U.S. DEPARTMENT OF LABOR

EMPLOYEE BENEFITS SECURITY ADMINISTRATION

HEARING ON REASONABLE CONTRACTS OR ARRANGEMENTS FOR WELFARE BENEFIT PLANS UNDER SECTION 408(b)(2)--WELFARE PLAN FEE DISCLOSURE

U.S. Department of Labor
Francis Perkins Building
Room S-4215(A-C)
200 Constitution, Ave., N.W.
Washington, D.C. 20210

Tuesday, December 7, 2010

The hearing was convened, pursuant to notice, at 9:00 a.m., ROBERT DOYLE, presiding.

APPEARANCES:

PANEL MEMBERS:

JOE CANARY

PHYLLIS C. BORZI

TIMOTHY HAUSER

JOSEPH PIACENTINI

ALAN D. LEBOWITZ

ROBERT DOYLE

I N D E X

P R O C E E D I N G S

OPENING REMARKS - INTRODUCTION OF PANEL

MR. DOYLE: Good morning. I am Robert Doyle, Director of Regulations and Interpretations for the Employee Benefits Security Administration at the Labor Department. Welcome to the Department of Labor and the Employee Benefits Security Administration's public hearing on the application of the 408(b)(2) regulation to the development of standards for welfare plans.

Prior to introducing today's hearing panel and an introductory statement from Assistant Secretary Phyllis Borzi, I'd like to address just a few procedural matters.

Notice of today's hearing was published in the Federal Register on November 5th with an invitation to interested persons to testify on the application of the 408(b)(2) regulation to welfare plans. In response to that invitation, we received nine requests to testify and we've taken those nine requests and divided them up into three panels.

For purposes of today's hearing, each panel member will be allowed ten minutes to present their testimony. Following the conclusion of that testimony, the government panel members will be afforded the opportunity to ask questions. With regard to those

questions, I want to emphasize that it's our interest to develop the public record as fully as possible, therefore no inferences or conclusions should be drawn concerning the panel members' views concerning or resulting from their questions.

Panel members will testify in the order in which they appear in the hearing agenda. To assist us today I have a few requests. First, prior your testimony, we ask that you identify yourself for the court reporter, your affiliation, and the organization that you are representing.

Second, limit your remarks to the allotted time and to assist you we have an electronic timer.

At the end of today's hearing we will keep the hearing record open until January 7th, that's about 30 days. And the record will be available to the public and we will post all submissions on our website.

Finally, I note that today's hearing is being transcribed and hearing transcripts will also be available on EBSA's website within the next couple of weeks.

Before introducing the panel, I want to thank Fil Williams of the Office of Regulations and Interpretations, my office, for his work in organizing and handling the logistics for today's hearing. Thank

you, Fil.

Now, to introduce the panel. To my immediate right Alan D. Lebowitz, Assistant Secretary for Program Operations, EBSA; Joe Piacentini, our Director of the Office of Policy and Research; Tim Hauser, Associate Solicitor, Plan Benefit Security Division of the Solicitor's Office; The Honorable Assistant Secretary, Phyllis C. Borzi; and to her immediate right, my right arm, and the person I couldn't do my job without, Deputy Director Joe Canary.

(Laughter.)

MR. DOYLE: With that, I turn to Ms. Borzi.

ASSISTANT SECRETARY BORZI: Thanks, Bob. I just want to say a few words this morning.

First, thank you so much for coming to the hearing and for participating in this hearing. I think you know that fee transparency is probably one of our highest, if not the highest, priority in our regulatory agenda. It's very important to make sure that people have all the tools at their disposal to be able to understand the benefits that they're offered. And, of course, for plan sponsors, fiduciaries, to understand the choices that they have when they offer people benefits. With a growing importance of health benefits and other welfare benefits in terms of the wide group

of benefits that plan sponsors offer, it's very important that we focus on these issues.

As you know, the 408(b)(2) regulation, when it was originally proposed in the prior administration was designed to cover both pension plans and health and welfare plans. Based on the comments that the Agency received we went forward and finalized the 408(b)(2) regulations a few months ago, but focusing only on the pension side. Making clear in the preamble to the regulation that we weren't forgetting about the welfare plan side, it's just that we wanted to look at those issues separately as many of you suggested that we do so.

So this is the first step in our effort to begin to look at these issues. I have spent quite a number of years in my career advising plan sponsors about the whole range of employee benefits and I have to say in my own experience the type of transparency and disclosure that my clients had when they were selecting health plans was far behind the type of disclosure that they had when they were looking at 401(k) plans and other kinds of financial instruments. Some people may say that's fine because the disclosure -- and certainly when I went back and looked at the comments that some of you filed, that's what you said.

And I assume we'll hear some witnesses today saying there's plenty of disclosure, there's plenty of transparency, we don't need to make any changes. That has not been my experience in advising clients. But we always walk a line here between trying to protect consumers, because that's part of the mission that the Employee Benefits Security Administration has, and not trying to unduly burden service providers and plan sponsors.

So today what we're trying to do is get some information out on the public record and this, as I said, the first of a series of efforts we will make to evaluate the need for transparency -- additional transparency and disclosure.

So, once again, thanks so much for your participation and your help. And why don't we just start with the witnesses, Bob?

MR. DOYLE: Okay. If we could call the first panel. So we'll follow the order of the agenda and start with Mr. Downey

SOCIETY OF PROFESSIONAL BENEFIT ADMINISTRATORS

By Thomas Doney, President of Cypress Benefit Admin.

MR. DONEY: Good morning. My name is Tom Doney. I'm the President of Cypress Benefit

Administrators, a third-party administration firm and a member of the Society of Professional Benefit Administrators, SPBA. The SPBA is a national association of independent third-party administration firms which manage client/employee benefit plans. It is estimated that 55 percent of all non-federal U.S. workers and their dependants, from every size and form of employment, are covered by employee benefit plans managed by such TPA firms.

SPBA member TPA firms operate much like independent CPAs or law firms, providing professional outside claim and benefit plan administration for multiple client employers and benefit plans. Many of these plans include some degree of self-funding and SPBA represents a wide range of benefit plans including small businesses, large corporations, unions, non-unions, municipalities and association-sponsored plans.

I agree with the Department's assessment noted in the July 16th, 2010 interim final rule on ERISA Section 408(b)(2) that a separate and more specifically tailored disclosure rule for welfare benefit plans is needed. I understand that one of the goals of disclosure is to provide comprehensive and useful information to plan sponsors when entering

service contracts to enable them to assess the reasonableness of the fees paid for the services.

While health plans currently disclose much of what the Department envisions, there are certain areas of the market where transparency does not presently exist. A tailored rule would provide a more level playing field in the industry and assist plan sponsors in understanding what they're actually paying for the services rendered.

Please understand that I view the role of the independent employee benefit consultants -- which includes insurance agents and brokers -- as an important and valuable asset to companies offering employee benefits. There are many examples of good work being done by employee benefit consultants, and, in my opinion, it's right that the consultant be remunerated for the work they do for the clients. However, I've also seen examples of payments to consultants, particularly from large national insurance companies, sometimes in large amounts that are not disclosed to clients.

Additionally, my concern and that of many in my industry is that the prospect of large payments from carriers to consultants can skew their recommendations to clients with respect to what administrators or

carriers the client should be utilizing for employee benefit plan administration.

My own TPA firm has, in several circumstances over the years, provided quotes to consultants for a client of theirs that was very price competitive and/or significantly less expensive. But the consultants never in fact presented our quote to the client to assist them in fully considering their benefit options.

My conclusion in many of these circumstances is that the consultant made the recommendation not based on what's best for the client necessarily, but rather what administrator or carrier would pay them the most for their business. Indeed, in a private conversation with an employee of a large Wisconsin-based insurance agency I was told that the consultants at the agency were instructed by the managing partners to place as much business as possible with one particular carrier due to commission and bonus policies of that carrier, not because of price competitiveness or service charges or advantages.

Consultants generally disclose commission payments made to them by administrators and insurance carriers. The problem, though, as I see it, is that it's not necessarily the individual group commissions that a consultant receives from the carrier, but rather

the additional bonuses and overrides they receive on an entire book of business with a particular carrier.

For example, a major national insurance carrier offers Wisconsin consultants a bonus of up to $12 per enrolled employee on an overall block of business not specific to one individual employer. Additionally, if the consultant retains that level of business for a second year and increases that block by as little as 25 percent it will get an addition bonus of 150 percent of that original amount.

So, if a consultant brings ten groups to this carrier with 400 employees each, an initial bonus of $48,000 is paid to the broker that year. Then if the consultant's entire block of business with the carrier at the end of year two is 5,000 employee lives, I'm saying those ten groups, plus an additional four groups with 250 employees each, an additional bonus of $72,000 is paid on that block. And those bonuses are in addition to the typical up-front consulting fee, usually somewhere between $2 and $3 per employee per month and stop-loss insurance commissions, usually 10 percent of insurance premiums that is almost always paid to them on a self-funding case.

In this particular example that I just gave, the consultant would have been paid $430,000 in

commissions and bonuses over a two year period for placing 14 employer cases with a major health insurance carrier, $160,000 of which would not typically be disclosed to the client.

So I can see a client disclosing the stop-loss commissions and the per-employee per month fees to an individual group, and in fact that often happens today; but how does one disclose to one particular group a $48,000 or $72,000 bonus that's paid to them as a result of having many employer clients with many employees placed with the carrier.

It's a myth that these types of bonuses and overrides are typically not disclosed to individual clients because it's difficult to accurately determine how much is attributable to a particular employer. The easy answer is obviously to say, well, if you've got $48,000 for 4,000 employees, just divide the overall compensation by the number of overall employees and multiply by the number of employees that one employer has to get the compensation amount, but bonuses are often paid on a sliding scale based on an overall block of business that gets calculated from time to time. So it's difficult to attribute a certain dollar amount to a certain group if the per-employee compensation scale changes regularly. And I suspect that a consultant is

not particularly motivated to disclose anything to a client other than that which can be directly attributed to a specific employer such as per-employee, per-month fees and stop-loss commissions.

So as a way to gain more business the savvy consultant could actually tell the employer that he's going to charge them a consulting fee and will waive all commissions while he reaps the rewards of receiving large bonuses from carriers based on an aggregated block of business not predicated on an individual employer's enrollment.

It should be made clear at this point that the circumstances wherein a consultant is a part of an agency or a consulting firm, and the consultant is typically responsible for sharing their commissions and bonuses with the agency employer. So not in all circumstances does the individual consultant retain all payments made by the carriers for the business that's written.

The point is that the proposed regulations that I've seen seem to revolve around the compensation one gets from enrolling an individual employer. That doesn't come close to telling the entire story when it comes to the consultant compensation. I am in no way interested in denying an employee benefit consultant or

their firm the opportunity to make as much money as they reasonably can from the important work that they do for employers. I do, however, believe that an employer whose employee benefit costs are second only to payroll must be completely aware of what they're paying, because, in fact, it's the employer who ultimately foots the bill, not just for the employee's claim costs, but for the administrative fees and miscellaneous compensation that's part of their benefit plan.

I would suggest that in future guidance published there be an example of how the Department envisions bonuses and commissions for placing business across a consultant's entire block being disclosed to clients.

I believe full disclosure of all compensation under both self-funded and fully-insured plans to be a critical part of the decision-making process for employers and that only when an employer fully understands what goes into all of their benefit costs will there be a level playing field for TPAs and carriers who rely so heavily on consultant representation to clients.

Other trade groups have asserted that additional disclosure rules are unnecessary for fully-

insured plans because adequate disclosure under ERISA already exists, specifically the Form 5500 Schedule A.

The Schedule A doesn't serve the goals of Section 408(b)(2) to assist plan sponsors in assessing the reasonableness of the fees paid for services. The Schedule A is issued after the end of the plan year and long after the plan sponsor has made a decision to select a particular service provider. And candidly, not all fees are consistently disclosed to the employer making it impossible for them to report correctly on Schedule A.

I believe that most state insurance laws do not require the types of disclosures addressed under the 408(b)(2) proposed rules. If there are some state insurance laws addressing similar disclosure issues, it appears that they are loosely enforced giving that fully-insured plans are currently less compliant with the spirit of 408(b)(2) than self-funded plans.

Finally, I've reviewed the interim final rule with respect to the financial disclosures as it regards to pension plans in the July 16th, 2010, Federal Register. I understand that you're interested in pursuing the same or similar rules as regards to welfare plans. Many commenters on the proposed rule expressed objections to the conflict of interest

disclosure obligations requiring narrative descriptions of potential conflicts of interest. In the interim final rule for pension plans, the Department adopted a different approach focusing on more detailed disclosure of compensation arrangements and I would like to encourage the Department to apply this same approach to welfare plans.

Thank you for your time this morning. I'd be happy to answer any questions you may have.

MR. DOYLE: Thank you.

AMERICAN COUNCI OF LIFE INSURERS

Todd Katz, MetLife

MR. KATZ: Good morning, Assistant Secretary Borzi and the members of the panel. It is a pleasure to be here with you today. My name is Todd Katz. I am an executive vice president for our insurance products at MetLife and I'm here today on behalf of the American Council of Life Insurers, the ACLI, to discuss whether Section 408(b)(2) rules should apply to products sold to employee welfare benefit plans.

The ACLI is a Washington, D.C.-based trade association representing more than 300 life insurers and fraternal benefit society member companies operating throughout the United States. ACLI member

companies provide life insurance, disability, accidental death and dismemberment, long-term care, and critical illness, and other coverages that are offered to employees through ERISA welfare benefit plans.

My testimony today will focus on these non-medical welfare benefit programs. We thank you for holding these hearings today and for giving us the opportunity to testify.

I want to emphasize at the onset that the ACLI supports appropriate disclosure to ERISA welfare benefit plan sponsors about the products they purchase for their employees, and commends the Department on its thorough and deliberate process.

The products sold by ACLI member companies are typically straightforward insurance contracts where the plan sponsor is paying a premium and the insurer is responsible for all obligations under the contract which primarily are claim payments. We believe that disclosure of product pricing, terms, and conditions are necessary to permit plan administrators to make informed decisions about the products to be included within a benefit plan. Augmented disclosures provided to plan sponsors, however, are not cost free. They should be required only when they add value by improving the ability of the plan sponsor to make

appropriate decisions for the plan.

We believe the current disclosures required by the regulatory framework for products sold to ERISA plans are more than adequate to provide plan sponsors the information needed to make these decisions. While concerns about indirect compensation of service providers, investment advice, bundled services, and conflicts of interest with plan fiduciaries drove the decisions to enhance the disclosures provided to retirement plans, these considerations are seldom present in the structurally simple arrangements for non-medical welfare benefits. In short, we believe there is neither a need nor a substantive basis nor a cost benefit justification for additional disclosure requirements under ERISA for these insured welfare products.

Extensive regulatory disclosures for non-medical benefit products are already in existence under both state and federal law. ERISA requires that insurers to disclose information to plan sponsors on an annual basis about premiums, brokerage commissions, claim payments, claim reserves, and related information so that the plan sponsor can complete Schedule A and Schedule C to Form 5500.

In addition the insurance industry is heavily

regulated outside of ERISA. State insurance laws and regulations mandate disclosures to both state insurance regulators and plan sponsors about welfare products.

For example, in addition to requiring that the policy forms and premium rates be filed for review and approval with state insurance departments, most states have adopted comprehensive disclosure requirements under broad advertising regulations that set forth mandated standards and other requirements related to the marketing and sale of non-medical benefits.

Model regulations promulgated by the National Association of Insurance Commissioners have been adopted in some form by approximately 42 states. These regulations require that insurance companies disclose the important policy features such as benefits, exclusions, limitations, renewability, termination, and premium changes. They require that advertisements be truthful and complete and not misleading. And they require that advertisements contain fair and accurate comparisons to other products and that insurers adopt certain procedures and safeguards.

As a consequence of both the law and business practice, plan sponsors receive comprehensive information allowing them to evaluate and select

insured welfare products, including the scope of insurance coverage that will be provided, claims administration and underwriting, the premium or other fees that will be paid for the insurance coverage and commissions, if any. These disclosures are often provided to the plan sponsor at multiple times, including in the response to the sponsor's request for proposal, or RFP, in marketing materials, in the insurance policy or evidence of coverage outlining the scope of benefits, and in the annual policy, Form 5500 and other reporting to the plan sponsor.

Because these products are simple and the sale and operation are already subject to both ERISA disclosures, adding on the disclosure required by Section 408(b)(2) would not enhance the ability for the plan sponsor to appropriately exercise their fiduciary duty.

Non-medical benefit products do not pose the risk that plan sponsors will not know how much they're paying for those services, or the benefits, or who is being paid. Indirect compensation typically is not received by the insurer providing the products or service and since there are no assets to manage, there cannot be concerns regarding conflicts at investment decisions.

Finally, in contrast to what might be found in retirement plan service arrangements, non-medical benefit products do not have termination penalties or fees leaving plan sponsors free to walk away from any arrangement that become unsatisfactory to them.

Appropriate disclosure of information concerning insurance products is necessary and is very beneficial. But adding Section 408(b)(2) type disclosures for non-medical benefit products to the disclosures already made would not add commensurate value for benefit plan sponsors and would add much more likely -- and would much more likely be unnecessary and redundant.

Given the new disclosure requirements would unavoidably impose increased expense on plans and participants, and potentially decrease the availability of benefits, we would respectfully submit that 408(b)(2) rules not be applied to welfare benefit plans. To the extent, however, that the Department believes further disclosure is needed, separate rules should be promulgated so that they can be narrowly tailored to the specific characteristics of, and the disclosure rules already applicable to, welfare benefit programs.

The ACLI would welcome the opportunity to

play an active role in the process of developing such rules.

On behalf of the ACLI, I commend the Department for its ongoing and thoughtful attention to these issues and welcome any questions later on in the discussion.

Thank you.

THE COUNCIL OF INSURANCE AGENTS AND BROKERS

Scott Sinder, Esq., Steptoe & Johnson

MR. SINDER: Good morning. My name is Scott Sinder. I am a partner with the law firm of Steptoe & Johnson and I serve as General Council for the Council of Insurance Agents and Brokers on whose behalf I am testifying today. And I thank you for the opportunity to do so.

My testimony will describe the views and concerns of the agent/broker community with regard to the Department's intention to develop fee disclosure regulations for welfare benefit plans under ERISA Section 408(b)(2), parallel to regulations it adopted this summer governing pension plans.

The Council is a trade association representing the nation's largest insurance agencies ad brokerage firms, which specialize in a wide variety of

insurance products and risk management services for business, industry, government, and the public. Operating both nationally and internationally, Council members conduct business in more than 3,000 locations, employ more than 120,000 people, and annually place more than 80 percent -- well over $200 billion -- of all U.S. insurance products and services protecting business, industry, government, and the public at-large. Council members also place the majority of U.S. employee benefit insurance products and provide a range of insurance-related consulting and administrative services.

The Council has long been an avid supporter of transparency and disclosure in our industry. We adopted a formal policy in favor of greater transparency in 1998. In 2004, we again, publicly took steps to enhance transparency and disclosure, working with the NAIC and the National Conference of Insurance Legislators to develop model state laws on transparency. As I will discuss, Council members are committed to disclosure of their compensation and routinely disclose information on how they are compensated, both directly and when more detail is requested by their client-insureds.

