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December 6, 2010

Phyllis C. Borzi
Assistant Secretary of Labor
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Ave NW
Ste S-2524
Washington, DC 20210-0001

Re: Reasonable Contracts or Arrangements for Welfare Benefit Plans
Under Section 408(b)(2) – Welfare Plan Fee Disclosure

Dear Assistant Secretary Borzi:

America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA) are writing to provide comments regarding the disclosure of information to group welfare benefit plans by service providers, including health insurance plans.[1] The Department of Labor, Employee Benefits Security Administration (EBSA) published a notice in the *Federal Register* on November 5, 2010 (75 Fed. Reg. 68383) announcing a public hearing on the application of disclosure standards to welfare plan service providers. Our comments are intended to help inform the EBSA in its consideration of any new disclosure requirements. Both AHIP and BCBSA have provided comment on this issue in the past, and we continue to believe that new disclosure requirements for health and welfare plan service providers are unnecessary at this time.

America's Health Insurance Plans is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's member health insurance plans offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs. The Blue Cross and Blue Shield Association is made up of 39 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for nearly 98 million – one-in-three – Americans.

AHIP and BCBSA strongly support the idea that fiduciaries should have access to sufficient information about the cost and quality of services provided to the plan in order to make prudent decisions and fulfill their responsibilities as required by ERISA. However, as discussed in our

[1] As used in our comments, a "health insurance plan" is a health insurance issuer that provides insurance coverage to, or administrative services on behalf of, a group welfare benefit plan. Insurance coverage includes life, health, disability, long-term care, dental, vision and supplemental products.

comments, we believe that the fee arrangements utilized by providers to welfare plans are fundamentally different from those used in the pension plan context and therefore different treatment is warranted. Moreover, there has been no Congressional concern in this area as there has been for pension plans (specifically, 401(k) plans), despite the ample opportunity Congress had to review these issues during the passage of the Affordable Care Act ("ACA"). In fact, we believe welfare plan fiduciaries already receive extensive information from health insurance plans in connection with the provision of administrative services to self-insured plans. To the extent that the EBSA believes additional disclosures are necessary, the information should be targeted and implemented in a manner that does not add to the cost or complexity of plan administration.

Identifying the Needs of Welfare Plan Fiduciaries

We commend the EBSA for conducting a hearing and beginning the process of determining whether additional information is needed by welfare plan fiduciaries as part of the decision-making process and whether such disclosures are already being provided under state and federal requirements. This analysis will determine if any specific problems exist and how disclosures can best be crafted to respond to those concerns.

The EBSA believes, and AHIP and BCBSA concur, that plan fiduciaries need access to information allowing the assessment of "the reasonableness of the compensation paid for services and the conflicts of interest that may affect a service provider's performance of services."[2] However, the EBSA has not identified any specific concerns or issues with respect to welfare plan disclosures that must be addressed. Although there has been considerable scrutiny regarding pension plans, there have been few, if any, complaints about information or other regulatory "gaps" involving welfare plans.[3] As noted, Congress had ample opportunity to address any concerns during its consideration of ACA and choose to not take any action.

There is a good reason why there is no demonstrated information gap for welfare plans. This is because many plans offer welfare benefits through the purchase of insurance contracts, which are

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[2] Employee Benefits Security Administration, *Reasonable Contract or Arrangement under Section 408(b)(2) – Fee Disclosure; Interim Final Rule,* July 16, 2010, 75 Fed. Reg. 41600. Although the rules are directed at pension plans, the EBSA has made clear its belief that the same general disclosure principles apply to welfare plans.

