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The Honorable Bradford P. Campbell
Assistant Secretary of Labor
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room S-2524
Washington, DC 20210

Mailed and submitted electronically (e-ORI@dol.gov)

Dear Assistant Secretary Campbell:

America's Health Insurance Plans (AHIP) is writing to supply additional information in response to questions raised in connection with our April 1, 2008, testimony concerning the Proposed Rule issued by the Department of Labor, Employee Benefits Security Administration (EBSA) on Reasonable Contracts or Arrangements Under Section 408(b)(2) – Fee Disclosure. AHIP submitted comments to the EBSA on the Proposed Rule on February 11, 2008.

This letter provides additional details on two specific points: (1) the extent of state regulatory oversight of insurance products sold to plan sponsors that explains our position that insurers should not be considered "service providers" when offering fully-insured products; and (2) the fundamental differences between health and welfare plans as opposed to pension plans with regard to service provider relationships that make the proposed disclosures ill-suited to the health and welfare context.

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]

State Oversight of Health Insurance Sold to Plan Sponsors

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

AHIP maintains that treating a health insurance company or health maintenance organization (HMO) as a service provider to a fully-insured group plan is not necessary and should not be required by the Final Rule. As explained in our comment letter and testimony, there are three practical reasons for making this clarification: (1) In a fully-insured plan, the risk is assumed by the insurance carrier and not the plan participants or beneficiaries; (2) the premiums and services are clearly delineated in the insurance contract and disclosed to the fiduciary, participants, and beneficiaries; and (3) insurance carriers and insurance products already are subject to significant state regulation.

During our testimony, we were asked to further explain the extent to which states provide oversight of fully-insured coverage provided to health and welfare plans. As background, we note that almost half (45%) of workers are in a plan that is fully insured.[2] As a general rule, small to mid-size employers typically fully insure their major medical benefits, while many large employers opt to self-fund major medical coverage.[3] Hence, small or mid-size employers typically: (1) have the security of insured products, for which the carrier already assumes the full risk of coverage; and (2) have clearly understandable premium and other cost information, enabling them to evaluate competing offerings.

Moreover, regarding the extent of state regulation, under the McCarran-Ferguson Act, states have broad authority to regulate insurance products and to require licensing for and oversight of entities that sell insurance (15 U.S.C §1011 *et seq.*). All states have extensive regulatory systems that provide strict oversight and regulation of virtually every aspect of an insurer's business operations. Thus, states oversee a broad range of issues with respect to insurance, including licensure of insurers and insurance producers, enrollee information disclosures, access to medical services, health care provider contracting issues, financial solvency, rate filings, benefit mandates, quality assurance and utilization review, and grievances and appeals.[4]

All states also require regulated entities to file detailed audited financial statements, and many states now require supplemental filings to allow the states to review claim and market conduct activities for certain lines of business. State insurance departments conduct detailed periodic on-site examinations, as well as desk audits on a more frequent basis. In sum, every aspect of a carrier's operations is subject to state oversight and examination.

We have attached as Exhibit A hereto a chart of state laws regarding policy and rate form approvals prepared by the National Association of Insurance Commissioners (NAIC) as an example of the breadth of this regulatory oversight. State insurance departments require a great

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[2] Kaiser Family Foundation/Health Research and Education Trust, *Employee Health Benefits 2007 Annual Survey.*
[3] Even in the case of self-funded health and welfare arrangements, the plan sponsor generally will purchase stop-loss insurance coverage to protect against individual and/or aggregate catastrophic losses. *See* Lewin Group, *Establishing an Analytical Framework for Measuring the Role of Reinsurance in the Health Insurance Market,* (March 20, 1997) (Prepared for the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services).
[4] For a full discussion of state regulatory oversight, *See Essentials of Managed Health Care,* Peter R. Kongstvedt, Fourth Edition, (2001), *NAIC Compendium of State Laws on Insurance Topics, Volumes I – III,* (November 2007), www.naic.org., and *How Private Health Coverage Works: A Primer 2008 Update,* Kaiser Family Foundation (April 2008).

deal of information from insurers offering products in both the individual and group markets. For example, almost all states have statutory authority to disapprove product forms and rates, and most states require prior approval of health insurance or managed care rates and forms before they can be used in the marketplace.

It is also critical to note that federal courts have broadly interpreted the ability of states to impose regulations in the area of insurance products *offered to ERISA plans*, including the ability to mandate which benefits should be covered (*Metropolitan Life v. Massachusetts,* 471 U.S. 724 (1985)), any willing provider requirements (*Kentucky Assn. of Health Plans v. Miller,* 538 U.S. 329 (2003)), requirements relating to assignment of benefits (*Louisiana Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529 (5th Cir. 2006), *petition for cert. denied* (2007)), and provisions for external review of claim disputes (*Rush Prudential v. Moran,* 536 U.S. 355 (2002)).

