PREPARED ORAL REMARKS OF

ALLISON R. KLAUSNER

ON BEHALF OF

THE AMERICAN BENEFITS COUNCIL

FOR THE

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

December 7, 2010

Good morning. My name is Allison Klausner and I am the Assistant General Counsel – Benefits for Honeywell International Inc. Thank you for the opportunity to speak with you today on behalf of the American Benefits Council. The Council is 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 would like to begin by commending the Department of Labor 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, plan fiduciaries must have meaningful information about the services that will be provided and the compensation that will be earned by the plan service providers.

At the same time, 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 Council believes the interim final regulations largely strike the right balance between these competing considerations in the retirement plan context. We also encourage the Department to strike an appropriate balance in the context of welfare plans.

We greatly appreciate the Department's decision to proceed deliberately and cautiously in considering whether, and if so, how, to apply the disclosure rules in the interim final 408(b)(2) regulations to health and welfare plan services arrangements. The Council strongly supported consideration of health and welfare plan fee disclosure on a separate track from retirement plan fee disclosure as health and welfare arrangements tend to involve remarkably different types of services and compensation arrangements, and very different legal structures. We commend the Department for reserving on welfare plan fee disclosure and beginning the initiative by first gathering information through this hearing.

* * * * *

We thought it might be useful to begin by providing an overview of a typical large employer's health and welfare plans, and mention the types of services arrangements that are utilized in these plans. As we think about fee disclosure in health and welfare plan services arrangements, a distinction can be made between fully-insured and self-insured arrangements.

Self-Insured Plans

Most large employers maintain a welfare plan that includes a self-insured group health option for most of their employees. This plan typically includes major medical coverage and may include dental and vision benefits. The employer will almost invariably maintain a cafeteria plan, to permit the employees to contribute to the plan's premiums with pre-tax dollars, together with a flexible spending account (FSA).

For the major medical plan option, employers generally share the cost of the plan with employees by contributing a portion of the premium.

As 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 and medical facilities, determine claims and appeals, process payments to both providers and participants, address inquiries via telephone or web-based tools, and maintain records. Generally, the premiums are not held in a trust or separate vehicle and claims are paid from the employer's general assets (which also hold amounts attributable to employee premiums) by way of a bank account that is dedicated to payment of claims.

In addition to engaging an insurer as a third-party administrator to handle most of the day to day responsibilities relating to the self-insured group health plan, other third party providers may be engaged to provide a variety of different services. Plans may, for example, engage service providers to handle disease management services, health risk assessments, and wellness programs. Likewise service providers may be engaged to provide plan design consultation services as well as services relating to audit and accounting, COBRA processing, FSA administration, and pharmacy benefit management services. Generally, a number of different service providers are engaged to provide the various services.

Although enhanced disclosure requirements may bring increased transparency, with respect to self-insured plans, the Council's members are not aware of a pressing need and, thus, are not clamoring for, new disclosure rules. We believe there are at least 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. In our experience, it is relatively unusual for the service providers to receive indirect compensation or to have more complicated compensation structures. The complexity behind defined contribution retirement 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. Those features do not appear to be as prevalent in the welfare plan context.

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

Fully-Insured Plans

Large employers also typically maintain a suite of fully-insured welfare benefit plan options. These plan options include, for example, group term life, accidental death and disability (AD&D), and long-term disability insurance.

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 (*e.g.*, claims processing) the employer ordinarily pays only the insurance premiums.

There appears to be relatively little utility in requiring insurers to provide new disclosures related 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 also worth noting that this year's health care reform legislation has changed the landscape. For example, with respect to fully insured health care plans, new rules limit the extent to which an insurer can retain premiums where the insurer's medical loss ratio falls below specified thresholds. These rules may limit the extent to which insurance premiums can be used to compensate plan service providers, such as brokers.

Other Welfare Plans

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

* * * * *

Due to the 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 passed along to plans and borne by both employers and employees. Moreover, procedures will need to be developed for gathering and reviewing any required disclosures. Put simply, before any new disclosure requirements are imposed with regard to services provided to health and welfare plans, it is critical that the Department consider that any new disclosure requirements will most likely, if not most certainly, affect either plan costs or the level of benefits provided, or perhaps 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 services arrangements. This fundamental approach of requiring disclosure only where there is a pressing need is the very approach the Department took in the context of the interim final 408(b)(2) regulations. The retirement fee disclosure regulations do not apply to every service provider. Rather, the retirement fee disclosure regulations only apply to service providers who fall within one of the three specified categories. These categories are meant to identify situations where (1) a service provider is in a position to have a material impact on the plan, (2) the compensation structure is complex or (3) there are potential conflicts of interest.

As we think about how the 408(b)(2) regulations would apply to health and welfare plans, we recommend that insurance companies issuing insurance be excluded from the definition of covered service providers. In this type of situation, 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, for example, where a third-party exercises discretion in processing claims. Mandated disclosures in such a context will not enhance transparency for the plan fiduciary and will merely add to the cost of plan services. It is possible that there are other situations where disclosure of fiduciary status would be appropriate but we

encourage the Department to specifically identify those situations, rather than broadly require disclosure any time a fiduciary service is involved.

The second category – platform providers to participant-directed individual account 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, which trigger disclosure. We believe the same standard that was used to develop the interim final 408(b)(2) regulation is appropriate, namely whether disclosure would help illuminate complex compensation structures or potential conflicts of interest.

We have heard some testimony today about brokerage services and pharmacy benefit management services, as well as good arguments on both sides of the question as to whether providers of these services should be covered. We encourage the Department to continue to gather information for the purpose of deciding whether enhanced disclosures would help employers evaluate competing providers and the reasonableness of services arrangements.

* * * * *

Apart from striking a careful balance between cost and benefit, I want to stress that the Council's members are wary of any additional regulatory requirements at this time. As we all know, 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 or no practical value.

We suggest that the Department consider waiting until the dust settles on health care reform before deciding whether to impose new disclosure requirements for health and other welfare benefits 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, rather than yesterday's marketplace.

* * * * *

Taken as a whole, the Council believes that enhanced disclosure in the context 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 requirements and we encourage the Department to carefully identify any perceived shortfalls before creating new disclosure requirements.

Finally, the Council notes that, to effectively implement any new disclosure requirements, additional guidance would need to be issued. Since the interim final 408(b)(2) regulations only apply if plan assets are used to pay for plan services and welfare benefit plans are generally not funded through a trust, it appears that the Department would need to issue guidance on when payments should be viewed as made from plan assets.

* * * * *

On behalf of Honeywell and all the members of the American Benefits Council, I want to thank the Department of Labor for its hard work on this project and all of the fee initiatives that it has developed in the last few years. We look forward to working with you on this important matter.