Exemption are intended to be effective 90 days after publication of a Final Rule and Final Class Exemption in the *Federal Register*. This date is highly problematic for both plan fiduciaries and their service providers.

Health insurance plans may have thousands if not tens of thousands of service contracts with ERISA plan fiduciaries in force at any one time.[4] Because of the time needed to negotiate some service provider contracts in order to provide open enrollment for employees in the last quarter of 2008, many health insurance plans are already entering into discussions with plan fiduciaries for health and welfare benefit insurance coverage or for administrative services that will be effective January 1, 2009.

In addition, if it is determined that the requirements apply to fully-insured health and welfare benefit insurance products that are sold to employee benefit plans, in many cases any changes to the underlying policy to comply with the Proposed Rule will need to be submitted to state insurance regulators for approval. State regulators typically must

[4] According to a recent employer survey, over 3.3 million firms in the United States provide health coverage to employees. (Kaiser Family Foundation/Health Research and Education Trust, *Employee Health Benefits 2007 Annual Survey*). It is estimated that 1.1 million of private-sector firms that offer health coverage do so through at least one self-funded plan. (Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, *2005 Medical Expenditure Panel Survey-Insurance Component*, Table 1.A.2 (2005)). Many large firms have contracts or agreements with multiple service providers related to their health coverage (for example, the employer will provide different coverage options such as HMO, PPO, and POS or will "carve-out" certain benefits such as behavioral health or prescription drug coverage).

approve any changes to the policy forms before they become effective which would include the inclusion of new or revised contract terms and conditions such as the disclosures required by the Proposed Rule. Such state approvals are frequently time consuming and administratively complex.

Although we believe health and welfare plan fiduciaries already receive extensive disclosures of information, health insurance plans will be required to examine their contracting process to make sure they are in compliance. As a result, requiring full implementation of the extensive requirements in the Proposed Rule and the Proposed Class Exemption in a too short period of time could result in significant administrative burdens for both service providers and plan fiduciaries.

In addition, the Proposed Class Exemption requires health and welfare plan fiduciaries to determine if existing contracts and agreements are in compliance with the Proposed Rule. It is reasonable to expect that fiduciaries will contact their service providers to request additional information or to ask questions about the potential application of the new requirements. Such a process will also require the dedication of administrative and operational resources by service providers and plan fiduciaries.

AHIP believes plan fiduciaries and health insurance plans service providers need sufficient time to implement the Proposed Rule. We suggest that service providers and fiduciaries be given, at the very least, 18 months from the effective date of the Final Rule to come into compliance. This timeframe will allow plan fiduciaries and service providers to make all of the necessary modifications to contracts and agreements – and to the contract negotiation process. In addition, the Proposed Rule should be applied to new contracts that are entered into or renewed after the effective date of the rule rather than retroactively applied to existing contracts and agreements.

Assuming the Final Rule will be published prior to July 1, 2008, AHIP recommends that service providers be required to come into compliance with the rule for contracts that are entered into or renewed with respect to plan years beginning on or after January 1, 2010. In addition, AHIP recommends that the Proposed Class Exemption be made effective for plan years beginning on or after January 1, 2010.

Creation of Model Disclosure Forms and Disclosure Provisions

In order to realistically compare some services provided by service providers, a plan fiduciary may need to examine similar information across the various providers. One possible approach to the disclosure requirements is to work with plan fiduciaries, insurance carriers, and service providers to develop model disclosure forms (similar to the Form 5500) and disclosure provisions that give fiduciaries information needed to make meaningful decisions. Such forms could be tailored to meet the needs of specific employee plans depending on the number of participants and beneficiaries or the type of plan. AHIP is available to work with the EBSA and other interested parties in developing model disclosure forms or other materials that would be used to inform plan fiduciaries.

The use of forms should be voluntary because service providers may have additional or varying contract terms that will have to be included. In addition, service providers and plan fiduciaries that utilize the model forms or disclosure provisions should be considered to be in compliance with the rule.

AHIP recommends that EBSA consider working with plan fiduciaries and service providers to create model forms and disclosure formats for information provided to plan fiduciaries. Use of such forms or disclosure formats should be voluntary, but plan fiduciaries and service providers that utilize the forms or disclosure provisions should be considered as meeting the requirements of the rule.