Although we strongly support efforts for

transparency and disclosure in our industry, we do not believe it appropriate to develop a new federally mandated disclosure framework for welfare benefit plans. Our concerns arise from our belief that robust, effective disclosure requirements already are in place of our industry, and an additional overlay of a new and burdensome federal regime is not warranted.

I'm going to give you a brief background on the industry and our role and then proceed to the disclosure discussion.

Council members assist employers in designing their welfare plans and in effectuating those plans, including most importantly the placement of insurance products with those plans. Those products include, among others, group medical, dental, vision, life, accidental death and dismemberment, health, short- and long-term disability and long-term care insurance. A single multi-state employer's plan easily can include 15 to 20 separate insurance products. In connection with the insurance products they place, Council members may also provide a variety of administrative services to the purchaser, including assisting plan sponsors with plan design, applications for coverage, claim forms, claims resolution, and COBRA administration.

The relationship among a purchaser of

insurance products, the broker or agent placing the insurance, and the carrier issuing the product, is governed principally by the contractual relationship entered into between the purchaser and the broker or the agent, and then, of course with the carrier by the insurance policies themselves. A well-developed body of state agency law and, in most states, statutory insurance law provide that the legal relationships between the employer on behalf of the plans that purchase insurance products and administrative services, the agent or broker that places that coverage, and the carriers that provide coverage, are contractual matters. Thus, for example, whether a broker is providing services to the plan instead of the carrier, or vice-versa, is determined by the relevant contracts.

Council members receive compensation in a variety of forms, including commissions from the carrier, fees from the plan or employer plan sponsor, contingent payments or overrides from the carrier when business originated by the broker passes certain thresholds (e.g., relating the premium income levels and client retention), and discretionary travel or other non-cash compensation from the carrier.

As mentioned, state insurance laws govern

whether and to what extent brokers or agents must disclose the types and amounts of compensation they receive. Under the laws of most states, brokers and agents are required to disclose in advance the types of compensation they receive. However, brokers and agents generally are not required to disclose in advance the amount of compensation they expect to receive, in part because the actual amount of compensation often cannot be known until after placement of the insurance. That is the case because the commission rates and forms of compensation vary by carrier as well as by program.

With respect to commissions, for example, welfare plan benefits programs vary in terms of carriers, products, price and usage. A single welfare plan could offer its participants multiple products for multiple insurers in several categories of coverage, as mentioned previously, group medical, dental, life, long-term care, et cetera. The commission earned by the broker will vary with the carrier and the premium paid on each particular policy. The premium in turn will vary with the take-up rates by plan participants, i.e., the extent to which participants choose a particular option on the insurance menu. Because brokers cannot determine in advance how these factors will play out, they cannot provide, upon placement,

more than general disclosure about the compensation they may receive.

As previously noted, brokers and agents generally accept contingent compensation, such as continent commissions, overrides, and bonuses. The level of such compensation explicitly is contingent on such factors such as volume, profitability, client retention, and premium income levels. The extent to which these factors will affect the actual level of compensation is not knowable at the outset of an engagement for a particular client. Additionally, some contingent compensation may be based on a broker's overall book of business with the carrier, not the premiums earned with respect to any particular plan. Thus, it is often not possible for the broker to determine with precision the extent to which its contingent compensation arises from insurance placed for any particular plan.

Under the existing disclosure regime, insurance agents and brokers already are subject to extensive regulation, including disclosure requirements, which sets them apart from other service providers. First, state law heavily regulates the placement activities of insurance agents and brokers as a general matter, and most states require compensation

disclosures when a broker is providing both placement and non-placement-related services. Over 40 states, for example, require a broker to have a written agreement in place with a client in order to collect fees from that client while at the same time receiving any type of insurer-provided compensation.

The fee disclosure requirements are quickly becoming even more relevant in the wake of the passage of the Patient Protection and Affordable Care Act in all market segments. The MLR carrier cost regime created under the statute, for example, is creating significant pressure on carrier commissions and some segments of the market are already migrating to a fee model. Aetna recently announced, for example, that it is going to sell all of its group insurance products on a net of commission basis and it has instituted plans to help smaller agencies implement and use client paid fees for their exclusive source of compensation.

In addition, as previously discussed, under Schedule A of the Department's Form 5500, the Department requires comprehensive and robust disclosure regarding commissions, fees, any non-cash compensation earned by insurance agents or brokers in particular. This is in contrast to other service providers.

Finally, where agents or brokers or their

affiliates act as fiduciaries and need the relief provided under Prohibited Transaction Class Exemption 84-24, they must comply with that exemptions' comprehensive fee and conflict-of-interest disclosure requirements.

In the rule adopted to govern pension plans, the Department cited concerns about the adequacy of information plans have regarding service providers' compensation and potential conflicts-of-interest. The rule reflects particular concerns with undisclosed, indirect compensation paid in connection with the investment of the assets of participant-directed defined contribution plans. The Council understands the Department's concerns and certainly did not oppose the Department's desire to enhance transparency in connection with those plans.

We disagree, however, with the suggestion that the placement of insurance products with welfare plans raises the same concerns as those that relate to 401(k) plan investment services. The two products are completely different, both in character and with regard to the existence of comprehensive state regulation. They have different purchasers, beneficiary concerns, and regulatory schemes. Service providers for defined benefit plans often manage assets for plan

beneficiaries, whereas insurance agents and brokers do not. Further, in the 401(k) plan context, services are performed on a daily basis; in contrast, insurance brokers act only at the plan level by, for example, simply selling products on an annual basis.

And significantly, as previously explained, under existing state laws, disclosure concerning relationships and fees already is required under existing state regulatory regimes. Imposition of the Department's rules for pension plans, which will require disclosure of the compensation to be received by the service provider, would thus be a duplicative burden for welfare plans at a cost the Department itself has acknowledged to be "economically significant" for welfare plan service providers.

For all the above reasons, we respectfully suggest that -- if the Department determines to adopt new disclosure rules covering insurance services provided to employee welfare benefit plans -- any such rule should provide that it will be satisfied by an insurance agent's or broker's compliance with the disclosure requirements imposed by state law. Alternatively, if the Department seeks to impose a new federal disclosure mandate in this context, we ask that it be the sole disclosure standard and that it be

deemed preemptive of the current state-imposed disclosure regimes under which we currently operate.

On behalf of the Council, I again, thank you for affording me the opportunity to speak to you today. And I'll be pleased to answer any questions. Thank you.

MR. DOYLE: Thank you. All right. We'll start with questions. Mr. Canary, anything?

MR. CANARY: Sure. Let me just follow up on the last recommendation. If we were to pursue --

PARTICIPANT: Could you pull that microphone closer to you?

MR. CANARY: Sorry about that. Let me follow up on a recommendation you just made about if we were to pursue regulatory -- regulations in this area that we should say that brokers would satisfy that regulation by compliance with state disclosure laws. It seemed that, also based on the testimony, there isn't necessarily uniformity in the state disclosure requirements and some states may not have any laws at all that require disclosure. So, following up on that, how would that work if we end up with dis-uniformity (sic) among the States in terms of accomplishing the sort of transparency that would be equivalent for all covered ERISA plans?

MR. SINDER: Welcome to the world of State insurance regulation. Some States do not have significant disclosure, although they all regulate to some extent in the negative at a minimum. I suppose you could deem that if they are not actively regulated you will do so, akin to the FTC's antitrust regulatory authority and that would be acceptable.

But this issue about the State burden, it's significant for us. You know, you are at a moment where you have all the provisions and requirements of the Patient Protection Affordable Care Act coming into play. A lot of the smaller agencies, in particular, are feeling that they may not have a future given the different dynamics that play the economic dynamics there. The imposition of an additional duplicative overlay of disclosure is going to add further costs and uncertainty into that already very difficult environment and that's the nature of our concern.

MR. CANARY: So let me follow up on that. I know you also mentioned that the organization had worked on model disclosure of laws with the NAIC. So rather than relying upon the individual State laws, would an alternative approach be that the regulation would be satisfied if the disclosure requirements in the model law were satisfied?

MR. SINDER: So I'm ahead of my clients and my members on this, but I will say two things. I think we could support that, especially if it were preemptive. I mean, this is a significant issue for us. You know, you have multi-state plans that are subject to the rules, theoretically, of each State in which that employer operates. So you already have that issue. And then you're going to add another layer. We endorse the NAIC model. We worked on it. We were the first producer group to be in that position and we would support your doing that, but especially if we could make that a single rule that would be universally applicable.

MR. CANARY: So one more question maybe for everyone. I got the impression that the Schedule A disclosure requirements currently would require disclosure of incentive, compensation, and bonuses, but I got some sense that there's maybe not comprehensive compliance or uniform compliance with those disclosure requirements in the industry currently. And, two, that it's a retrospective review rather than a perspective disclosure that would be used in making a decision on purchasing an insurance product. I guess can you each speak to the issue as to whether you think the Schedule A disclosure requirements really are sufficient for

purposes of at least the incentive compensation you spoke to?

MR. DONEY: I think you answered my question -- or you answered your own question. I think you're correct in that the point of Schedule A being uniformly used is sketchy at best. I know that there are requirements with respect to having a Schedule A filled out and submitted. But I would further submit that it does not happen across the board.

And, secondly, I guess my point was that it's retrospective. And that it makes it difficult for an employer who is making decisions about employee benefit plans to make a decision about -- including with whom they're going to work as an agent or broker based on future potential compensation that is really not disclosed up front.

So, yeah, I think that those are two issues that need to be addressed.

MR. CANARY: Mr. Sinder.

MR. SINDER: A couple points. The Form 5500 until, I think, four or five years ago, it had a single line on Schedule A for broker/agent compensation and there was confusion about how to apply the incentive compensation, how it was reported. That has been clarified by Department and that's now specifically, I

believe, listed. My understanding is that especially after that change compliance improved, at least our members are making every effort to comply. I can't speak to folks beyond our community. I was going to say something else.

MR. CANARY: Perspective versus retrospective.

MR. SINDER: Oh, the perspective versus retrospective. You know, the point was made that you can change brokers, you can change plans. Our view on the 5500 is it's part of a relationship. You know, we're in a relationship business. You work with somebody over years, hopefully, it's not limited to a moment in time and then you leave them. If the 5500 reporting is surprising in any way to the plan fiduciaries or to the employers, they respond. So if it's inconsistent with their expectations, they will change brokers, they will change carriers. And the competition in our space for those service relationships is intense. So I actually think it does serve that purpose, although it is admittedly not a prospective disclosure.

MR. KATZ: My comments will echo some of what you just heard. I think the first part about whether there is a compliance or an enforcement issue is sort

of separate and our understanding is that the process is working, that the information is being provided on the Schedule A's and the plan sponsors are getting that information. And if that isn't happening, then that should be looked at. But that's certainly what member companies, we believe, are complying with fully.

In terms of the second question about, you know, prospective and retrospective and how it works, I think it gets to this general question of where is value being added in the context of helping plan sponsors make good decisions. And so certainly giving stuff retrospective is giving them information that says what happens. I think what has to happen is the overall body of regulations and practice need to be looked at in concert to assess whether or not plan sponsors are getting enough information or they have concerns. And I know some organizations representing plan sponsors will testify here today and give their perspective. Our belief is that they are and especially as we think of more simple products like life insurance and disability where the transaction is very straightforward it's our belief that plan sponsors are well informed in making those decisions and that additional levels of disclosures wouldn't enhance that.

MR. CANARY: Thank you.

ASSISTANT SECRETARY BORZI: I just have a couple of questions. One of the things that I found when I was in private practice is -- and this is something that is common to the problems that plan sponsors have and plan fiduciaries have in the 401(k) area -- and that is, not everyone understands fully the range of potential sources of compensation for their service providers. So I know if you could give us a sense, for instance of -- and you gave us some examples of compensation for TPAs, but what are the sources of compensation for TPAs? And then I'm going to ask about brokers as well and then I'm going to ask you about the kinds of compensation for these non-health situations.

MR. DONEY: Because TPAs are in the realm of self-funding and administrative of self-funded medical plans, you have to, I think, separate the TPA from an insurance carrier, if you will. Both TPAs and --

ASSISTANT SECRETARY BORZI: Although, obviously, insurance carriers act as TPAs.

MR. DONEY: Exactly.

(Simultaneous conversation.)

MR. DONEY: That was exactly my point that insurance carriers will administer self-funded medical plans much like TPAs do and there is that ongoing competition for that business. TPAs typically tend to

be much smaller entities, independently owned, like my own TPA firm that I own, and don't necessarily have the advantages of a very large insurance carrier. When we compensate a broker or an agent or a consultant, it's typically done in two ways. One is, we will compensate on a per-employee, per-month basis, some sort of a fee. As I said in my testimony, typically $2 to 3 per employee per month which they will get on an ongoing basis. The second way is generally the broker will receive a percentage of the stop-loss insurance that a client is buying to protect against very large losses. That's typically 10 percent of the premium paid on the fully-insured portion of the self-funded medical plan for stop-loss.

ASSISTANT SECRETARY BORZI: I meant the kind of compensation that the TPA itself would get. So what are the sources of --

MR. DONEY: Generally a TPA will receive administration fees on a per-employee, per-month basis, varies widely across the country. We've got clients in 49 states --

ASSISTANT SECRETARY BORZI: Uh-huh.

MR. DONEY: And we see a lot of variation there. So if you're administering a medical plan or a dental plan, or a disability plan, or any of the above,

a TPA will typically receive, per-employee, per-month compensation for that.

TPAs will generally share with brokers and agents the commissions from the stop-loss insurance.

ASSISTANT SECRETARY BORZI: Uh-huh.

MR. DONEY: The formula is typically the broker agent will receive 10 percent, the TPA will receive 5 percent on a 15 percent commission. That's fairly typical.

Many TPAs will receive compensation from pharmacy benefit management companies --

ASSISTANT SECRETARY BORZI: Uh-huh.

MR. DONEY: -- for administration, administrative fees on a per-script basis or on an ongoing basis, along those lines. And then, you know, TPAs will receive compensation that varies widely based on other products or services.

ASSISTANT SECRETARY BORZI: Like a provider -- for putting together a provider panel, selecting this network versus --

MR. DONEY: Exactly.

ASSISTANT SECRETARY BORZI: -- all these rent-a-network --

MR. DONEY: Right. Exactly. And I can tell you that my own TPA firm has a division that does

claims review and negotiation on behalf of clients and will receive compensation on a percentage of savings basis if we're successful at negotiating savings for our clients. So that's generally what a TPA would be worried about.

ASSISTANT SECRETARY BORZI: I know this isn't your situation, but an insurance company that serves as a TPA, a company that has already pre-existing relationships in a health plan area, what additional forms of compensation do they get?

MR. DONEY: You know, I think -- and, again, because I'm not an insurance carrier, I couldn't say with any real specificity or any assurances, but I think in large part, large insurance carriers who want to be in the self-funded business and act as a TPA, if you will, rely not necessarily on the income for the administrative services for self-funded plans --

ASSISTANT SECRETARY BORZI: Right.

MR. DONEY: -- but rather ancillary -- the opportunity to sell ancillary services life insurance and dental insurance and other insurances that --

(Simultaneous conversation.)

ASSISTANT SECRETARY BORZI: We call it cross-selling.

MR. DONEY: Exactly.

ASSISTANT SECRETARY BORZI: So that's what happens here.

MR. DONEY: I suspect that an insurance carrier would be in the TPA business for that exact reason for a much wider range of services.

ASSISTANT SECRETARY BORZI: Okay. And brokers, what are the sources of brokers' compensation?

MR. SINDER: You want to break it down in two ways. There's insurer provided compensation and client provided compensation.

ASSISTANT SECRETARY BORZI: Uh-huh.

MR. SINDER: On the insurer's side there's a couple of categories. You have kind of the upfront payments which is either commission which is a percentage of the premiums that are paid, or more and more typically today in the benefit space, it is a fee per employee who is enrolled in a plan. So a per-head type of fee as he discussed.

There's also kind of the back-end payments. These are the contingent or override payments. They are not based on any particular client, it's book of business. It's overall relationship between the producer and that client or that carrier. It can be driven by overall volume, retention levels, which decrease administrative costs, and profitability;

although profitability is less of a factor in benefits compensation.

On the client side there are fees. And the fees can be either for placement services, and, as I mentioned in my formal testimony, there's a movement now on some of the carriers' part to not compensate the brokers at all. Go to a net of commission model where the only compensation would be coming directly from the employer. And that is a negotiated contract between the broker, the agent, and the employer. It can cover placement services for actually buying the different insurance products and a range of other administrative support services.

ASSISTANT SECRETARY BORZI: How common are these net of commission arrangements? They're fairly new in the marketplace.

MR. SINDER: Well, they're especially new in the insured space. I think that in the property and casualty world, you'll remember most of these folks are on both sides of that line and for larger clients they're doing self-insured plans, for example, they had been common for a while. But over the last ten years I think you've seen a migration up on it. It's a way to control your exposure in a number of ways as the employer.

There's also arrangements where you can do a fee arrangement and credit commissions that are being received toward the fee. So that becomes a -- again, it's very disclosed in that context as a contractual matter.

ASSISTANT SECRETARY BORZI: These are retrospective types of compensation arrangements? Are they?

MR. SINDER: I don't think so, if I understand your question. Generally you negotiate this at the outset, the beginning of the year, say.

ASSISTANT SECRETARY BORZI: The types. But the amounts would be --

MR. SINDER: The types, the amounts -- well, yeah, the -- if it's a fee deal with the employer, then the fee is usually set at the beginning of the year. Now, how much the employer pays contrasted with the commission that's being paid by the carrier, for example, that would, of course, have to play out through the year as you see what enrollment levels are and the like.

ASSISTANT SECRETARY BORZI: Okay.

MR. SINDER: The one thing I will note is that some of the larger carriers who do the self-insured business, they also receive a per-head payment

as the TPA. And, you know, our view is that the brokers really place the products, not so much the carriers and so they may try to do some of the cross-selling. But if you really dig into some of those models, I think what you'll see is that many of those carriers have become really servicers for that self-insured space and they need that TPA revenue to fund their activities.

ASSISTANT SECRETARY BORZI: Mr. Katz.

MR. KATZ: I am going to answer this question in the context of the companies that the ACLI represents. I really won't be talking about health insurance.

ASSISTANT SECRETARY BORZI: Yes, I --

MR. KATZ: Although I can talk a little bit about dental at the end of this because MetLife does do dental.

ASSISTANT SECRETARY BORZI: Okay.

MR. KATZ: But revenue for insurance companies typically comes in two basic forms, premium and fees. So premium is very straightforward. That's the amount that the employer will pay for the typical insurance that they've purchased. And typically that is either on a per-thousand or per-unit depending on the type of coverage whether it's disability or life --

life insurance.

Fees typically are paid for services that are outside the construct of insurance. And so for some benefits as was just talked about, the insurance company may be a TPA and maybe provide services and be paid fees for those services. And both the premium and the fees would be outlined in detail in the proposal and given to the policyholder or their intermediary broker consultant in advance.

ASSISTANT SECRETARY BORZI: In your testimony you mentioned -- you went through a variety of components of the premiums and the fees. Are they bundled or unbundled when you're disclosing them to the potential client?

MR. KATZ: Sure. The premiums include the cost of insurance and any services that the insurance company would need to administer those insurance services. So, for example, claim payments or beneficiary management and things like that, that's all in the concert of the overall premium. And the insurance company would need to do those services. They couldn't have somebody else do those services in the concert of these products.