In sum, state regulation of fully-insured products provides sufficient oversight of such fully-insured products and assures that health and welfare plan sponsors are fully aware of the extent and nature of the insurance coverage and the cost. Any proposed regulation that imposes additional requirements on service providers regarding fees, compensation, and conflicts of interest must take account of the extensive regulation already imposed on fully-insured ERISA products, and should not add additional administrative burdens to those administering such benefit plans and their service providers. Any additional regulation and disclosures imposed on service providers should be considered in light of one of the central purposes of ERISA, namely to avoid "creat[ing] a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996).

Differences Between Health and Welfare Plans vs. Pension Plans

As discussed in our comment letter and testimony, there are fundamental differences between health and welfare plans and pension plans with respect to the goals, structure, and incentives of each type of arrangement. Both ERISA and the EBSA's regulatory activities recognize that different approaches are appropriate for pension plans vs. health and welfare plans.[5] In fact, Congress has also recognized these differences in its recent legislative activity with respect to ERISA plan disclosures.[6] The Proposed Rule should clearly distinguish between pension plans as opposed to health and welfare plans with respect to what disclosure requirements should be applied to service providers.[7]

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[5] *See, e.g., Report of the ERISA Advisory Council Working Group on Plan Fees and Reporting on Form 5500* (November 2004); *Report of the ERISA Advisory Council, Working Group on Plan Fees and Reporting on Form 5500* (November 2006) (Working Group Report); and U.S. House of Representatives, Committee on Education and Labor, Hearing Testimony on H.R. 3185, the "401(k) Fair Disclosure for Retirement Security Act." (October 4, 2007).

[6] On April 16th, the House Committee on Education and Labor approved H.R. 3185, the "401(k) Fair Disclosure for Retirement Security Act" which addresses many of the concerns expressed about pension plan disclosures.

[7] Consistent with these distinctions, the EBSA has traditionally treated pension plans and health and welfare plans differently with respect to reporting requirements and other regulatory oversight. *See e.g., 29 C.F.R. §2520.102-3 (j) through (n) (Contents of Summary Plan Description); 29 C.F.R. §2520.104-44 (Contents of the Annual Report);*

A pension plan "(i) provides retirement income to employees, or (ii) results in the deferral of income by employees for periods extending to the termination of covered employment or beyond . . . ." (ERISA §3(2)(A)). The primary goal of a pension plan is to make sure the participant or beneficiary has future retirement income. The service provider or affiliate may provide services (and assess charges) both to the plan and to individual participants. The service provider and affiliates can directly impact the amount of future retirement benefits available to participants and beneficiaries. The fiduciary thus needs information to answer two important questions: (1) the underlying costs incurred by the plan and/or investment accounts (since this reduces future income), and (2) how the performance of plan assets and/or its investment accounts are affected by actions of the service provider, affiliates or other parties.[8] This information is critical because the pension plan fiduciary may not be informed in its contract with a service provider regarding the fees charged against the individual participant's or beneficiary's account. In fact, it is this information gap that the ERISA Advisory Council identified and that Congress is trying to address with legislation.

In contrast, a health and welfare plan provides the participants and beneficiaries, "medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death or unemployment . . . ." (ERISA §3(1)). The goals of a health and welfare plan are to provide clearly defined health care or disability benefits over the course of the plan year and to predictability fund these costs. To meet these goals, the fiduciary needs to know: (1) what benefits and related services are being provided, and (2) how much the service provider is being paid by the plan sponsor to provide these benefits or services. The service provider and affiliates provide administrative and related services to the plan sponsor and are paid by the plan sponsor. The service provider and affiliates administer the benefit but do not have the ability to impact the overall coverage or benefits available to plan participants. Neither Congress nor the ERISA Advisory Council (or anyone else as far as we can determine) has identified any problems with disclosures made to health and welfare plan fiduciaries.

Conclusion

AHIP and its member health insurance plans appreciate the opportunity to provide additional input with respect to the proposed disclosure requirements in the Proposed Rule. We believe that health and welfare plan fiduciaries and the beneficiaries and participants of such plans already receive meaningful and material information when making decisions about plan options. We ask that the EBSA withdraw the Proposed Rule with respect to health and welfare plans in recognition that the operational requirements of such plans differ from pension plans.

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and 29 C.F.R. §2520.104-44 (Limited Exemption and Alternative Method of Compliance for Annual Reporting by Unfunded Plans and Certain Insured Plans).

[8] According to testimony presented to Congress and the ERISA Advisory Council Work Group, the concern is that pension plan fiduciaries, participants, and beneficiaries may not understand or be aware of the fees and charges assessed against their investments and pension benefits. *See ERISA* Advisory Council Working Group Report (November 2006), *Testimony of David Certner on behalf of AARP*, House Education and Labor Committee (October 4, 2007).

Sincerely,

Stephanie Kanwit
Special Counsel

Cc: Office of Regulations and Interpretations, Employee Benefits Security Administration

Attachment