For fee-based services, typically I would think about that outside the construct of the insurance

company that it's not -- or the insurance product, it's a separate product. So the insurance -- so I'll give you a great example, as an insurance company may insure long-term disability services and charge a premium for that, and they may provide administrative services for short-term disability services and they may charge a fee for those. And they're both explicit and it's clear what's covered under each of those.

ASSISTANT SECRETARY BORZI: But the purchaser would have no way of being able to evaluate the reasonableness of what went into your premium; right?

MR. KATZ: Typically --

ASSISTANT SECRETARY BORZI: Because you just say here's the premium and it includes the following things.

MR. KATZ: Right. I mean, typically the way it works is the purchaser would hire a broker or consultant who would lay out the specifications required for the given product to a number of different insurance companies who would provide bids and they would be compared and the outline --

ASSISTANT SECRETARY BORZI: By the broker?

MR. KATZ: By the broker, and the broker with their client would make a choice as to who they would want to do business with.

When you get into the components, just to give you the vast majority of the costs in these programs are the claim payments. So it's a relatively small amount that's covering what I would consider the expenses of the insurance company. And the insurance company, I think this is the important distinction, unlike some of the 401(k) stuff where you could go out and maybe buy that stuff on your own, in the welfare plan benefits for this, you couldn't do that.

ASSISTANT SECRETARY BORZI: Yeah.

MR. KATZ: You need an insurance company to pay the claim.

(Simultaneous conversation.)

ASSISTANT SECRETARY BORZI: No. I understand that and I'm not necessarily suggesting that we would require you to separate out all these things. I'm just trying to understand what goes into these figures.

MR. KATZ: Yeah, typically an insurer's proposal would be an overall price which includes the cost to pay any claims, plus any expenses that the insurance company would have to administer the program, plus any commissions that they're going to pay out to any broker. That all would be included in the price.

ASSISTANT SECRETARY BORZI: Uh-huh. And the brokers' commissions are included in the price too, you

said?

MR. KATZ: Absolutely.

ASSISTANT SECRETARY BORZI: It's included in the premium. Okay.

MR. HAUSER: Mr. Sinder, in your testimony, if I understood it, I think you indicated that the States typically mandate some sort of upfront disclosure of the type of compensation a broker receives, but not the amount of disclosure which you said would be hard to estimate. And I guess the question I have is, what is meant by type of fee? What precisely do they have to disclose? Does it, for example, include from whom they will receive compensation? And with respect -- and then if it doesn't include amount, which may be hard to estimate, most of the fee arrangements you described in answering Ms. Borzi's questions seemed determinant in the sense that they're percentage based, they are contractual arrangements and is there a requirement that you disclose what those percentages are, what those contracts entitle the broker to, and if not, is there any reason why that shouldn't be mandated?

Sorry, that's a lot of questions. I follow up if you --

MR. SINDER: I'm trying to unpack it in my

mind. On the fee side, when I say fee, and what we mean by "fees" are payments made by the client, by the employer or the plan. It's generally by the employer for us. So those are not only disclosed, but they're negotiated, as a general matter, because the employer is agreeing to bear those costs. They are required to be memorialized in a written document if the broker at the same time is also receiving any carrier-provided compensation. So those would be disclosed by the way the business works in conjunction with those fee and commission disclosure requirements.

For carrier-provided compensation, they're generally required to tell them that they're being paid by the carrier. In fact, that's the NAIC model rule. Then the client is -- and the Council policy is that the client is entitled to ask for as much specificity as they want and we encourage our members to provide.

MR. HAUSER: Okay.

MR. PIACENTINI: I guess I want to focus on what are the potential effects of different degrees of transparency. Maybe I'll start by going back to the first example that Mr. Doney talked about, that certain kinds of indirect contingent bonuses typically are not disclosed. And I guess I'm hearing affirmed that they're not required to be disclosed under the NAIC

model, at least not in any specificity. So with respect to those kinds of payments and I understand there are challenges that it's not always easy to predict or even after the fact to attribute exactly what compensation is resulting from what client. So if somehow that was disclosed in more detail what the compensation is, where it's coming from, what would the effect of that be? Would the consultants now change the recommendations that they're making from what they would have been? Would the client interpret the recommendations differently? Would the compensation arrangements change rather than be disclosed? We heard that at least one company, maybe some companies are moving away from commissions. What would the effects be and who would benefit and who would not?

MR. DONEY: I think the intent of all of this is to make sure that the ultimate consumer who is, in our circumstances, the employer benefits most from any kind of regulation with respect to disclosure. It's difficult to speculate what, you know, the end result would be particularly from an employer's standpoint if they knew exactly what was being compensated to their consultant or their broker or their agent. Because, again, to a certain extent it's difficult to attribute certain dollar amounts to one specific employer because

it's all based on a much larger block of business.

So I think the issue here is that many brokers and agents are incented to do things that are not directly attributable to one particular employer, but rather an entire book of business and therefore the individual employer has no idea what that ultimate compensation is going to be to the broker, although they're paying for it. It's built into the cost of the premiums and the insurance the insurance company would be charging or the fees that ultimately go to what an insurance company or administrator is going to be paying. A very large percentage of a broker's compensation often is predicated on bonuses, retention bonuses, overrides and those sorts of things that an employer simply doesn’t know exists.

And I think to your question, what's the effect going to be, I think you're seeing it already. There's -- I can tell you in the Midwest Coventry Insurance has reduced its broker compensation by 50 percent, made that announcement that it's -- and I'm sure you're aware of that. Aetna is doing premiums net of compensation and allowing the broker/agent to negotiate their own deal. So I think that you're seeing the effect now of the fear of larger disclosures coming out and I suspect that that will continue.

MR. SINDER: I'm going to disagree on a couple of points. First of all, the overrides and contingent compensation generally are less than 10 percent of an insurance brokerage's revenue from a carrier. So that's point one.

Point two, these are reported on the 5500 form. You have rules which say that you need to allocate those retrospectively when you can do it across the clients that it was paid for. So even though it's an aggregation, even though it's hard to calculate up front, especially they are reported and disclosed.

The commission things that you're seeing in the market have absolutely nothing to do with disclosure. You haven't made any rules, you haven't changed anything yet. There has been disclosure for a long time at certain levels. New York has recently kind of upped its disclosure requirement, but basically it's been relatively stable the last few years. The commission decreases are attributable, solely, to the Patient Protection Affordable Care Act. There is tremendous pressure on the carrier community to reduce its administrative costs. The Act and the NAIC have determined that the agent/broker portion of the compensation is on the administrative cost side, the

carriers are reacting.

Now, you asked what the impact will be of disclosure. My view is, if you want to continue to have an employer-provided insurance marketplace which are tremendous proponents of, you need to be sure that the employers can get service for that, that they have somebody to help them pick their plans and sort of work through this quagmire as well as the regulatory overlay, COBRA administration, for example.

You're in an environment where you're decreasing the compensation that agents and brokers are going to get. This is particularly true in the smaller marketplace, that under 100 market. At some level those are the employers that need the most help. They don't have a dedicated HR person, they don't have dedicated personnel who can figure this out. They need the agents and brokers. And you're in an environment where there's downward pressure on the compensation they can receive. So my view is, you need to tread very carefully. Because if you increase the disclosure in a way that's going to increase our compliance costs, you're going to see a migration away from servicing those small employers that at this moment in time probably need more help than they've ever needed before. So I think from an impact perspective that's

what I'm hearing from our members and that's what we worry about.

MR. HAUSER: Do you agree with Mr. Doney though that for some of these smaller employers there's nothing in the current regulatory structure that would mandate that they find out from the brokers up front who they're getting compensation from or no?

MR. SINDER: If there are no fees so the employer is not paying anything directly, generally there's no requirement that they divulge any more specific information beyond who's paying them.

MR. HAUSER: Right. Then if I understood you, the State law, I guess, entitles people to ask for that information. But is there anything that compels that they actually give it when asked?

MR. SINDER: Well, there is a market out there and my general experience as a lawyer with clients is when my client asks for something and I won't provide it, they find somebody else who will. But you can't lose sight of that marketplace dynamic. It's a very competitive business. And so you have to situate it in that way.

MR. HAUSER: And do you think that marketplace works as well for these under 100 employers that you were talking about as for the larger

employers? Or do you think there's a distinction to be drawn there?

MR. SINDER: I think that the agent/broker community competes very vigorously for that under 100 market. I think you're going to see agencies and brokerage firms go out of business.

MR. HAUSER: But in terms of the transparency of the -- you know, and the clarity of the disclosure, do you think there's a difference in the under 100 folks to get that kind of information as opposed to the bigger folks?

MR. SINDER: If they want it, I think there's ability for them to get it. I think oftentimes they can't process it because of their operational capabilities, even when they have it.

MR. HAUSER: And just one more follow up can you think of any reason why -- I'm assuming these commission arrangements are, at least from the broker's perspective they've been established up front and while you can't say what the precise number is, there is a percentage or some calculation that, you know, would yield a precise number. And certainly if I were a broker, I would insist on that in my deals. So is there any reason that can't readily be disclosed or do you think as a practical matter it is typically

disclosed to folks?

MR. SINDER: I don' think it does yield a number up front. I mean, I think that sometimes the contingent commission override is zero. And so I think if you're going to do an up front disclosure of the --

MR. HAUSER: I'm sorry, not that the number is going to be known up front, because you're not going to know that until you know what numbers go into your variables. But the formula is established up front; is that wrong?

MR. SINDER: The formula is established up front. Some of the formulas are complicated and I think that you have to evaluate in the context of looking at -- it's not on product. Most plans, even for small employers are cafeteria-style plans where you'll have a minimum of six to eight products. Each of those has a compensation component to it. And so that's when the disclosures get very cumbersome and complicated. The degree of precision gets cumbersome and complicated. We were asked what if the formula changes after you've done the initial disclosure, and after placement, is there a follow up disclosure obligation?

The State regulators do grapple with this. These rates, at a minimum, are all filed in all the

states along with their constituent components in terms of what the different cost metrics are. And in the majority of states there's affirmative approval of those rates. So the States are blessing the compensation arrangements as part of that. There is strong pressure from the Department of Health and Human Services, in particular, to be sure that every state does that rate review and to participate in the exchange going forward, every state will. So when you talk about that 100 marketplace, there is a lot of scrutiny on increases in premiums, you have to justify it, and so as a practical matter every state will have that review for that space that we're going to focus on.

MR. HAUSER: Thanks. And does the policyholder have a right to see those rate documents that are on file with the State insurance departments?

MR. SINDER: I think they do under the filed rate doctrine.

MR. LEBOWITZ: I wonder if I could just follow up here just a little bit with more of an observation because we have, in recent years, been involved in a number of investigations, both civil and criminal investigations in the insurance brokerage context. And what we've seen is kind of a variety of

offenses, bid rigging, false reporting, undisclosed compensation of various sorts and number of criminal prosecutions and civil actions that have involved our agency and others. And it certainly suggests that in these cases there's a lack of transparency and that many clients of brokerage firms have no idea what is going on behind that curtain. Obviously in those cases they had no idea what was going on. They were the victims of these crimes. But it certainly does tell us that there's a need for more -- that some additional transparency up front, some additional disclosure up front would be helpful in confronting these kinds of problems.

And it would seem to me, on your point that if commissions are being driven down that there may be even more of an incentive in some respects at least in some hopefully small portion of the industry to try to find ways to make up for that compensation that's being lost.

MR. SINDER: With all due respect, we are, of course, very familiar with the bid rigging investigations and some of the other issues and I will never defend that. Those were impermissible illegal acts and I don't think any level of disclosure would have prevented or prohibited them. And so we need to

police bad conduct and enforce the rules we have. But I do think it's a separate question about whether the cost of the additional disclosure, the cumbersomeness of processing it, and the value of the additional disclosure to the prospective clients, is worth that cost separate and apart from the bid rigging and some of the other bad actions.

MR. DOYLE: A couple of questions. I would like to start with Mr. Doney. And again a lot of this goes to trying to draw lines as to where the problem lies -- if there is a problem. I mean, we heard in certain areas it seems there's a fair amount of disclosure where at least the client gets kind of the information they need to assess the product and its cost.

So I guess the first question is, the products Mr. Katz was talking about, the traditional kind of insurance, maybe non-health products, do you think there're problems in that particular area?

MR. DONEY: I honestly could not speak to that because I am really exclusively focused on the medical/dental area of employee benefits.

MR. DOYLE: Okay. So you don't do non-medical?

MR. DONEY: That's correct.

MR. DOYLE: Secondly, the issue that you seemed to focus on strikes me as more one of potential conflicts-of-interest where consultants are receiving commissions or payments that may influence their ability to be objective in advising their clients.

MR. DONEY: I think that's an accurate statement. We have a number of examples of times where we know that we had a highly competitive quote, but in the end the client never -- or the potential client never even saw the quote as a result of the decision made by an agent to not show the quote. We further know that there are circumstances wherein it's the incentive of an agent/broker to build up a block of business with one particular insurance company because of the backend compensation that they receive in terms of bonuses and overrides.

And I guess I'm not saying that that's necessarily something that shouldn't exist out there. And I'm also not saying that the majority of brokers and agents that we work with across the country make those kinds of decisions. I do think, however, that the -- from a competitive level playing field in the TPA business, specifically, because it's as I indicated sort of typically an independent, smaller entity with margins that are generally far lower than larger

insurance companies. The TPA business is not in a position to be able to pay though the kinds of overrides and bonuses that generally can come from large insurance carriers. So there's not as level a competition that we think should exist out there based on the fact that very often an employer just simply doesn't know what goes into the compensation for a broker. And in some circumstances don't even know that the TPA business exists. And that's the point of my testimony.

MR. DOYLE: And, again, when we focused on 408(b)(2), we focused on a couple of things, one, the ability of the fiduciary to determine the reasonableness of the compensation that they're paid for the services and to assess potential conflicts-of-interest. So I'm trying to just kind of get a handle on what exactly we're talking about, if we're talking about only the circumstances where services are being rendered in, again, kind of the non-pension area, or services are being rendered and there's indirect compensation that the plan fiduciary would want to take into account in assessing the reasonableness of the overall cost. So obviously -- and conflicts-of-interest would come up, I guess where there is a consultant.

In terms of your practice, okay, because as you were going through kind of your direct compensation, you also indicated you potentially could receive indirect compensation as a result of a variety of services, claims paying, PBMs, what have you. So what do you do up front? Because these would seem to kind of have the same issues some of the brokers do.

MR. DONEY: Sure, understood.

MR. DOYLE: And speculating.

MR. DONEY: When we do a proposal for a potential client, we list very specifically all of the compensation that we have both on the fees that we charge on a per-employee, per month basis as well as stop-loss commissions or any PBM remuneration that we may be receiving. It's listed very specifically. In addition to that, in our administrative services agreement which is the contract between ourselves and the employer, we have a schedule that shows all of the compensation as well. So we fully disclose those kinds of situations.

MR. SINDER: Can I make one comment?

MR. DOYLE: Sure.

MR. SINDER: In the pension context, the service that's provided to the plan or to the plan participants is the management of their assets. And

there's no guarantee on how well that management will be. And so ultimately the only thing you can evaluate is kind of past performance and what you're paying them for the management service.

On the welfare side, the service that's provided to the plan and the participants is the actual insurance that's purchased, the product, at the end of the day. You know what that costs, and the idea, and this is one of the roles of the broker, is that the carrier is going to be able to make good on that promise, or the TPA is going to be able to manage the resources to make good on the promise. In that context, at least for the agent and broker, they're helping the plan select that provider. But ultimately you know exactly what it costs, you know exactly what you're getting.

On the pension side, you don't really know what you're getting and so you're left really to evaluate at some level the compensation that past performance piece.

MR. DOYLE: Right.

MR. SINDER: And I think it is a significant difference. So there is a lot of knowledge in our space about what is being paid and there may be some deficits. But they don't go to the core service that's

received by those plan beneficiaries.

MR. DOYLE: Yeah, I'm not sure I agree with that. Certainly with regard to certain products, you know, if I'm buying life insurance I guess I know how much I'm paying per thousand dollars for life insurance and I can easily compare that with other issuers.

If I'm paying a consultant or relying on a broker to advise me, and I'm assuming in most cases that that broker is looking out for my personal interests and therefore if giving their recommendation is giving me a recommendation based on their kind of analysis, I think it would help me to know if that broker is being compensated or how they are being compensated by the various providers, if at all, with respect to which they're taking into account in advising me.

MR. SINDER: I understand that and they do understand as a general matter. I think the question is the degree of specificity and how much we're going to pay for that.

MR. DOYLE: Right. Right.

Any other questions?

(No response.)

MR. DOYLE: Thank you very much, panel.

(Pause.)

MR. DOYLE: All right. Good morning panel two. Again, we'll follow the order of the agenda and that would mean Mr. Kilberg will kick us off here.

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

William J. Kilberg, Esq., Gibson, Dunn & Crutcher LLP

MR. KILBERG: Good morning. Thank you very much. My name is William Kilberg. I'm a partner with the law firm of Gibson, Dunn & Crutcher. I am here this morning representing the Pharmacy Care Management Association.

I have a PowerPoint that I will leave with you after this presentation. My testimony will essentially be a summary of that larger document.

It is our position that mandatory disclosure rules should not be applied to Pharmacy Benefit Managers or PBMs for three reasons. First, the concerns underlying the disclosure obligations relating to pension plans are not applicable.

Second, PBMs already have a high degree of transparency.

And third, the Federal Trade Commission and the Department of Justice have concluded time and again that mandatory disclosure could have profound anti-competitive effects.

The fundamental justification for the new rules applicable to service providers and pension benefit plans and the data relied upon by the Department in formulating those rules was to address a demonstrated need for greater transparency in the contracting for investment services to define contribution plans, specifically the providers of pooled investment vehicles.

In that context, amounts received or retained by service providers reduce dollar for dollar the funds that could provide retirement benefits to plan participants. Those concerns do not apply to PBMs or other service providers to welfare benefit plans.

The PBM market is highly competitive with more than 60 PBMs which is a 20 percent increase from 2004 when the FTC identified some 40-odd companies in the industry, each competing for business from public and private health plans. According to a Price Waterhouse study, PBMs typically reduce the cost of prescription drugs by 30 percent.

The FTC has, on repeated occasions, stated that the PBM market is operating efficiently and that plans have the information necessary to judge the reasonableness of the fees PBMs charge and the quality of their services.

Plan sponsors have a variety of tools available to them which they can employ when they negotiate with PBMs. They retain consultants knowledgeable about the economics of the PBM industry and how PBMs operate. Smaller companies, often are represented in negotiations by third-party administrators or insurance companies who act on behalf of a number of companies in order to enhance their bargaining power.

Given the vigorous competition between PBMs, plans or plan sponsors can negotiate the arrangements they prefer including pricing that best fits their individual needs. For example, some plan sponsors have negotiated contracts with PBMs for a pass through of all or some stated percentage of rebates that PBMs receive from drug manufacturers. Similarly, arrangements with a PBM that passes through the price that the network retail pharmacies charge are common.

Plans have negotiated audit rights with PBMs to ensure that PBMs are acting consistently with governing contractual arrangements. Many plan sponsors belong to third-party accreditation programs, like the URAC Pharmacy Benefit Management Standard and the Pharmacy Coalition of the HR Policy Association that have developed transparency standards that call for the

disclosure of rebate information, pricing structure, audit arrangements and formulary decisions.

As members of these organizations, plan sponsors have access to and can use those materials in negotiations with PBMs.

As I indicated, the Federal Trade Commission and the Department of Justice have extensively examined the PBM industry in recent years and have consistently shown that the PBM market is highly competitive. This examination of the industry has been thorough, it is concluded that market forces are operating to provide the transparency sufficient to allow consumers of PBM services like ERISA-covered health plans to make informed decisions regarding the selection of PBM providers.

After extensive study of the industry, a joint FTC/DOJ task force concluded in 2005 that competition in the marketplace would work to advance disclosure of information that health plan sponsors need to enter into appropriate contractual arrangements with PBMs. The FTC has repeatedly warned that disclosure of closely-held proprietary financial information could well produce anti-competitive results that would impede PBMs from lowering the costs of prescription drugs to consumers.

In its analysis of the market, the FTC has consistently focused on its concerns that once proprietary information is disclosed it will be difficult, if not impossible to keep it confidential. Disclosure of rebates and particular drugs could, in the FTC's judgment, result in tacit collusion among drug manufacturers.

The FTC has objected to numerous State statutes that would more closely regulate PBMs. Most recently in 2009 a proposed New York State statute would have required PBMs to make substantial disclosures to health plans during contract negotiations and annually thereafter. The FTC opposed this legislation indicating first that these disclosures might increase the cost of the PBM services because they may preclude health plans and PBMs from entering in to cost-effective contracts for the provision of pharmacy benefits.

And, second, they may have the unintended consequence of publicizing proprietary business information in a way that could foster collusion among drug manufacturers.

The FTC indicated that allowing competition among PBMs is more likely to yield efficient levels of payment sharing, disclosure and prices than contract

terms regulated by government regulation.

And, finally, the FTC concluded that there is no theoretical or empirical reason to assume that consumers require sellers' underlying cost information for markets to achieve competitive outcomes. Similar studies by the Congress Budget Office, by Price Waterhouse Coopers have come to similar conclusions.

Most of the impetus for mandatory disclosure comes from the pharmacists and their allies. PBMs work to save money by negotiating aggressively all parts of the supply chain to push down costs. And PBMs have strong incentives to bargain hard with pharmacies, especially under variations of the commonly used spread model.

The pharmacies understandably would like to handicap this approach. They are much better off with the pass-through model because PBMs' incentives to bargain hard are reduced. And pharmacies compete with PBMs mail-order pharmacies and are trying to get competitive advantage by knowing the PBM's cost structure.

As the FTC has repeatedly pointed out, mandatory disclosure could well have anti-competitive effects. The PBM marketplace is highly competitive, direct contract negotiations between PBMs and plans

have resulted in disclosures more than sufficient to allow plans to make reasonable contract arrangements with regard to fees and quality of service.

Given the number of parties that would have access to any mandatory disclosure materials and the lack of any enforcement mechanism in ERISA, there is no practical way to keep information confidential once it is disclosed. This contrasts with PBM disclosures under the new healthcare law, PACA, which only require aggregated data. It includes strong statutory confidentiality protections.

In Medicare Part D, no disclosure is required to the plans themselves due to the confidentiality concerns. And in both instances the FTC testified before the Congress to this effect.

At bottom then, the Department should not mandate a disclosure regime that could result in anti-competitive consequences about which your sister agencies have warned repeatedly over the years.

Thank you very much.

NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Zachary French, Vice President

MR. FRENCH: Good morning. My name is Zachary French and I'm here today appearing on behalf

of the National Community Pharmacists Association. NCP represents the interests of America's community pharmacists including the owners of more than 23,000 independent pharmacies, pharmacy franchises and chains. Together they have more than 315,000 employees including 62,400 pharmacists and dispense over 41 percent of all retail prescriptions.

NCPA feels very strongly that the proposed legislation should apply to contracts or arrangements involving the provision of administrative services to employee welfare benefit plans, specifically pharmacy benefit management service contracts. PBMs should be required to disclose critical information about their primary revenue sources as well as their potential conflicts-of-interest. This will give plan fiduciaries the necessary tools to assess the reasonableness of PBM compensation and any conflict of interest that may affect the service provider's performance.

In other words, plans really do need to know where all the money is buried so that they can make well-founded determinations of whether the compensation they are paying is in fact reasonable.

Over the past few years, due to in large part proliferation of acquisitions as well as mergers, the PBM marketplace has become extremely concentrated. The

big three PBMs commonly known at MEDCO, ExpressScripts, and CVS CareMark manage the drug benefits for approximately 95 percent of Americans with employer-based health coverage.

From 2003 to 2007 these three PBMs saw their profits actually triple from just over 900 million to $2.7 billion. In a truly competitive market, it is reasonable to assume that these types of dramatic increases would actually occur? In spite of these facts, the PBMs are minimally regulated both at the state and federal level in large part due to their extremely aggressive lobbying efforts and very effective lobbying efforts in the States that have actually managed to enact some of the PBM regulations. The PBMs have been very successful in claiming that such State regulation or legislation is not applicable to PBMs serving ERISA plans.

One of the PBMs' primary revenue or profit streams is derived from rebates provided by drug manufacturers to the PBMs for driving brand drug market share on drugs purchased on behalf of PBM clients. PBMs retain all or a very significant portion of these rebates even though they are generated by the welfare benefits plans' pharmacy spend. This is a clear conflict of interest on the part of the PBMs serving in

its role as a service provider to a welfare benefit plan. But there are other sources of direct, as well as indirect, enumeration that the PBMs earn and they have spent a lot of time renaming them so that they are either disguised or hidden from the actual plan sponsors. These include indirect enumeration such as educational sponsorships, data management payments, and other euphemistically named programs.

The DOL held a hearing on this very same issue in 2008. Testimony was provided at that time to the effect that there was no evidence of any problems in the PBM industry. Well, to the contrary. Between 2004 and 2008, substantial enforcement actions instituted against each of the major PBMs indicating fraudulent and deceptive conduct have resulted in over $370 million in damages. These cases also shed light on some of the questionable and widespread practices in the PBM industry including the misuse of kickbacks or misuse of rebates, I should say, the existence of kickbacks, submission of false claims and even drug switching.

During the 2008 proceedings on this issue, the PBM industry relied heavily on the fact that in 2003 the Congressional Budget Office estimated that a proposed amendment to Medicare -- I'm sorry, the

Medicare Modernization Act, that would have required some level of transparency by PBMs involved in Part D would cost taxpayers $40 billion over ten years.

In addition, it was suggested that PBM transparency would in some way enable tacit collusion among drug manufacturers. In contrast the recently enacted Healthcare Reform Legislation now actually mandates a certain degree of PBM transparency. And this is in the form of really aggregated required disclosures of all PBMs that serve any of the State insurance exchange health plans as well as in Medicare Part D.

This federal mandate was scored by CBO as cost-neutral. And due to the fact that the federal legislation provide for confidentiality between the PBM and the plan sponsor, there is virtually no risk that such data will become public information and in any way impair the negotiation of ability of the PBMs with drug manufacturers. Likewise, a similar confidentiality provision could be applied to the disclosure under debate today.

Now, it is true that some large employers, employers with the requisite amount of negotiating power have been able to demand certain measures of transparency from their PBMs. And the PBMs are likely

to argue that because of these contractual agreements the mandatory disclosures proposed by EBSA are absolutely unnecessary. However, the smaller ERISA plans do not have the negotiating power or even the knowledge base to demand the same disclosure. For this reason, it is critical that all of the regulations under discussion today should apply to all PBMs serving ERISA plans in order to establish at least a baseline or minimal level of required disclosure.

Now, there is a growing recognition of the value of transparency across healthcare, specifically PBM transparency. Federal law now dictates that PBMs that will serve any of the to-be-created State insurance exchanges and Part D plans disclose certain aggregated information to the Secretary of HHS and to the plan sponsors. Under MMA, the PBMs that serve Part D plans are already required to disclose to the Secretary the manufacturer rebates and price concessions for the purpose of determining whether the plans are passing through the direct and indirect price concessions they negotiate.

A few larger employers, again, with significant negotiating power, are now requiring various disclosures. However, as encouraging as these provisions are, these end roads are simply a starting

point and the PBMs serving ERISA plans have a long history of using their status as ERISA plans to evade regulation.

In conclusion, the totality of circumstances, the extremely concentrated PBM marketplace, the minimal amount of state and federal regulation, and also the lack of any verifiable harm to the PBMs by requiring transparencies should lead us to consider the potential benefits to plan fiduciaries clearly indicating that the proposed regulation should apply to service providers, to welfare benefit plans, and specifically to pharmacy benefit management contracts. Disclosures will allow fiduciaries to confirm that the PBM is providing the service it was hired to provide, that being to secure the lowest possible drug cost for the plan.

Without transparency the plan fiduciary has no way to verify that the PBM is in fact sharing manufacturer rebates and at what levels or that the PBM is negotiating the lowest possible cost for specific drugs. And I'll be happy to answer any questions during the question and answer period. Thank you.

LAW OFFICES OF DAVID A BALTO

David Balto, Esq., Washington, D.C.

MR. BALTO: Good morning. I'm David Balto. I'm a senior fellow at the Center for American Progress. I appreciate the opportunity to testify before you today. I used to be the policy director of the Federal Trade Commission and had the privilege of being an antitrust enforcer for almost 20 years. I brought some of the first cases against PBMs. In my private practice I advise plans, consumers, pharmacies and even PBMs on competition and consumer protection issues.

In day one in antitrust school when I became an antitrust enforcer they taught us that the three things to make a market work effectively were transparency, choice and a lack of conflicts-of-interest. Why is it? It should seem obvious. We need transparency so we can make effective choices, so we can understand how the market works. We need choices so that we can make competitors compete against each other so we get the best benefit for our bargain. And then last we need a lack of conflicts-of-interest to make sure that when someone is acting on our behalf that they truly are acting on our behalf.

I know from my experience both as a government enforcer and in private practice representing parties, that in all three of these

measures the PBM market fails. And the Department of Labor regulations that you're considering are absolutely necessary to effectively protect plan sponsors in this broken market.

Zach has gone and described to you the lack of competition. There's been tremendous mergers leading to significantly high concentration. By the way, later on in day one in antitrust school they taught us that rapidly increasing profits are the best sign of a market that is not performing effectively. And as Zach has demonstrated profits in this market are skyrocketing. And let me make this clear to you, those profits are undisclosed, indirect compensation. That is what they are making money on. They are -- PBMs are going and getting rebates and other kinds of funding from pharmaceutical manufacturers that is undisclosed and we -- PBMs do serve an important function, but to fully protect plans we need adequate disclosure here.

PBMs were originally intended to be honest brokers. Entities that would be independent and aggressively bargain for the lowest prices, the highest rebates, and to an extent they do that. But also to the extent that they're able to hide these forms of compensation, effectively play the spread, pretend that they're giving -- receiving one thing to the plan

sponsors, but actually pocketing something else. The market does not work as effectively as possible. The PBMs, the three major PBMs, just the three major PBMs, have profits of over $3 billion a year. Those profits -- a greater portion of those profits should be in the pockets of the plans.

Now, how do we know the market is not working effectively? No other market has the record of significant consumer protection violations based on deception and fraud. If you look at page 4 of my testimony, I've listed the cases, over $370 million in damages and fines. There is a multi-state group of 30 state attorneys general who are investigating the PBMs, they continue their investigations. This is what they've received to date. What's at issue in these cases? Undisclosed, indirect compensation, gaming the system, playing the spreads. It's a lack of disclosure that enables them to do that.

What's the solution that these states have turned to? Look at the consent order that 30 states have implemented against Caremark. It requires disclosure. It requires the disclosure of these kinds of rebates.

Now, the record increasingly demonstrates that for some very powerful plans, especially large

buyers such as Tricare, the Department of Defense, large state entities like the state of Texas or the state of New Jersey, they recognize the benefits of transparency. And the speaker for PCMA was correct that there are large sophisticated buyers who are securing transparency. If you look on page 6 of my testimony you will see the benefits of that transparency; hundreds of millions of dollars of benefits.

But the fact that they're able to secure these savings doesn't say anything about the vast majority of plan sponsors who simply do not have the market clout to go and negotiate for the same level of transparency.

Now, one important distinction I want to make between this panel and the panel you just heard from is State regulation. All those people on the first panel could point to the fact that there is State regulation of brokers. But there is really very, very little State regulation, if any, of PBMs. There are a couple States who have adopted PBM transparency provisions, and there are about five or six other States that have PBM registration requirements, but PBMs are really a segment of the market that goes wholly unregulated.

Obviously the PBM industry makes much of

things that my former agency has said about PBM transparency. And I'd like to really address those issues in detail. I would like to go and apologize for the past on behalf of my former agency. I used to write these comments, these comments oftentimes can be valuable when they're based on strong empirical evidence. They are not valuable when they are just basically on a theoretical model.

And what you have basically are comments that preceded the enforcement actions by the States based on a theoretical model and the enforcement actions, I think, really undermine the comments the FTC has presented.

First, Mr. Kilberg sort of tries to sell you a pig in a poke. He says there was this massive FTC/DOJ investigation in which 100 Sherlock Holmes went out and thoroughly scoured the PBM industry and concluded it was competitive. Folks, it was a half-day hearing, you know, there were five people who testified. I was one of them. There was no extensive investigation. In fact, during this period of tremendous consolidation of PBMs, the FTC never once conducted an extensive investigation of any PBM merger. And today we know the FTC has sort of recognized that they were sold a pig in a poke. They're reopened an

investigation of the CVS Caremark merger recognizing the significant conflict of interest and competition issues raised by that merger. I guess that's sort of buyers' remorse.

Second, Mr. Kilberg tries to sell you a parade of horribles issued by the FTC. The FTC says in these reports that conceivably, theoretically, economic theory might teach you. They cite one article that says that if the buyers were extraordinarily stupid and shared information with competing plans -- I'm sorry, competing manufacturers, that it might lead to tacit collusion. Well, that's a fun economic article, and if you've got about five or six hours for me to debate the economic argument, you know, that might be extremely boring. But we don't need to.

Do we think that Congress, the Department of Defense, 30 state attorneys general, two or three States are all so stupid that they've ignored the potential for tacit collusion? Do we think that any of the dozens of major plans that have secured transparency are just too stupid to recognize this concern over tacit collusion? No. The FTC model is based on, you know, just this interesting theory. But we know transparency has existed for year. And you can look at the FTC record and there hasn't been a single

case brought against anybody for so-called tacit collusion from any of the PBM transparency arrangements.

Thirty States weren't wrong. Congress isn't wrong, the Department of Defense isn't wrong, transparency is good. For the Department of Labor to propose regulations extending the disclosure regulations to PBMs is absolutely the right thing to do and will give the plans greater tools so it can effectively get the benefit of the bargain that it should and it more effectively reduced the costs -- increasingly escalating costs of pharmaceuticals.

Thank you very much.

MR. CANARY: I guess I will start again. I just have two questions. I think one issue is the extent to which there is State or federal regulation of PBM activity in making disclosures to customers. And I know there's some sense that that may be minimal. But could you identify what it is? Which federal law or regulation currently, if any, would govern PBM disclosure practices?

MR. BALTO: I think that Mr. Kilberg is correct that both under PACA and the Medicare Modernization Act, there is some kind of general disclosure that's necessary. And I think under one or

two State's laws there is primarily the State of Maine, there is a disclosure requirement.

MR. KILBERG: Every state -- even though Mr. Balto talks about 30 states because 30 attorneys general were involved in two cases, every State other than Maine has rejected the kind of disclosure that we are talking about here. And in the attorneys general settlements, which by the way did not produce damages. These were settlements, many of the payments are Sye Pray (ph) payments. So put things in a little bit better perspective. But in the Caremark settlement, for example, that Mr. Balto referenced, which requires only the disclosure of certain aggregated data with regard to certain types of transactions, there's a very strong confidentiality provision that I can read to you. It says:

"Prior to any disclosure of confidential information required pursuant to this document, confidentiality agreement must be signed by client payors, employees, and each and every agent, consultant, attorney, auditor, or any party acting on behalf of the client payor who will have access or receive Caremark's confidential information, no information disclosed shall be made available to any other party in the absence of a signed and executed

confidentiality agreement between such party and Caremark."

So even in that context there has been serious concern about confidentiality and these kinds of disclosures.

Just a point with regard to the FTC/Department of Justice investigation. It was a two-year project. The findings of the study were researched -- I'm sorry, were reached after 27 days of joint hearings. There was testimony from 250 panelists. There was a transcript of about 6,000 pages. We can make all of that available to you. It was not something that was reached, you know, quickly or lightly. This was not theory. This was an investigation of an industry, its competitiveness and specifically the conflict-of-interest issues.

You know, Mr. Balto has testified numerous times before the Federal Trade Commission. He does have an expertise in that area. He is a former employee of the Federal Trade Commission and each time they have rejected his views. There's a reason for it. The data goes the other way.

MR. BALTO: Just to keep the record straight, I've testified once. There was a half day of hearings, there were six witnesses. It's a short like two or

three paragraphs in the report. That was the only -- that was the only review of it in that report.

MR. FRENCH: I would just add, I didn't give you my background as a preamble to my testimony. But I served for nearly four years as a senior vice president with a large PBM that had nearly 10 million lives in its book of business. So, when I talk to you, I'm not talking to you about something that's theoretical, something that happened in a hearing, but I'm talking to you from an actual practical application of it.

I will tell you flatly, as senior vice president of client services, clinical services, as well as sales, when we went out and either renewed a client or secured a client, we weren't necessarily worried about the confidentiality that's sharing information that related to transparency would entail, what we were concerned about was lowering the value of that deal with an informed buyer.

So, I mean to everyone's protestation here from a PBM standpoint, that is not a significant issue when going out and trying to win business. The reality of it -- or retain business -- the reality of it is that there are always bilateral confidentiality agreements between the PBM and the plan sponsors. This is sort of business as usual. So I mean, again, there

is virtually no risk in terms of sharing the transparency that relates to individual plans pharmacy spend on a day-in and day-out basis. It's just there's virtually no risk.

MR. BALTO: I represent health plans that negotiate with PBMs and Mr. French has it exactly right that these confidentiality provisions are quite typical.

MR. CANARY: So a different subject I'd like to see if you can elaborate on which I take there is probably going to be some disagreement.

(Laughter.)

MR. KILBERG: Conceivable.

MR. CANARY: At least, Mr. Kilberg, the outline of topics focused on what should be considered compensation for purposes of 408(b)(2) and two things you suggested be excluded, discounts and rebates received by PBMs or an affiliate with respect to acquisition of or contracting for goods and services for sale to PBM clients, and then income earned by the PBM or an affiliate on investment of its own assets.

Could you elaborate on why you think that should be excluded?

MR. KILBERG: Sure.

MR. CANARY: And I think I heard from Mr.

Balto, at least, some emphatic sense that that should not be excluded.

MR. KILBERG: You have the recent Labor Department FAQS, frequently asked questions and answers, and a line was drawn there, at least temporarily until you had an opportunity to investigate further with regard to forms of direct compensation and indirect compensation. We have no concerns about disclosure of fees for direct -- in the form of direct compensation. Our concerns go to what we call "spread" or cost of goods sold. PBMs earn money in two ways. They earn money through fees which are always disclosed and they earn money through spread. That is to say the difference between the price they pay for drugs, and the price at which they sell them. Either because they have a negotiated agreement with pharmacy chains for the purchase of drugs at a certain price, specific drugs and specific prices, or they have arrangements with manufacturers, either of generic drugs or brand name drugs to purchase the drugs and provide them through their own mail -- PBM's own mail order pharmacies. They also have arrangements with manufacturers that depend upon volume sold and so on. All of that goes to the cost of goods sold. We'll sell you the drugs for less if more drugs in fact are

marketed. That's the -- it is that concern, it is the disclosure of the cost of goods sold which animates our testimony.

MR. FRENCH: I can tell you from personal experience that PBMs can create a spread on virtually anything. Just as an example, right now there is a particular emphasis on generic dispensing rates because for every dollar a plan usually invests in GDR, or generics, I should say, they get back two. So it's a two to one sort of a return. IMS has validated that.

PBMs have historically created a spread on generic dispensing rates. They do that by guaranteeing say 63 percent GDR and if they achieve say 67 percent, many of them will pocket that 4 percent spread or delta. So if you exclude spread pricing from transparency disclosures, they will come up with a way to essentially create a spread across any number of components that are part of a plan's pharmacy spend which I think any definition of transparency would say that the plan should receive full benefit of their pharmacy benefit spend.

All of these revenue streams that the PBMs insist are theirs and should be hidden from the plan sponsors are generated in large part or exclusively from the spend. That is how they make their money.

Administrative fees as well as clinical programs are really the only two items that they can look you in the eye and tell you that they actually generate in a straightforward manner. I know that from experience.

MR. CANARY: Mr. Balto.

MR. BALTO: I think Mr. French has it absolutely correct. Look at it from a competition perspective. You know, it's one thing for the FTC or PCMA to say things about how competitive the market is. The market isn't competitive if things aren't disclosed. You've got to have disclosure otherwise, you know, competition won't work. Disclosing the spread is important for two reasons. First, it makes it an item of competition. It's something that people can recognize and then they can make sure that they're getting the full benefit of that. And then second, more as important, they can recognize conflicts-of-interest. So if, you know, the spread doesn't seem to be as high for certain drugs as other drugs, maybe there's something else going on that they're not aware of, there's some kind of kickback or rebate scheme that they, you know, that really sets the incentives of the PBM to, for example, prefer branded manufactured drugs, more expensive drugs, over generic drugs.

MR. CANARY: Thank you.

ASSISTANT SECRETARY BORZI: I've got several disparate, I guess, questions. The first question, I guess, is for Mr. Kilberg, and that is, you've talked about the highly competitive marketplace and yet we heard Mr. Balto say, and certainly that's -- as a consumer that seems to me my anecdotal reading that really there are three big PBMs and the rest that control, according to Mr. Balto's testimony, 95 percent of the employer-sponsored marketplace. Do you disagree with that?

MR. KILBERG: The 95 percent number is a new one to me. I'm not sure what exactly he's referring to. There are three large PBMs that together have a sizeable portion of the market. And their behavior has been reviewed by the FTC, there have been some mergers that have been reviewed and so far have past muster. The findings of the FTC remain that there is healthly competition because you have -- (a) you have so many other companies in the industry, the barriers to entry have not been that high. Secondly, you have competition among these three and a few other fairly large PBMs for the -- you know, the largest segments of the market.

ASSISTANT SECRETARY BORZI: Could you provide

us, for the record, a list of all the PBMs that are out there and what their market share is?

MR. KILBERG: Sure.

ASSISTANT SECRETARY BORZI: That would be useful, I think.

MR. KILBERG: To the extent that I know and can find out what the market share is.

ASSISTANT SECRETARY BORZI: Yeah.

MR. KILBERG: But I will certainly provide you with what --

ASSISTANT SECRETARY BORZI: Well, don't you represent the trade association?

MR. KILBERG: I represent the trade association. I don't know what the trade association has in the way of that data. But, I'll provide you with --

ASSISTANT SECRETARY BORZI: Okay.

MR. KILBERG: -- as much information as I can obtain.

ASSISTANT SECRETARY BORZI: Thank you.

The second question is, you talked in your testimony, and Mr. Balto actually has in his testimony some examples of the kinds of transparencies, the kinds of disclosure that at least some of the large purchasers, large employers have been able to

negotiate, and yet you're overall testimony is that, if people are required to disclose this, harm will occur. So can you give us some examples of some harm that has occurred as a result of these negotiations, these transparencies?

MR. KILBERG: There hasn't been because, in those arrangements that are negotiated, there are confidentiality provisions. Generally, the disclosures are kept in terms of aggregated data, not individual pricing for individual drugs. And you have -- you have the opportunity on the part of the purchasers, generally employers, to make decisions as to tradeoffs. How much of the rebates they want, because there's an incentive when you -- you know, when you transform everything into simply a fee for service and you take all of the rebates, all of the discounts, that you lose the incentive that the PBM has to continually drive those prices down, because that's how the PBM makes money.

ASSISTANT SECRETARY BORZI: Uh-huh. Nobody is against anybody making money.

MR. KILBERG: Certainly not. So, you know, many of these are expressed in terms of percentages of rebates to be shared and very detailed auditing provisions.

ASSISTANT SECRETARY BORZI: Yeah, tell me about the auditing provisions. Because how can an employer -- I mean, for instance, it's a very common provision in contracts between employee benefit plans and PBMs that you will deal with the average wholesale price. So how do you figure out the average wholesale price? How does the client -- how does the plan sponsor know that what you tell them the rebate should be or the price is, how do they know that that's right?

MR. KILBERG: Because they come in and they look at your books. They have auditors who come in and see exactly what was done. There also are standards -- there are organizations that provide the information with regard to pricing, maximum allowable cost, average wholesale prices, and so on. And so the data is available. The consultants know what the data is, the large employers certainly do. The TPAs tend to. The insurance companies do. I mean you have -- now you have these private organizations like URAC and the HR Policy Association that are providing similar services making much of this information more available to smaller employers.

ASSISTANT SECRETARY BORZI: So would you say that most of the employee benefit plans audit?

MR. KILBERG: I don't know the answer to

that. I assume that the large ones do. I don't know -- and I'm sure that the insurance companies do. I don't know -- when you say "most" I don't have an answer to that. I can try to find out if we have that information with regard to percentages and, you know, what those audits may consist of.

ASSISTANT SECRETARY BORZI: So, I guess you wouldn't have a problem if we were to decide that for a fiduciary to discharge its duty to determine whether reasonable compensation has been paid that they would have to audit PBMs?

MR. KILBERG: That's really for them to decide. Do they want to take on that cost versus, you know, the other savings that they may get in negotiations with PBMs or the other money that they may have. Right now the marketplace -- in our view the marketplace works. And, you know, we don't believe that you need the government to come in and tell people when to audit and when not to audit. We believe that there's a value in allowing the parties to negotiate their own arrangements and their own tradeoffs.

ASSISTANT SECRETARY BORZI: And the comments that have been made by Mr. French and Mr. Balto about the concerns that they raised, I must say that I had concerns myself about your comment about taking off the

table any kind of disclosure about indirect compensation. Assuming, for the sake of argument, we were to take your advice and not require disclosure of indirect compensation, how might a plan sponsor determine whether conflicts-of-interest were going on with respect to the PBM operations?

MR. KILBERG: Well, you know, plan sponsors are aware of how PBMs operate, the fact that they have their own -- you know, if you're buying drugs from PBMs through a mail-order pharmacy, you know that the PBM has a pharmacy. So I don't believe that's a problem. You're not hearing a clamor from plan sponsors, large, small, trade associations for this kind of mandatory disclosure. You're hearing it from competitors. You're hearing it from the pharmacists because the PBMs and the pharmacists are in competition with one another. And the PBMs are often in a role where they audit the pharmacies as part of, you know, one of the services they provide. It creates a certain amount of tension which I think we've seen, you know, this morning.

ASSISTANT SECRETARY BORZI: Mr. French, how would you respond to that?

MR. FRENCH: Well, I don't think it's so much about tension as it is about practices. First of all

there are very few PBM audits that are actually conducted at the behest of plan sponsors on a year-in and year-out basis. What's more, because of the varying degrees of sophistication, in terms of contracting for services in the PBM marketplace, there is a very large, let's say, disparity between the sophisticated buyer and the average to maybe low-information buyer. Down toward that other end of the spectrum audits hardly ever come up and they hardly every occur, not only because of the lack of knowledge, but also because it costs money to do audits.

ASSISTANT SECRETARY BORZI: Sure.

MR. FRENCH: The PBMs don't make it easy to do that sort of business with them. So in fact they have restrictions and limitations that are negotiated as part of the contracts. And I sat in those negotiations to make sure that there were definite restrictions put on the health plans relative to their ability to audit and receive full transparency. So a lot of times what you see is audits being conducted based upon, you know, the performance of the PBMs such as dispensing accuracy or the pharmacy's dispensing accuracy rates, things of that nature. But seldom does it go to the heart of transparency because that's the crown jewels with the PBM.

So I would say in this regulation you have an opportunity to level the playing field for both -- I mean, we've heard a lot about HRPA today. If you go and look at the 60 companies that are part, or subscribe to that association, they're the crème-de-le-crème of corporate America in the United States with very, very large employee bases. And they do not require that PBMs write transparent deals on each sort of percentage of their book of business. All they require to receive their certification is that they agree, in some cases, to offer transparency. But still if you look at the number of what's called traditional deals, where the PBMs exploit in a non-transparent way spreads, various sources of revenues that are derived and leveraged from the plan pharmacy spends those traditional deals are still the overwhelming majority of the contracts that are written today. Transparency in pass-through deals represent a very, very small percentage of that. And I believe that goes to the sophistication of the sales organization and the complexity of the actual contracting process.

ASSISTANT SECRETARY BORZI: Mr. Balto, what -- and then I'll stop because I know my colleagues have questions, but for the clients that you've represented, what would you say the key elements of transparency you

try to negotiate in those contracts are with the PBMs?

MR. BALTO: I think what's most vital is knowing the relationship between the PBMs and the different drug manufacturers, knowing what kinds of compensation they receive, knowing the basis for that compensation. You know, this is -- you know, each plan -- the plans are very -- sophisticated plans are very aware of their drug spend, less sophisticated, less aware, but, you know, this kind of information is information you can readily turn to another PBM on and make sure that you're getting the best benefit of the bargain.

ASSISTANT SECRETARY BORZI: So it would be not just the types of compensation but who -- back to Tim's question from the last panel -- who you're getting the compensation from?

MR. BALTO: Yeah, I think who -- yes. Both.

ASSISTANT SECRETARY BORZI: Okay. Thanks.

MR. HAUSER: I guess this is for you, Mr. Kilberg. As I understand the testimony or your testimony that the chief reason why we should be reluctant to mandate disclosures here is a concern unique, maybe to this industry at least in the health context about collusion among the pharmaceutical companies that if we mandate this kind of disclosure it

might end up being anti-competitive because if they have access to the internal cost data they'll have a better sense of where they can price and how they can price and it will make it harder for the PBMs to negotiate. And so I guess one question is, well, do we have any reason to believe, or what is our evidence for believing the pharmaceutical companies don't already have a really good idea of what these arrangements are?

MR. KILBERG: Because they're not disclosed. I can only refer you and suggest that the Department might want to talk with the Federal Trade Commission. They are concerned about what they refer to as "tacit collusion" that's one of the concerns. The other concern is interrupting what they see as a competitive marketplace now and arrangements and the negotiation of arrangements which they think is better, more creative, than would otherwise take place under regulation.

Let me just say one last thing here. You know, there's a lot of talk about rebate spread. These are not dirty words. These go to what any supplier of goods or services protects, the cost of providing those services, the cost of the goods that you're selling. That's essential competitive information which every, you know, seller of goods or services tries to keep proprietary. And that's we're dealing with here. It

is not a matter of disclosing the types of compensation or from whom rebates are received. That information is in the ordinary course disclosed in every contractual relationship that I'm aware of in the PBM industry, every contract I've seen has disclosed the nature of compensation. What they don't disclose is the amounts and what the spread is, what the rebates actually are.

MR. HAUSER: So going back, I guess, to my question though, putting aside -- and if I have other questions you can generally -- I assume that one of your answers will be because the FTC said so in response to all of them.

MR. KILBERG: Yep.

MR. HAUSER: So putting that aside, do we have any reason apart for the fact that there are confidentiality provisions in the agreements with the customer to assume that the pharmaceutical companies don't already know what the rebate structure is and what the pricing structure is and the like that the PBMs are getting? Or is it entirely based on the fact that there are confidentiality provisions in these agreements?

MR. KILBERG: Because there are confidentiality provisions, because it would -- you know, each manufacturer would like to know what every

other manufacturer is doing in competitive drugs, you know, competing in the same illness segment. I'm not sure what the terminology is. So I assume that they're not anxious to -- they'd each like to have the information for themselves, but they're not anxious to share it with the others.

MR. HAUSER: And when the PBMs are negotiating with the pharmaceutical companies, do they get similar sorts of confidentiality --

MR. KILBERG: Yes.

MR. HAUSER: -- deals from the pharmaceutical companies, don't tell our competitor what the deal is?

MR. KILBERG: Yes.

MR. HAUSER: And so if we were to mandate disclosure of some sort but to -- say just hypothetically we provided that, the disclosure could be contingent on some sort of -- on the PBM's right to insist on some sort of confidentiality agreement that would prevent the disclosure to pharmaceutical competitors or to anybody outside of, you know, say the Department of Labor and -- well, that might be it -- would that do the trick? Or is there --

MR. KILBERG: You know, it's hard for me to answer without knowing precisely what we're talking about. I mean, in the -- you know, with regard to the

Part D, for example, the information is disclosed to CMS, but it is not disclosed to the plans. And that's -- you know, that's with regard to a very limited market and where you can get some protections.

You know, I'd worry about disclosing to the Department with Freedom of Information Act requests out there. I mean, how would we protect against that?

ASSISTANT SECRETARY BORZI: Isn't that the same problem with CMS?

MR. KILBERG: Could be. But they have statutory protection. So I'm assuming that because of that statutory protection it has not been at issue. But I don't know how we would do this under ERISA. So it's hard for me to answer.

MR. HAUSER: To the extent that the plan customer's costs are being -- or their charges are being calculated with reference to the PBM's cost structure, you know, based on rebate amounts or the cost to the PBM of the particular prescription and the like, I mean, presumably in that circumstance -- tell me if I'm wrong, but there wouldn't be an issue with mandating that there be disclosure of the actual prices on which those numbers are based? I mean, if you can back it out anyway I assume.

MR. KILBERG: I'm not sure I understand.

MR. HAUSER: Well, if the nature of the -- if the deal involves pass throughs of savings in one way or another, shouldn't there be ready disclosure of the calculation -- how those savings numbers were derived?

MR. KILBERG: Yes. And in individual arrangements where there are pass throughs, there is that disclosure. But the data is aggregated and you will know with regard to a plan, but you won't necessarily know how much came from which drug.

MR. HAUSER: And when you say that the plans can do these audits, how does the audit work if they can't look at kind of a drug company by drug company kind of prescription by prescription basis, or am I misunderstanding?

MR. KILBERG: You know, I'm not sure how the audit is done. It may very well be that there's a confidentiality agreement with the auditor and so the information is not passed through in detail. I don't know -- I don't have enough knowledge of how audits are done to be able to answer your question. But there are protections that are built into this in order to assure that that information is held as closely as possible.

MR. LEBOWITZ: Can you find out?

MR. KILBERG: I certainly can. I can ask.

MR. LEBOWITZ: And let us know.

MR. HAUSER: And do you think that it should make a difference whether or not the PBM is taking on the discretionary fiduciary role or not and the level of disclosure that would be mandated.

MR. KILBERG: Well, you know, a number of States have looked into the question as to whether PBM should be fiduciary, not necessarily ERISA fiduciaries, but use the fiduciary term, the District of Columbia, that lawsuit -- that bill was challenged and was held to be preempted. The Maine statute was held not to be preempted, so you got this conflict. But that's how they went about it, by creating a fiduciary notion they created an obligation to disclose which we believe is antithetical.

MR. HAUSER: And two more questions; one for you and one for the others. But I was sure whether you finished answering a question Phyllis had asked you, so I just wanted to make sure you did, if there was anything more you had to say. And I can't recall the question, but it was essentially -- it was essentially on the one hand these guys are telling us that if we want to worry about market, power, and collusion and the like, we really should be more focused on worrying about the PBM industry than the collusion and market power of the pharmaceutical companies. And you started

to answer and said, in addition to the fact that you read the FTC as not being with the premise of that question that you thought there were barriers to -- that there weren't significant barriers to entry in this marketplace and you maybe had a couple other observations why you didn't think market power was a big issue here.

MR. KILBERG: I made that comment strictly on the fact that the number of companies in the PBM industry has increased over the years. Even though there's been consolidation among some of the big ones, there have been a number of smaller companies that have entered and are competing, I assume, in other ways. Competing with regard to services that they provide, providing more administrative services, some may be providing more -- you know, more disclosure, for that matter, if that's what individuals want. But they would be, you know, they would be dealing with segments of the market.

MR. HAUSER: And then for you, Mr. Balto and Mr. French, why isn't -- why isn't the PBM industry right in being concerned about a broad disclosure regime if we mandate, you know, broad disclosure to all of the plans that use PBMs and presumably that's a pretty large number of plans, isn't it inevitable that

the information is going to get out one way or another and be used by the pharmaceutical companies in a kind of counter competitive way?

MR. BALTO: You know, let me step back and say, so the FTC when they talk about this issue they cite one economic article. They don't cite any other cases where this kind of disclosure, they don't say in the cucumber industry this led to this and we brought this enforcement action.

Second, think about pharmaceuticals for a minute. You know, we've got many single brand categories, so there's nobody to collude with. I mean, you were talking about a situation with the -- and then there are other markets, you know, where there are dozens and dozens of generic drugs in which it is probably highly unlikely that there would be collusion. But basically this is all a theoretical argument. You know and we have very little evidence here that there is a potential -- that there is a potential for collusion here.

MR. HAUSER: You can continue, but then apart from the FTC which you, I guess, view as not having done an empirical analysis here. I mean, can you point us to anything empirical going the other way?

MR. BALTO: That this kind of disclosure does

not lead to collusion?

MR. HAUSER: Uh-huh. Or in this context?

MR. BALTO: No, I can't. I will think about that. But the reason -- you know, it's a fun theoretical argument, but to believe it you would have to -- you know, I mean, everybody is moving towards transparency or everybody with power, it seems, want to move toward transparency. But your obligation is to protect all of the plans, not just those who are powerful enough to seek out this greater transparency. And there are obviously tools, as Mr. French has testified to, in which PBMs and plans can go and protection the confidentiality of that information.

MR. HAUSER: Do you have anything to add, Mr. French?

MR. FRENCH: Yeah, I would sort of second what David says. I believe that just sort of standard bilateral on nondisclosure agreements would be useful. But it's kind of strange that a health plan would be required to sign a -- sign an actual nondisclosure based on them being given information that relates to their health spend. So I don't know if the actual information that we're talking about is really a basis for collusion among the actual manufacturers. I think that's something worth looking at.

So at the end of the day we're talking about sharing with them revenue streams that the PBM has created for itself by sort of slicing and dicing the spend of health plans in retaining that money for their own usage. I don't think we're talking about anything elaborate that goes to the actual nature of spreads or trying to invalidate spreads, the point is, if you're -- if you're using spreads are they reasonable in conjunction with that particular plans' health spend? I mean, should 50 or 30 or 40 percent of the health plan spend go to a retail spread. I don't know. Is that reasonable? Those are the types of questions you should ask in the specific.

MR. LEBOWITZ: I would just follow up for a second. Your organization is made up of pharmacies. Pharmacies sell a lot of things, not just prescriptions. So, I mean, this is part of this argument that I get lost in a little bit. If one of your customers, one of your member's customers said, you know, I'd like to buy that hairdryer, but I won't buy it unless you tell me how much you paid for it and any kind of deals that you had with the manufacturer or the distributor of that hairdryer. I mean, why is this argument any different from that? Your member would certainly not comply with that request, more than

likely.

MR. FRENCH: Well, you know, clearly in that consumer situation you're making that decision for yourself, unto yourself, and whatever the price is, is the price. In the pharmaceutical or the pharmacy benefit arena, you're being asked to pay a premium into a specific plan and you're expecting someone as a fiduciary to go out and make decisions that are reasonable. I mean, you don't want them going out and spending money that otherwise it's not a wise investment or allowing companies to be predatory and take advantage of the lack of transparency in order to otherwise take money from you that you don't get a benefit from.

So, I mean, you make a cost benefit analysis in that sort of analogy that you just gave and it's very simple. The PPM marketplace is much more complex and it's using other folks' money to result in profits for you that is not otherwise disclosed.

MR. BALTO: You know, Mr. Lebowitz, it's a different -- there you're purchasing something else. When the health plans I represent go and purchase something from a PBM they're not buying the drugs, they're buying the management of money. They're buying the, you know, get the drugs at the lowest cost. And

you want to know -- the plans want to know, what are all the sources of revenue that are there so I can get the drugs at the lowest cost?

MR. KILBERG: But is that same concern there --

(Simultaneous conversation.)

MR. LEBOWITZ: Mr. Kilberg, is that what you're doing here, you're managing money?

MR. KILBERG: I don't believe so. Not managing money. We are -- it's hard to say if we're selling drugs and services and at a price and prices can be compared from PBM to PBM and that's why there are, you know, certainly for large employers and for insurance companies that aggregate groups of employers as do TPAs. There are requests for proposal. And these things are hotly competed for.

MR. HAUSER: In circumstances where the PBM is charging a set price for drugs on a formulary or whatever that they set up and an established set of fees that are contingent or calculated with reference to their cost structure, why shouldn't the disclosure answer be different in that context than in the context where there's some passive sort of arrangement built in.

I mean, I guess I'm getting back to Alan's

question about why in that circumstance does the consumer -- the plan consumer need to know anything about what the PBM's cost structure is?

MR. BALTO: You mean in a situation where there's total pass through of rebates?

MR. HAUSER: No, where there's not. If the PBM is just saying, here's what we're charging for our services, and it's not calculated with reference to rebates, costs, anything else, or maybe that arrangement just doesn't exist in the real world.

MR. BALTO: You mean it's just administrative fee only arrangement?

MR. HAUSER: And yeah, maybe with flat charges for prescriptions that are disclosed in advance and the plan signs off on or not, but without knowing what the PBM is actually paying for those prescriptions.

MR. FRENCH: That exists.

MR. HAUSER: So why in that context is disclosure important or do you think it is?

MR. FRENCH: Well, I guess, bear in mind nobody is saying disclose the percentage -- percentages that you are making off of spreads. They're saying, disclose the fact that there are spreads and what the amount of the spread is -- the total aggregate amount

of the spread is. That's very different than an administrative fee where they put it out there and it can be compared on an apples to apples basis with another administrative fee.

So if the administrative fee is $2 and 35 percent per RX and you're out, which all PBM buyers do go out, and shop competitively, in most cases and they compare apples to apples. You don't have that same sort of clarity when you're talking about spreads or even knowing the existence of a spread. Just divulging the fact that you have a spread is some degree of transparency.

MR. PIACENTINI: I'd like to ask a sort of different kind of question, I think, although this line of questioning brings me here. We've been talking mostly about money. So my question is really more about the drugs. Is it the case that all of these different arrangements in fact end up influencing what drugs get dispensed to whom and when and if so, would transparency in these arrangements have an effect and change what drugs get dispensed to whom and when and what would that effect be?

MR. BALTO: That's a terrific question. Look, those four -- those cases against each of the three major PBMs and I'll leave it to Mr. Kilberg to

find another industry that has this record of significant actions brought against it for conflicts-of-interest and deceptive conduct. But those specifically involve this, rebates, undisclosed rebates and kickbacks that the pharmaceutical manufacturers were using to switch members of plans to drugs that ultimately were more expensive or sometimes hazardous to their health. You know, if the rebates had -- you know, if there had been a situation where the rebates had been disclosed, you know, at least plans could have been able to make intelligent decisions about that. And that's why, you know, at least in this one case, they've made that a requirement of disclosure.

MR. KILBERG: Well, I don't believe that's relevant to anything. You know, those cases did involve issues of drug switching, those practices have been remedied. There are now, pursuant to these settlements, very detailed rules that each PBM has to follow with regard to its pharmacy committee. They all have committees outside physicians and experts to deal with, comparisons between drugs and whether one is drug is comparable to another.

But your question really goes to disclosure that already exists, and that's with regard to formularies. The formularies have to be -- that's one

of the things that you look at when you're determining which PBM to deal with whether you have a formulary that meets your requirements, how detailed the formulary is. Is it one that just has generic drugs and certain brand drugs in it?

MR. PIACENTINI: I guess I didn't mean to limit my question just to the formulary that sort of faces the consumer or the doctor. But to go to the incentives that are facing the PBM and others sort of in the chain. My question is whether there are financial influences that mix with clinical influences in deciding what drugs end up getting dispensed. You know, maybe I'm imagining a problem and if so your answers should be short if it's a unanimous, no, that's not a problem.

MR. KILBERG: Not with regard to dispensing of the drug. With regard to what's on the formulary, certainly. And whether you have, you know, and that's something you do look at and decide whether you want -- you may not want to treat certain illnesses. For example, you may not want certain specialty drugs or, you know, which may be very, very expensive. Those are decisions that the plan sponsor makes. Those are not decisions that are in the hands of the PBM.

MR. FRENCH: If as a contractor for PBM

services you are aware that brand manufacturers pay PBMs for diving market share of your particular product. That should be important to you. And if you look at the generic dispensing rate of any given PBM, and look at the percentage of rebates they receive, you'll get a pretty clear picture of where their interests and priorities lie.

Historically the big three have garnered most of their revenue, not from administrative fees, or even from clinical feels, they've garnered them from brand drugs. So as brand goes down, so does the total rebate, because they're not driving as much market share.

As generics go up, even though theoretically they're supposed to be making more profit per script and move overall revenue because allegedly there are more generics coming into the marketplace, the fact of the matter is that the largest part of their revenue streams usually come from drugs that are brand-name drugs when you factor in all the revenue streams that the manufacturers funnel to them for driving that. And I just think that it is in the interest, especially as generics become more and more of an interest, that alone really should be a catalyst for fuller disclosure around these sort of revenue streams. It makes a

difference to the fiduciary sponsor of these plans. It has to.

MR. PIACENTINI: Thanks.

MR. DOYLE: Do we have any reason to believe that CFTC -- or FTC has changed its view on --

MR. KILBERG: No. They testified most recently with regard to the healthcare reform, Bob, and have reiterated their view in that testimony that's, you know, 2010. And, of course, we have the 2009 letter to New York State.

MR. DOYLE: And their views are drive principally out of cost concerns and setting aside the collusion in the marketplace. But --

MR. KILBERG: Competitiveness, conflict of interest, those are the things that they have specifically studied with the Department of the Justice.

MR. DOYLE: And do we have any reason to believe there's not some merit to that?

MR. BALTO: Pardon, I'm sorry. I didn't hear your entire --

MR. DOYLE: Do we have any reason to believe there isn't some merit to that or that we shouldn't share the concerns?

MR. BALTO: First of all, I disagree about

the position in 2010. I mean, the FTC had an opportunity, as I document in my testimony, and CBO scored in putting the revisions in PACA, the FTC certainly had an opportunity to and chose not to, you know, weigh in on, you know, and suggest that the PACA provisions would lead to an increase in -- lead to the kind of cost increases that CBO had identified before.

As to the 2009 letter issued by the FTC, that was for a provision in the statute which, you know, didn't have any protections in a -- and was much broader disclosure than what you are considering.

And, Mr. Doyle, as to your second question, is there any reason not to discount them? Look, I think you should recognize them for what they are. They're theoretical concerns and, you know, infrequently states and, you know, federal regulators just do not sign on to the concerns raised by the FTC. Your mandate is different than their mandate.

I used to be the policy director, I would write dozens of these letters and our success rate wasn't good enough to get me into the major leagues. So, you know, I just, you know, if there was an empirical basis to this, you know, I think you -- their comments would be taken with a much greater degree of credibility.

Can I just mention one other thing? There's been a -- you know, although I'm here as a Senior Fellow for the Center of American Progress, I frequently represent consumer groups and important consumer groups such as AARP, Consumer Federation of America and U.S. Perg have come out in favor of these transparency standards and advocated for the transparency standards, for example, under healthcare reform. So this isn't just a battle between two competitors. When consumers weigh in on this issue, they weigh in on the side of transparency.

MR. DOYLE: Any other questions?

(No response.)

MR. DOYLE: I'm almost thinking we need a hearing on this issue.

(Laughter.)

MR. DOYLE: But this won't be it, so thank you very much, members of the panel.

And we'll take -- let's take a short ten-minute break and we'll convene about 11:55.

(Brief recess taken at 11:42 a.m.)

(Hearing resumes at 11:56 a.m.)

MR. DOYLE: All right. If I could have your attention. Thank you.

All right. We shall proceed with the third

and final panel for this hearing. And, again, we'll go in the order in which you appear on the agenda. Mr. DeFrehn.

THE NATIONAL COORDINATING COMMITTEE FOR MULTIEMPLOYER PLANS

Randy G. DeFrehn, Executive Director

MR. DeFREHN: All right. Thank you. Can everybody hear me okay? Okay. I usually don't have that problem without the microphone, but I thought I would ask.

Good morning, my name is Randy DeFrehn and I'm the Executive Director of the National Coordinating Committee for Multiemployer Plans. We go by the NCCMP for obvious reasons with a name that long.

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 plan participants. 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 labor and management to administer.

Approximately 26 million Americans active and

retired workers, their families and survivors receive health benefits from the roughly 3,000 multiemployer health benefit programs. Our organization is an advocacy organization. We are actually the only one who was established exclusively for the purpose of representing the interest of these plans.

We appreciate the opportunity to be here today and present testimony and answer questions at this hearing. As we noted in our comments on the proposed regulations -- excuse me, I have a bit of a cold here, so -- the issue of transparency and service provider fees is a significant one for all plan sponsors. We note that Title I of ERISA requires certain annual reporting requirements applicable to employee retirement benefit plans and their vendors, however, we believe in many cases the disclosure requirements are too removed from the decision-making process. Therefore we wish to highlight to specific areas, compensation of pharmacy benefit managers, and transparency in commissions and incentive compensation arrangements paid to independent insurance brokers and agents. Something you've heard about already this morning, don't need to get into a lot of the details, and we don't intend to.

I think you certainly have heard enough from

the last panel, in particular, about some of the pros and cons of the issues. However, we are a little bit concerned about how those plans -- how those issues affect multiemployer plans, their sponsors, and the trustees' ability to fulfill their role as fiduciaries in purchasing services from these kind of vendors.

The financial relationships between drug manufacturers and PBMs have a profound impact on the underlying economics of PBM pricing and the direct cost paid by plan sponsors. However, there is very little disclosure of those relationships. Drug manufacturers 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 PBMs 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 requirement of the plan fiduciaries, the disclosure needs to be sufficient to allow plan sponsors to assess whether and to what extent the deals offered by the PBMs are in the best interest of plan participants, rather than simply furthering the financial interest of the PBM. For most purposes, a plan sponsor's bargaining position on behalf of the participant is strengthened by simply understanding the extent to which the PBM's financial involvement with each of the above entities as well as the mechanics for each of the program results in revenue to the PBM; and how that revenue is used: either to reduce pricing with the plan through revenue sharing; or whether it's retained by the PBM.

PBMs provide revenue sharing arrangements with plan sponsors to lower cost and drive particular 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 participants to more cost effect treatments, or treatments for which the PBM and their drug manufacturer partners benefit.

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, et cetera) in which a PBM is engaged in with a specific manufacturer, and for which a PBM receives payment is very useful information during a PBM selection process as well as in the monitoring of the effectiveness of a PBM's 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 drug 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. PBMs routinely quote mail order dispensing fees of $0.00 per prescription. 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." The 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.

The second area in which the NCCMP, among others, believes the 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 a single insurer. Under the current ERISA reporting and discriminate requirements, commissions are subject to disclosure through retrospective reporting to plan sponsors. However, the current requirements do not provide a 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 PPA minimum loss ratio regulations as brokers and agents seek addition sources of noncommissioned income.

As noted by Cynthia Borrelli in a 2008 article published in the Federation of Regulatory Counsel Journal, 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 over $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 the carrier.

A second form of compensation considered common in the marketplace is a "contingent commission" which we heard about this morning. Contingent commissions may be paid in addition to the 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," if you will, which benefits the insurer and the broker, not the customer. The contingent commission schedule is often known to the producer at the beginning of a given period of time (usually one year); however contingent commissions actually earned are calculated some time after the 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 the contingent commissions in that an incentive structure based on profit, volume, retention and/or business growth is generally put in to 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 has adopted model rules relating to the 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 the 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 that amount); and obtained the customer's documented acknowledgement that such compensation will be paid to the producer or affiliate.

According to the NAIC less than one-third of the states have adopted the NAIC Model Act as proposed, despite the fact that many critics consider that these standards are too weak to address key defects in the current system. Even those standards however, provide a floor upon which to build.

As states are inconsistent with respect to when disclosure of contingent commissions 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 steerage 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 require that mandating advance disclosure of the prospective payments is in the best interest of plan participants.

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

MR. DOYLE: Thank you.

MR. DeFREHN: Thank you.

AMERICAN BENEFITS COUNCIL

Allison Klausner, Assistant General Counsel-Benefits, Honeywell, Inc.

MS. KLAUSNER: Good morning. My name is Allison Klausner and I am the Assistant General Counsel, Benefits at Honeywell. Thank you for the opportunity to speak to you today on behalf of the American Benefits Council, a public policy organization

representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

I commend the Department for its hard work on the interim final regulations under section 408(b)(2) of ERISA. The Council strongly supports transparency in arrangements for plan services. To evaluate the reasonableness of a proposed service provider arrangement and to negotiate effectively with potential providers, one must have meaningful information about the services that will be provided and the compensation that will be earned by the plan service providers.

The Council is mindful that additional burdens and costs imposed on plan service providers may result in increased plan expenses and reduced participant benefits. The interim final regulations largely strike the right balance between these competing considerations in the retirement plan context and we encourage the Department to strike an appropriate balance in the context of welfare plans.

We appreciate the Department's decision to proceed deliberately and cautiously in considering

whether, and if so, how, to apply the disclosure rules to health and welfare benefits. Health and welfare arrangements tend to involve remarkably different types of services and compensation structures. From retirement plans we commend the Department for observing on welfare plan fee disclosure and beginning the initiative through this hearing.

To set the stage for today's testimony, I will provide an overview of a typical larger employer's health and welfare benefit plans, and mention the type of service arrangements that typically are utilized. Most large employers do maintain a welfare plan that includes a self-insured group health plan. The employer will almost invariably maintain a cafeteria plan to allow the premiums to be paid on a pre-tax basis together with a flexible spending arrangement.

A self-insured arrangement, the employer pays a fee to one or more third-parties, typically an insurer. The third party will generally provide access to a network of physicians in medical facilities, determine claims and appeals, process payments to both providers and participants, address inquiries, provide telephone and web-based tools and maintain records.

In addition to engaging an insurer as a third-party administrator to handle most of the day-to-

day responsibilities relating to the self-insure group health plan, other third parties may be engaged to handle other services such as disease management services, health risk assessment, and wellness programs. Likewise providers may be engaged to provide plan design consultation services, audit and accounting, COBRA processing, FSA administration, and, of course, pharmacy benefit management services.

Although enhanced disclosure requirements may bring increased transparency, with respect to self-insured plans, the Council's members are not aware of any pressing need and, thus, are not clamoring for new disclosure rules. There are two primary reasons for this viewpoint.

First, while it is common for there to be a number of different types of service providers to self-insured plans, these service providers are largely paid on a fee-for-service basis. The service providers tend not to receive indirect compensation or to have complicated compensation structures. The complexity behind DC plan compensation structures as well as a concern about potential undisclosed conflicts of interest underlie the need for enhanced fee disclosure in the retirement plan context, but they don't appear to be features that are as prevalent in the welfare

plan context.

Second, the Council's members' plans are sufficiently large to be provide leverage; the leverage necessary to negotiate favorable service arrangements. The spiraling cost of health care has created enormous pressure to find ways to contain costs and the Council's members do report that substantial information is obtained and used to evaluate service provide arrangements.

For the fully-insured plans, large employers do maintain a suite of fully-insure welfare benefit plan options such as those for group term life, accidental death and dismemberment and long-term disability.

Multiple service providers are typically not engaged with respect to the provision of benefits under a fully-insured plan, although the insurer may engage subcontractors or affiliates to provide certain services, ordinarily the employer only pays the insurance premiums.

There appears to be relatively little utility in requiring insurers to provide new disclosures relating to the compensation they earn in connection with fully-insured plans. Fully-insured plans tend to be transparent in the sense that the premium is the

only compensation the insurer is receiving and the services to be provided are clearly set forth in the insurance contract.

While the Council's members tend not to maintain fully-insured health plans for the vast majority of their employees, although they may for some populations or locations, it is worth noting that this year's health care legislation has changed the landscape. For example, with respect to fully-insured health care plans, new rules do limit the extent to which an insurer can retain premiums where the insurer's medical loss ration falls below specified thresholds. These rules may limit the extent to which insurance premiums can be used to compensation plan service providers, such as brokers.

Although attention is most often given to health plans, both insured and self-insured, there are other insured welfare benefit plans. It is important to remember that employers maintain other types of plans such as severance pay plans. These arrangements are almost invariably entirely paid by the employer and usually do not have substantial third-party service provider involvement. Thus, disclosure appears to be ill-suited to this context.

Due to challenges of providing affordable

health care and welfare benefits coverage in the current economic environment, the Council's members are keenly aware of the possibility that new disclosure requirements affecting welfare plans could increase plan costs and reduce benefits without materially enhancing transparency.

While plan service providers would most likely bear the direct cost of any new disclosure requirements, it is likely that these costs will be borne ultimately by the employer and the employee. Thus, before any new disclosure requirements are imposed with regard to services provide to health and welfare plans, it is critical that the Department consider any new disclosure requirements will most certainly affect plan costs and the level of benefits or both.

The Council's members respectfully request that the Department carefully and thoughtfully identify areas where additional disclosure might provide meaningful support in assessing the reasonableness of plan service arrangements. The fundamental approach of requiring disclosure only where there is a pressing need is the approach the Department took in the context of the interim final regulations. The retirement fee disclosure regulations only apply to service providers

who fall within specified categories. These categories are meant to identify situations where a service provider is in a position to have a material impact on the plan. The compensation structure is complex, or there are potential conflicts of interest.

So, we think about how the regulations would apply to health and welfare plans, we recommend that insurance companies issuing insurance be exclude from the definition of covered service providers as the insurer is merely receiving a premium for services described in the insurance contract. When considering if other health and welfare plan service providers should be included as covered service providers, we suggest that the Department evaluate whether disclosure will enhance the process of negotiating reasonable services arrangements.

The first of the three categories in the interim final regulations covers persons who act in a fiduciary capacity. If covered, these persons must disclose whether they reasonably expect to provide fiduciary services. While we appreciate that rules requiring disclosure of fiduciary status may be appropriate in certain circumstances, we see little utility to requiring disclosure for common services where fiduciary status is apparent. There may be

situations where disclosure of fiduciary status would be appropriate, but we ask the Department to specifically identify them.

The second category, platform providers to participant-directed individual accounting plans, is largely inapplicable to welfare plans.

The challenge is with the third category of covered service provider -- persons who provide enumerated services and receive indirect compensation. This is the category where it is critical to carefully evaluate whether different types of welfare plan services should be enumerated services triggering disclosure requirements. We believe the same standard that was used to develop the interim final 408(b)(2) regulations is appropriate, namely whether disclosure would help illuminate complex compensation structures or potential conflicts of interest.

Apart from striking a careful balance between cost and benefit, I want to stress that the Council's members are very wary of any additional regulatory requirements at this time. This is a period of enormous change and new challenges for health plans in light of the Affordable Care Act. The new legislation represents a sea change in the regulation of health care and large amounts of time and resources are being

spent digesting and implementing these changes. The thought of yet a new challenge on the horizon is disconcerting, to say the least. And if the end result is to trade reduced benefit levels for transparency, the Council's members would much prefer to retain benefits rather than be compelled to receive fee disclosure information that may have limited value.

We suggest that the Department consider waiting until the dust has settled on health care reform before deciding whether to impose new disclosures for health and other welfare benefit plan service providers. Health care reform is leading to innovation and new ways of structuring plan services. Thus, if any new disclosure regulations are to be written, it would be wise to have them designed for the future marketplace, not yesterday's marketplace.

Taken as a whole, the Council believes the enhanced disclosure in the contest of health and welfare plans is appropriate only if it will provide a stronger foundation for negotiating more effectively with plan service providers. There does not seem to be a strong demand for enhanced disclosure and we encourage the Department to carefully identify any perceived shortfalls before creating new disclosure requirements.

On behalf of Honeywell the American Benefits Council's members, I want to thank the Department of Labor for its hard work on this area.

U.S. CHAMBER OF COMMERCE

Eric Keller, Esq., Paul, Hastings, Washington, DC

MR. KELLER: Good morning. Thank you for the opportunity to testify. My name is Eric Keller. I'm a partner and employee benefits attorney at Paul, Hastings, Janofsky & Walker here in Washington. I am testifying today on behalf of the U.S. Chamber of Commerce where I am a member of the employee benefits committee. The Chamber is the world's largest business federation, representing more than three million businesses and organizations of every size, sector and region.

The Chamber and its members appreciate the concern for greater transparency in plan fees and the effort to address these concerns. The Chamber fully supports transparency of expenses and encourages appropriate disclosure of plan fees. However, we do not believe the disclosures required for retirement plans are necessary for welfare plans.

My testimony today will focus on two areas of concern. First, there's no demonstrated need for the application of feel disclosure rules to welfare plans.

Second, promulgating fee disclosure rules for welfare plans will create an unnecessary burden on employers and will likely lead to increased plan costs while providing little to no benefits for plan participants.

Our first area of concern is the lack of a need for addition regulation in this area. We are not aware of any substantive record demonstrating the need for plan fee disclosure in the welfare benefits marketplace. In fact, in 2004, the ERISA Advisory Council studied welfare plan, the Form 5500 issues and did not uncover any glaring deficiencies in he ability of plan sponsors to understand welfare plan costs even with the very limited role that Form 5500 plays in revealing welfare costs. The Council even raised the option of completely eliminating the Form 5500 requirement for welfare plans. Thus, it appears that plan sponsors are currently well informed of welfare plan costs and additional regulation would be unnecessary.

Furthermore, the differences in the operation between welfare and retirement plans make additional disclosure for plan sponsors in the welfare plan area unnecessary. That majority of contracts and policies for welfare benefit plans or services are between the service provider and the plan sponsor and not the plan.

So long as the plan sponsor does not pay fees from plan assets, Section 408(b)(2) does not apply.

Moreover, in a fully-insured plan, the premiums are fully disclosed to plan sponsors and are regulated by state insurance law and now indirectly by the new medical loss ratio provisions of the Affordable Care Act. Commissions and other indirect compensation paid to brokers are already fully disclosed on schedule A of Form 5500.

Service providers to plan sponsors of self-funded welfare plans disclose extensive fee and compensation information at multiple stages of the building and contracting process. For example, in response to RFPs, as part of the contract negotiations, and after post-contract implementation as part of audit and reporting requirements. Consequently, we believe that the way fees are paid and disclosed in the welfare plan do not require the additional disclosure regulations that apply to retirement plans.

Secondly, applying the fee disclosure rules to welfare plans in the current environment would create an unnecessary burden for plan sponsors and likely lead to increased costs. As you are all acutely aware, the Affordable Care Act has created a myriad of changes that are complex that will take many years to

implement for which plan sponsors are currently devoting extensive resources to complying. Attaching additional regulatory requirements at the present time without a justified case for the need, would provide little or not addition benefits for participants.

In addition, the costs incurred by insurers and other plan service providers and complying with these new requirements would likely be passed on to plan sponsors and participants and further increase the health care expenses.

In conclusion, the Chamber does not believe that it is appropriate or necessary to apply the disclosure provisions that apply to retirement plans to welfare plans.

Thank you for the opportunity to testify this morning.

MR. CANARY: I'll start. Maybe a scope question. So there are certain welfare plans that are funded -- engage in investment activity, the multipart plans would be a group that clearly has pretty extensive investment policies and practices. Is that type of activity more akin to pension plan investment activity where the 408(b)(2) rule might apply not so much as a welfare plan, per se, but because those welfare plans are engaged in investments that are

similar to what pension plans are doing?

MR. DeFREHN: Back in the days when there used to be reserves in the welfare plans, you mean? Actually, I think you'll see, if you take a good look at the types of investment policies for welfare plans they're quite different than they are in pension plans because of their short-term nature and they're mostly held in cash equivalents. There's very few arrangements where you'd see the more exotic kind of investment arrangements that the welfare plans get into, as they can with some of the particularly defined contribution incentives.

MR. CANARY: Okay. I think I'm not sure you all are really coming from a funded welfare plan perspective where you would have comments on that question.

MS. KLAUSNER: Honeywell, itself, does not have a multiemployer plan that we have to contribute to on the welfare side of the house. And I'd have to confer with the Council's members to find out how often they have them as well.

MR. KELLER: I would have to confer with the Chamber on its views. Although I will point out my own experience in private practice that most employers that maintain funded welfare plans, you know, because of the

tax limitations on getting deductions that now they're mostly pass-through entities so I share your observations in that area.

MR. CANARY: Okay. Second to last question is, on the disclosures regarding insurance agents and their incentive compensation, I think you made a distinction between independent agents, and I guess it would be captive or exclusive agents or employees of the insurance company. Did you mean to suggest that the disclosure really should be limited to the independent and there isn't a need for similar kinds of disclosures you're dealing with in exclusive agent or an employee of the insurance company receiving incentive comp?

MR. DeFREHN: I think there are certainly incentive compensation arrangements even within a single insurance carrier. But the opportunity for direction in order to in a self-dealing way I think exists more with the independent broker who can direct business to different types of companies and they do so in a way that takes the client away from product that they think they're buying in more to one that the broker would receive the greatest compensation for.

MR. CANARY: And I got the impression that neither one of you believe that additional upfront

disclosure regarding that sort of compensation should be required as a regulatory matter?

MS. KLAUSNER: I would agree that we are not looking at it as necessary for a regulatory matter. I think we look at it as part of the process that fiduciaries must engage in. And depending upon the breadth of the benefit and issue, the number of lives perhaps being covered, the benefit being provided would determine, you know, what process is engaged in. How much detailed information is necessary to make an appropriate choice as to what insurance carrier, perhaps, to use to pay the benefit when it becomes due. Which insurance carrier perhaps can actually process claims and maintain records and interface with your systems? You know, which insurance company you have the confidence in if you're dealing with something that is relatively simplistic, you might be able to do it with a little transparency. You know you're buying a $1,000 benefit for a dollar that may be all you need, you know, basic information. If it's something more complicated, you might need to engage in a process whereby you in fact get more information.

But, again, that's a matter of satisfying your fiduciary requirements as opposed to filling out a checklist that you ask for certain information through

a disclosure document.

MR. KELLER: I'd agree that there is no additional need for disclosure in this area. Particularly in the premiums for brokers, indirect compensation, that's typically an area where the plan sponsors, it's part of doing its due diligence and exercising its fiduciary obligations would ask, you know, questions regarding the premium rating that the agent is going to receive. And that's information that, you know, is already currently available in the marketplace and would be disclosed as part of any competitive bidding situation.

MR. CANARY: Thank you.

ASSISTANT SECRETARY BORZI: I have a few questions. First, Ms. Klausner, I think both you and Mr. Keller talked about how increased transparency wasn't necessary for fully insured plans because you just play the premium. How do you know that the premium that you're paying is reasonable?

MS. KLAUSNER: We do go out there and bid. We put it out for an RFP or an RFI and identify what opportunities are out there. And like with other discussions that we've had with the Department on fees, we're not only concerned with whether or not, you know, we're getting the lowest premium for the thousand

dollar life insurance benefit or per thousand dollars. We're concerned as well about their ability to interface with our systems, to in fact maintain the records to pay the benefits when they're due, and of course, to be a company that will be around and available to pay benefits, you know, in the future, you know, through rating agencies or other mechanisms. So it's not a matter of knowing whether or not the fee that we're paying and the premium is the only fee they're getting, it's a matter of whether the fee we're paying will in fact purchase the benefit that we intend to have for our participants for our employees, and whether or not that benefit will in fact be available at the time that it needs to be paid.

ASSISTANT SECRETARY BORZI: Yeah, I was more thinking about in the health benefit context rather than these other benefits?

MS. KLAUSNER: In a health benefit context, you know, like I said, we have relatively few fully insured plans. And I think the Council's members have relatively few, again, compared to the fact that we are, you know, a big player, you know, in the self-insured market.

And, again, our concern is to say, you know, we have a plan design and we need to know that there is

somebody out there. And, you know, we start with, and I think I mentioned this at a couple of other fiduciary-related hearings, the first place to look is the plan design. And that is something that is in the purview of the plan sponsor. So the plan sponsor comes up with a design. We need to then have it bid out as to whether or not somebody can support paying benefits under that plan design. And as to whether or not, you know, they, the insurer, you know, build the ability to be profitable and pay our plan design benefits. Whether they go out and buy tires from, you know, the ABC Company or, you know, the XYZ Company or whether they do it in-house as long as they can do it and do it well, then we're comfortable regardless of whether our premium is the only fee or whether or not there are other compensation arrangements underneath.

ASSISTANT SECRETARY BORZI: Mr. Keller, the Chamber obviously represents millions and millions of small businesses as well. And I can see how Honeywell can do this, but can you speak for a minute to how the small business owner knows that the premium that they've been quoted is reasonable?

MR. KELLER: Well, the clients for whom I have represented over the years which include many small businesses, I mean they will frequently work with

their broker. The broker goes out and obtains quotes from a variety of insurers based on the design of the policy or the plan that the employer wants and it just as with a larger employer that has a self-funded plan, it's a competitive process. And the premium, you know, quoted, you know, sometimes vary, but if -- you know, if the client is interested in analyzing why a particular premium is more for a particular policy level of coverage, I mean, they could make inquiries as to that. But, I mean, it's just as with any other aspect of the employer going out and buying a service, typically the employer is not going to call the broker and say, hey, I want one quote. I mean I -- and even -- and we all -- certainly there are some businesses that aren't as sophisticated.

ASSISTANT SECRETARY BORZI: I understand, but how do you know that the five quotes that you get are reasonable?

MR. KELLER: Just with anything in the competitive marketplace. I mean, you would -- I guess I think you're asking like, how do you go behind the curtain to know like what's the margin that --

ASSISTANT SECRETARY BORZI: Yeah. I mean, basically what you're saying to me is you just -- whatever is bundled in the premium, you have no way of

unbundling it so you just have other ways to compare; is that right?

MR. KELLER: Well, you certainly could ask, you know, what's the loss ratio. You could as ask for that type information. I mean, I think it's something that in a smaller employer they'll probably rely typically on their broker, but the broker will go out and solicit bids from multiple insurers.

ASSISTANT SECRETARY BORZI: So presumably the rule on the Affordable Care Act that requires disclosure of minimal loss ratios, the MLR --

MR. KELLER: Absolutely.

ASSISTANT SECRETARY BORZI: -- is going to be very helpful in getting the kind of information the plan sponsors need.

MR. KELLER: Absolutely.

ASSISTANT SECRETARY BORZI: Okay. Let's switch briefly to the self-insured marketplace. Ms. Klausner you said that generally you pay a fee for service in the self-insured marketplace. And I think I'm quoting you correctly, that the service providers that you deal with quote/unquote, "tend not to have indirect compensation." Obviously some of them do, like PBMs. So tell me, you know, your company is one of the biggest in the marketplace, so tell me how you

get information from PBMs and what kind of information do you think as a plan sponsor you need to be able to make the comparisons? And tell me about your experiences in getting it.

MS. KLAUSNER: Our experience is that with our current provider, before we engaged in going out for a bid, with our current provider when we would just renegotiate for, you know, the next contract term, we actually do in fact ask the information. We ask what are all the rebates, and we ask for all the pass throughs, and by all the different varying names that they come through with. Once we understand as many of them as we can, we determine whether or not we're going to negotiate for all of those to be passed through to ourselves.

So, similar to the defined contribution plan fee discussions that we've had given Honeywell's size and the number of lives that are covered, we have been able to successfully go down the path whereby number one, services are unbundled, even in the PBM arena; and number two that there is either no revenue sharing or that any revenue sharing is in fact incorporated into the fee structure so that ultimately it is clear and comes back to the plan or to the employees.

ASSISTANT SECRETARY BORZI: And do you audit

the PBMs?

MS. KLAUSNER: We have the ability to audit and we do, do some auditing at a high level to make sure that we do believe there's a reasonableness in the calculation of things such as rebates.

ASSISTANT SECRETARY BORZI: So what kinds of things do you audit?

MS. KLAUSNER: We audit, as somebody else mentioned on the last panel, at the aggregate level. Part of the concerns are ensuring that we marry all of these ideas with things like HIPPA. I mean, we do recognize that obviously there's confidentiality provisions and BAAs and, you know, just so many different layers that get built into. By the time it comes back to me, the employer, I mean, we just have, you know, a high level of confidence that the information has been processed correctly and that rebates have passed through correctly.

ASSISTANT SECRETARY BORZI: Are there people who specialize in auditing PBMs?

MS. KLAUSNER: Well, this has been an area which has proved to be complicated and complex to in fact put into place. And the primary reason that I am aware of in the industry, you know, from an industry perspective, not necessarily a Honeywell perspective,

is that PBMs are reluctant to have auditors who may in fact have engaged or will engage in litigation against them. And, therefore, you know, there is a balance that is difficult to strike in negotiating --

ASSISTANT SECRETARY BORZI: It's virtually impossible to find an auditor then?

MS. KLAUSNER: I'll stick with, we're challenged. Well, you're challenged to find an auditor that is sophisticated enough to really be able to work through the varying type of -- I'll just call it -- rebate situations, or, you know, wholesale situations where data and dollars are passed back and forth. So it is an area of challenge. And I think that at the end of the last panel, Mr. Doyle, you suggested that the PBM needed its own hearing and I do agree. As I said in my testimony, as a general matter, the Council's members don't see that in the health and welfare community we need a whole lot of regulation to help us make sure that plan designs are in fact supported through reasonable contracts. Because that's why the goal was here, do we need regulation to allow for us to have reasonable service arrangements and contractual provisions to support those arrangements? And it may not be wholesale that we need them and there might be areas that the Department can specify. And

although I haven't delved into it enough to know for certain, perhaps PBM is an area in which you might want to look a little more closely.

ASSISTANT SECRETARY BORZI: So do you, when you put out your RFIs for service providers, do you have a question that you regularly ask about whether or not they get other forms of compensation?

MS. KLAUSNER: Yes, but I'll actually go back one step and to identify that because there are so many dollars involved, not through a funded situation, but still so many dollars that get moved around in terms of supporting PBM as well as, you know, other health care that we start with actually an RFP for a consultant.

ASSISTANT SECRETARY BORZI: Ah, and so it's your consultants who ask those questions?

MS. KLAUSNER: Well, we developed together as a partner, you know, the actual RFP and the questions and the scoring methodology. But some of the things that are included in this was in our defined contribution RFP that we did a handful of years ago was that there were questions that were geared toward the provider, the winning provider would agree to be able to satisfy, you know, the 408(b)(2) rules as they are today and as they begin to be developed, and as we reasonably interpret them so that the goal to be that

we partner towards compliance, not just generally, but under 408(b)(2) rules.

So, yes, we do have a consultant who will first have to agree, of course, to, you know, look at the whole marketplace that's reasonably large enough to support a client like Honeywell and then we help them develop the RFP and then everything, of course is scored blind and we have all kinds of confidentiality provisions. The goal is really, again, process, process, process. And we make extremely clear to all those who hear about it, as well as all those who are involved in it, that, you know, the bottom line fee, the bottom line number is not necessarily the winning factor. It is a factor, but it is not the winning factor.

ASSISTANT SECRETARY BORZI: Again, focusing on the PBMs, how tough is it for you to get them to give you some of this information and allow you to audit?

MS. KLAUSNER: It is a challenge. It is absolutely a challenge. I will also say that part of the challenge is that it had historically been so complex before some of the litigation that was settled over the last number of years. So, again, like with, you know, the Affordable Care Act and the goal toward

saying that if regulation is appropriate in certain areas, let's let some of the current dust settle so we can identify what would be most appropriate allowing some of the new legislation to work its way through the marketplace to innovate and then see what we need.

Well, the same thing with the PBM industry. You know, there was all the big litigation. There were the settlements. We're still going through a process of change. And one thing that we have to be very cognizant of is that we don’t want to not only squash innovation in terms of delivery of pharmaceutical benefits, we don't want to squash the innovation of pharmaceuticals as a whole.

And I'm not here to testify on, you know, the pharmaceutical business, but, you know, in discussions it's become very apparent that, you know, the reason the United States is set up one way and you know, other, you know, Canada or some of the European countries are set up another way have varying reasons. But the outcome may impact pharmaceutical innovation. And if our ultimate goal is to ensure that people have health care we want to be very cognizant of not only having plan designs, have reduced benefits or plan designs and not have increased costs, we want to make sure that there's actually health care.

And that brings me to like a comment back to your fully insured. Perhaps, you know, the members of the Chambers of Commerce do not know everything that goes into whether or not the premiums for a fully insured plan are correct or reasonable. But they can get some information from general survey to know that they're in the ballpark and a reasonable ballpark. And if we put too much emphasis on creating disclosure and too much emphasis on increasing costs, we may move some of these insurers out of the marketplace and find again that we're in a situation where the law requires everybody to have health insurance, but there is no health insurance to be obtained.

ASSISTANT SECRETARY BORZI: Sure.

MS. KLAUSNER: And, again, just very sensitive and I don't know where that line is drawn but be very cognizant of the impact of additional regulations on the ability to have health care which is the ultimate reason why we want to have reasonable contracts.

ASSISTANT SECRETARY BORZI: Okay. Mr. DeFrehn, I take it that -- well, I know that a lot of the multiemployer plans are very large as well. Have you had the same series of experiences with the PBMs? I take it from your testimony no.

MR. DeFREHN: Well, I've seen -- excuse me. In the multiemployer space there's been a lot of consolidation in the purchasing of pharmaceutical benefits over the last 20 years. There are large purchasing coalitions that are all over the country. A number of individual international unions have gone back to their individual local unions and aggregated those groups and asked them to join in, in a kind of vertical coalition. And what I've seen there is that it's pretty consistent that the information necessary for the consultants -- the same kind of consultants that Allison is using -- to do the kind of adequate job in evaluating exactly what they're paying for is extremely difficult to come up with a good number. It's like grabbing the balloon in one place, you might get ahold of it here, but it's going to pop up somewhere else. And it's very difficult to really take a look at all of the different sources or income without at least having some requirement for them to be able to get that information whenever it's requested.

I think just one final comment along that line. I think Allison had mentioned in her testimony about looking at specific services when we were talking about application of these rules to welfare plans broadly. I don't necessarily believe that it is

necessary to have them apply to all types of welfare plans broadly, but I do think that in areas where there are instances where there is substantial indirect compensation and where there's substantial opportunity for self dealing and other conflicts of interest, I think those areas in particular are important to focus your attention on and I think we would all be in agreement there that we need to make sure that we are getting what we think we're paying for.

ASSISTANT SECRETARY BORZI: Okay. I think I'll stop because I want to give my colleagues some time as well. I know, I'm the one who has to leave.

MR. DOYLE: I was going to say, feel free if you have to go to your next meeting.

MR. HAUSER: Maybe this will be my last question on PBMs. I sure hope so.

(Laughter.)

MR. HAUSER: If either of you or anybody on the panel can explain to me what is meant by the auditing as done on the aggregate basis, because I think that's what Mr. Kilberg said on the previous panel 2, I guess I don't understand what that means. When you say the auditing is done in the aggregate basis does that mean there isn't a sample taken, for example, of the invoices on the prescription drugs,

that you don't see the actual contracts? How does one audit something on an aggregate basis in this context?

MS. KLAUSNER: I think at a starting point we wanted to make clear that they are not necessarily going down to, you know, the local pharmacy's receipts. Okay. So we're not looking at the local pharmacy receipt for, you know, Allison Klausner who needed X drug on December 7th. So, you know, that already is going to be an aggregated number leading up. So what's happening is, you know, the whole -- all of the use for Lipitor or some other, you know, drug that's used, you know, at a large level will be looked at in the aggregate to determine whether or not they've dispensed, you know, I don't even know the numbers, you know, 100,000 pills in the month and they've dispensed them at the mail order level and then there's contractual relationships with wholesale suppliers or drug manufacturers that they take at, you know, a monthly level or a drug-type level as opposed to going down into receipt by receipt down to, you know, this particular pharmaceutical distribution house, you know, in Illinois sent out certain drugs versus the one that's located in, you know, Arizona, or the one in Maine.

So there's a much higher level. We're not

going down to the participant experience and building up.

MR. HAUSER: Do you have anything to add, anyone else?

ASSISTANT SECRETARY BORZI: I'm sorry, I'm going to have to leave. Thank you so much.

MS. KLAUSNER: Thank you, Ms. Borzi.

MR. HAUSER: And maybe just one more question for you, Ms. Klausner. As I understood the American Benefit Council's point of view, and the Chamber's too, I guess, a lot of it was that you don't think there is much indirect compensation in this context and so we don't have the same concerns as in the pension world. Second, that with the Affordable Care Act, people have their hands full and that imposes a lot of complexity already, don't add to that. But in those circumstances -- well, putting aside for the moment health plans, when we're talking about life insurance plans, disability plans, all the different kinds of plan arrangements that aren't governed by the Affordable Care Act, and don't have new obligations imposed upon them, in those contexts and in circumstances when we know there are species of indirect compensation, for example, with respect to brokers and agents, and the like, why shouldn't we mandate simple disclosure of

what the indirect compensation is in those arrangements? Does ABC have a view on that?

MS. KLAUSNER: I think I'd have to consult with the Council, you know, to ensure that I represent the Council as a whole. But, again, on the larger employer level, even in the fully insured life insurance or the AD&D context, we're not necessarily even using a broker. You know, we have already developed relationships and resources where we can go out and do an RFI and find out, you know, how many cents per dollar to get, you know, life insurance on a very large body of lives. And, you know, then we can determine, obviously, very simply, you know, how many pennies difference each insurer is going to offer us and then determine again, once again, how it till fit into our total benefits scheme in terms of being able to provide the benefit and the simplicity.

On the small employer market, you know, I do have emphasize that although they may use a broker and the broker might get some form of a fee or the broker may have a smaller window into the availability of opportunities to purchase the life insurance or the AD&D, we don't want to be in a position where our friends who are small employers are priced out of the market because there's so much added burden as a result

of making sure that disclosure meets a certain requirement.

MR. HAUSER: Well, obviously we don't want to price people out of the market, but just in focusing on that small market for a minute, I mean, if -- we've seen -- we have certainly -- I don't know what counts as evidence in this area, but we have certainly seen circumstances in which small employers, mid-sized employers have used RFIs and have appealed to brokers and those brokers received undisclosed compensation from various carries and their decision making seems to have been affected by that compensation they were receiving, both in terms of who they were including in the bid process and in the way they presented the bid to the ultimate plan consumer. And so, I guess the question is, if we know, if we've seen examples of this kind of disclosure, or this kind of problem, what is it that you think kind of argues against mandating just a flat disclosure -- and it's something apparently Honeywell negotiates for when it's dealing with its people, it wants that disclosure. So why would we -- and that doesn't drive people away or keep them from competing for Honeywell's business. So why should we have a concern that just requiring that when a plan is dealing with a broker, an agent, a consultant, someone

putting together an RFI that they disclose if they've got money in it that's coming from a third party and not in addition to what's coming from the plan. And if there is something empirical that would tell us what those numbers look like, or that they're actually even approaching a level where they might drive somebody out of the plan business, I would invite you to offer it to us. But go ahead, what --

MR. KELLER: Well, I'd have to consult with the Chamber to get its views. But I think as a general matter, you know, all these issues go to the consumer behavior of the fiduciary. So the fiduciary, the plan sponsor is making their decision in terms of what policy to procure. And just like any other purchasing decision, companies know that to be a good purchaser you should ask the right questions. You should understand who you're dealing with, what their background is, what's their experience.

We create tips all the time for every conceivable situation and certainly I am sympathetic to the fact that your inclination is, why wouldn't we do the same here? But it is an area where there is already information available to the purchaser, even a small purchaser, who wants to know what his market rates for my area, or my life size, and it's just like

any other component of their business, we don't regulate, you know, when they want to go out and buy a truck, who they've got to -- what type of disclosure the agent who is selling him the truck has got to give. And so, at what point in terms of creating regulations are we just creating more regulations than really are necessary for the perceived need.

MR. HAUSER: Well, I agree with that, but, you know, when I bought my car recently there actually was a fair amount of mandated disclosure. And it's just a question of what kind of disclosure should be required? And I guess the argument on the small employer side of it is, well, Honeywell's in a position to insist upon this level of disclosure. The small employer may not be. You know, a small plan, they're dealing with a broker, they think they're getting advice that's in their interest and that isn't influenced by anybody else, but they're not really in a position to get disclosure of what these numbers are, whether it's something to be worried about or not. And, you know, yes they know approximately what the market price is, but they don't -- they're looking for guidance on how to select. And as Ms. Klausner pointed out, it's not just about price, it's about price, it's about the level of services, it's about many things.

And if the person that's advising them on how to weigh all of those many things has a financial incentive that's being paid by somebody other than the plan, why shouldn't we just require them to disclose that and what's our basis for believe it would cost anything much?

MS. KLAUSNER: I mean, one of the -- my reaction in listening to your description about what might be the ill that we're trying to remedy is that disclosure may not be the right remedy for that ill. So if I'm a small employer and I get information that, you know, Eric the broker is only charging me 70 cents because he can get his other 20 cents from the insurance carrier if I in fact pick it, because it's his brother-in-law and he can spin some wonderful story, so long as the insurance product that he's providing for me to consider is as good an insurance product as the other ones for which there is no, you know, relationship in terms of self-dealing, I'm not sure I as a small employer care. I think the ill is that the broker needs to be held to a standard of integrity. And whether that integrity is something that is held under a fiduciary standard or a business standard is not one that, you know, I as Allison, or I as Honeywell, or I as a member of the American Benefits

Council can really opine on.

MR. HAUSER: But what's the Chamber and ABC's view on holding brokers to fiduciary standards?

MS. KLAUSNER: That is something I would absolutely have to go back and discuss. But for the context of this hearing, for this hearing where we're asking whether or not we should be mandating disclosure for purposes of making sure we can satisfy the reasonable contractual relationship, the arrangements for the service product through a reasonable contract, will disclosure help us get there? Because as a small employer I may not even understand, because, again, the same sophistication that I may not have and it does not mean that small employers hire less sophisticated people, but there's going to be less resources to tap in expertise for everything.

MR. DOYLE: I think we're struggling kind of with the same issue here. And I take your example at the end of the day, the small employer may not care that, you know, the broker is getting X amount of dollars or whatever in commissions in a related kind of party-type deal.

But I guess we're struggling with whether -- if I'm a small employer, I might be able to use that information, at least, and that's kind of the approach

we took under 408(b)(2), whether it makes a difference at the end of the day, at least if I had the information I could think about it. I could think, you know, there is some, maybe they're getting a commission from one company and while its product may be good or at least even better than one that they're not getting the same amount of commission from or no commission from, at least I could factor that into my analysis of, you know, is there something more to that recommendation or not?

MS. KLAUSNER: So perhaps an alternative to consider is not mandating disclosure, but instead educating small employers on how to satisfy their fiduciary duties.

MR. DOYLE: Well, that is definitely an option. I think one of the beauties or benefits of pursuing the 408(b)(2) framework is that it doesn't put the burden solely on the small employer who may be suffering from a lack of leverage or even knowledge about what they should be doing as a prudent fiduciary. But it kind of shares that burden with the service provider and maybe a consultant or broker in this case, to participant in that process.

In any event, and, again, kind of following up if we take kind of a narrow view and I don't know

that a whole, broad disclosure regime makes a lot of sense or is necessary with respect to a lot of products in the welfare plan area, but I am struggling with the conflict of interest issues that do come up, particularly in the mid- to small-employer communities that are wholly reliant on brokers, accountants, what have you, in terms of the operation of their plans and whether there's something more we can or should do in that regard.

Maybe I'll turn to Randy a little bit, and say, you know, again, if we were to focus on specific areas where there might be challenges for the plan sponsor, what would those be?

MR. DeFREHN: I think you already said them, Bob, it's the areas where there are areas of substantial indirect compensation and opportunities for conflict of interest. Those are the two biggest areas and I think we've been talking about them today. It's the commissioned and non-commissioned kind of other compensation that we just went through and the PBMs where things are just really fuzzy. But those are the areas I would focus on rather than saying, you know, broadly speaking all welfare plans have to go through the same kind of --

MR. DOYLE: Well, I'm tempted to follow up on

the commission because I mean, I think -- at least we've tried to do a lot of work on the Schedule A and I'm assuming since you're saying "commission" you kind of agree with some of the earlier parties that testified that, you know, prospective rather than retrospective --

MR. DeFREHN: Yeah, that's exactly the --

(Simultaneous conversation.)

MR. DOYLE: -- helpful --

MR. DeFREHN: You can't make a decision --

MR. DOYLE: But I am curious, what do fiduciaries ask now? I mean, they know most of the time when they're engaging an agent or broker that there are going to be commissions and all, do they not make those inquiries or --

MR. DeFREHN: It's size driven. I think we will all agree with that. The larger funds, the larger companies are all sophisticated enough and employ enough experts to be able to get down into the weeds. The middle-size groups are trying to balance the cost against, you know, what they get and they're trusting their advisors even more.

When you get into the smaller group, people are completely in the hands of the experts and they have an insurance dealer/broker they've dealt with,

they buy their auto insurance, their homeowners insurance with him, so obviously this guy is an expert in all aspects of insurance, therefore I can turn over my -- you know, my business and I know this guy is going to take care of me. I have no idea what questions to ask. And as a place with 15 employees or 30 employees or even 150 employees most of these guys are worried about running the business and not worried too much about it because they know this guy is going to take care of them.

If we at least put out there up front, oh, by the way, yes, I do get paid commissions which help offset your costs or may not, but may be additional revenue. But there are other areas as well that I thought that you should know about that if I work with this company, this company, and this company they also give me other forms of compensation. And I find out that the only ones that are on my bid list are the three companies that give him some other kind of compensation it may raise some red flags.

MR. DOYLE: Joe, any questions?

MR. PIACENTINI: I think I'll ask just one. I think I'll ask just one. So I've heard from at least two of the witnesses that, you know, there is a lot of concern about the cost of disclosure. And it sounded

like you were talking mainly about the administrative costs of the disclosures, just having to get the information and hand it over that there is some cost of that. And I understand that.

Across the day we've heard some people say that there are other perhaps larger financial stakes on the table. You know, if we talk about the size of PDM rebates or the size of broker commissions, these are larger amounts probably than these administrative costs. So what I'm inferring then is that you think either that in fact those things are not a problem or that those things can be a problem but that disclosure wouldn't fix it.

MS. KLAUSNER: I think I'll go back to perhaps restating what I had intended to try to convey before which is on the larger employer market those things aren't important. However, we have the leverage and the expertise to actually ferret it out without regulation. Just understanding our fiduciary obligations to understand, you know, what it is that we're purchasing, you know, how those views are coming together, how all the costs are moving and what product or what's actually provided as a benefit.

MR. PIACENTINI: So the market can fix it --

(Simultaneous conversation.)

MS. KLAUSNER: The market on the large side. On the large side. On the smaller side, I think we're finding that the question is whether or not you're improving the opportunity to have benefits. And on the health insurance side, specifically, as opposed to the out-of-the-life AD&D goal, whatever, you know, we'd like to see how the medical loss ratio rules take care of some of that issue. Again, understanding that as a general matter for every dollar you spend 85 cents need to go to providing health care and I realize there's a lot of gray there and a lot that needs to be worked out. But let's let that work out. So if a company understands that they have a plan design that's intended to cover certain things, fully insured, and that for their premium every 85 cents will go there, they know 15 cents is going to helping the insurance company or anybody who they work with to make this process smooth will go to other things, or profit. I'm not sure they need any other information.

MR. KELLER: I mean, if the concern is margin, what's the margin? Because it seems to me that's part of the -- we're talking about medical loss ratio. We're talking about how much of the premium dollars are effectively being used to deliver benefits rather than being kept as profit. And so if your

question is, you know, how far should we go in terms of making sure that insurers, other folks in this space aren't making too much money off, I mean, it seems to me that's not -- that's not really because even in the retired plan context, if you have a TPA or somebody like that who pays -- you pay a flat fee based on the number of participants, it's not like we pull it behind the curtain and ask, well, how much are you really making based on that administrative fee? I mean, we don't -- so, I mean, I understand the focus on understanding in terms of like loss ratios and things like that and maybe it's because it's of the Affordable Care Act and the new focus on that, but to say that now we want to know what is the line of the questions were on the PBM side in terms of other products, am I being gouged, am I being charged too much for this service?

I mean, I understand the concern, but we don't even do that in the retirement plan context. We don't go into each specific service that the TPA has entered and say, are you gouging this person. I mean, it's all based on disclosure of what the fees are and is it reasonable based on the marketplace?

MS. KLAUSNER: If I could just comment to just show another side unlike perhaps the Chamber's members. You know, Honeywell, as well as I think

substantially if not certainly close to all of the Council's members do actually pull back the curtain on the defined contribution side and ask for, you know, all of the different services that are being provided, you know, what is the fee, and if we don't need that service, can we drop that fee?

On the smaller employer side, where it's more of a bundled service on the DC side, they might have to look at more in the aggregate because again it's just, you know, less flexibility and less leverage. So, again, that's sort of the same distinction that I think we're finding, perhaps imperfect comparison on the self-insured which tends to be the large employer market and the fully insured health care which tends to be the small to mid-sized market.

MR. DOYLE: Okay. Thank you. I have one follow up. I mean, we have a fairly broad representation of the plan sponsored community here and at the risk of asking you to just disagree with your own testimony, to some extent, if there are areas whether it be PBM or the brokers or the consultants who are receiving multiple compensation from various parties, if there is a specific area where you believe that the Department in a very narrow defined way can provide some assistance to ensure that fiduciaries get

the information they need to take into account conflicts of evaluate the reasonableness of the compensation I invite you to share those with us. I mean, I think we have an opportunity to do something constructive, and I don't think it's our interest in doing something that's not constructive or that's going to result in unnecessary costs or burdens or cause entities to go out of business or redefine the industries. But if in some small way there's something we can do to facilitate the process of selecting service providers more by plan fiduciary as I think we'd like to do that and we invite your input.

MS. KLAUSNER: I think if you look at it, you know, from, you know, the smallest concern to, you know, the areas in which it's worthy of evaluating -- you know, I mentioned severance pay plans, like let's not forget that if we use the concept of welfare plans we could be very, very broad. So I don't think anybody has expressed an interest no matter where you fall in this world.

MR. DOYLE: Exactly.

MS. KLAUSNER: And then we've talked about, you know, the health care, you know, the more simple health care environment of, you know, fully insured versus self-insured and we've expressed why that might

not be, you know, favorably, you know, received.

The one area that you discussed, you know, at great depth both in the panel that preceded us as well as, you know, in this panel is in the PBM industry. And I think that it's unique in that there is multiple levels in the distribution channel to get to the point of actual receipt of benefits by an employee or participant.

If I need, you know, something non-pharmaceutical in health care there could be levels, but generally, you know, I go to a facility and they use the x-ray machine and perhaps they owe somebody on the lease for the x-ray machine, or they own it and they have to pay it back. So I think that the multiple levels of the distribution --

MR. DOYLE: Well, I invite you to think about it and if you have thoughts, please share them with us.

With that I'm going to thank this panel.

I'm going to remind everyone that we are going to keep the hearing record open for those who want to supplement either their testimony from today or others who have not had the opportunity to testify, we welcome whatever input they would like to share with us. We will leave that record open until January 7th and we will post all the submissions on our web site so

that it will be public.

With that, I want to thank everyone who has participated and thank you for your attendance.

And we are now officially adjourned.

[Whereupon, at 1:09 p.m., the meeting was adjourned.]

C E R T I F I C A T E

This is to certify that the foregoing proceedings of a meeting of the Employee Benefits Security Administration, U.S. Department of Labor, held on Tuesday, December 7, 2010, were transcribed as herein appears, and this is the original transcript thereof.

_____

LISA DENNIS

Court Reporter