[3] *See* Government Accountability Office, *Changes Needed to better Protect Multiemployer Pension Benefits* (October 2010) (recommendations for improved monitoring and assistance to pension plans to safeguard participant benefits); Government Accountability Office, *Conflicts of Interest Involving High Risk or Terminated Plans Pose Enforcement Challenges* (June 2007) (focusing on lack of disclosure by service providers in defined benefits plans); Government Accountability Office, *Enforcement Improvements Made but Additional Actions Could Further Enhance Pension Plan Oversight* (June 2007) (suggestions for improving EBSA oversight of pension plans); and Government Accountability Office, *Changes Needed to Provide 401(k) Plan Participants and the Department of Labor Better Information on Fees* (November 2006) (recommending increased service provider disclosure to fiduciaries and increased fee disclosure to plan participants).

rigorously regulated under federal and state law. In fact, the vast majority of small employers offer insured, rather than self insured, health and other welfare benefits. As a general matter, only where employers self-insure benefits should there be a "services" relationship that would be covered by any new disclosure requirements under section 408(b)(2). Typically only large employers self-insure. These employers are sophisticated purchasers who conduct RFPs and use consultants, lawyers, and other specialists to analyze service relationships. There is no evidence that large plan sponsors are not able to obtain fee information and evaluate the comparability of different third-party administrators (TPAs) bidding for business. This approach contrasts with the pension plan arena where even small employers enter into arrangements for services (rather than insurance), and, typically, these small employers do not have access to consultants and other experts.

AHIP and BCBSA believe that the EBSA should consider alternative approaches to responding to any concerns regarding disclosures of information to welfare plan fiduciaries. For example, the EBSA has conducted very effective educational outreach to both pension and welfare plan fiduciaries, and less formal guidance could be issued highlighting factors that plan fiduciaries should consider in selecting and monitoring welfare plan service providers, such as fees, accessibility to plan participant populations, quality of services, compliance with legal standards, and others, without requiring the issuance of a new comprehensive rule. For example, guidance regarding selecting auditors and pension consultants, available on the EBSA website, are helpful and widely used resources that could serve as models for similar guidance targeted to the welfare plan community.[4]

AHIP and BCBSA support the EBSA in its efforts to conduct hearings and other fact finding to determine whether welfare plan fiduciaries would benefit from additional disclosures in making decisions on the services provided to the plan, the cost of such services, and any conflicts of interest that may affect the service provider's performance of its obligations. However, in the event that the EBSA identifies gaps, we recommend that the EBSA first consider other approaches to, including additional educational outreach and informal guidance, rather than comprehensive rulemaking.

Understanding the Difference Between Payments to Welfare Plan Service Providers and Pension Plan Service Providers

The effect of service provider fees is significantly different for pension plans and welfare plans, and this difference justifies different treatment under DOL regulations. The primary goal of a pension plan is to provide participants and beneficiaries with an accumulation of assets to provide future income to fund their retirement. The fees paid to pension plan service providers

[4] *See* "Selecting an Auditor for Your Pension Plan" and "Selecting and Monitoring Pension Consultants—Tips for Plan Fiduciaries" available at www.dol.gov/ebsa.

have a direct impact on the amount of retirement benefits because fees to manage investments are paid from plan investment vehicles, and fees for recordkeeping services are also typically paid by the plan (either directly through assessments to participant accounts or indirectly though the investment fees charged to plan investment options). As a result, at least with respect to 401(k) plans, high fees can directly reduce the benefits that are available to fund retirement benefits.

By contrast, services fees are far less directly borne by participants, if at all, in the welfare plan context. Welfare plans provide participants and beneficiaries access to a defined level of health insurance coverage or a fixed payment (e.g., life insurance death benefit) when a particular event occurs. With respect to health plans, the costs of administration are typically charged on a per member per month basis to the plan, which are explicitly approved by the plan sponsor in its contract. The services fees do not reduce, or otherwise impact, the benefits that are payable under the particular plan to participants in the case of an accident or illness. As noted above, in the context of insured coverage, the cost is subject to state requirements that mandate that the amounts charged be reasonable and actuarially justified.

In addition, we note that service providers that act as ERISA plan fiduciaries (or investment advisers under the Investment Advisers Act) are a key focus of the new Section 408(b)(2) rules for pension plan service providers. Unlike pension plans, most health plan service providers do not have a fiduciary relationship with the ERISA plan (with the possible exception of acting as a fiduciary with respect to appeals of benefit determinations). Health insurance plan service providers do not hold or manage plan assets in a trust or investment manager capacity, nor do they provide investment advice with respect to plan assets. The absence of a typical fiduciary relationship and the absence of "plan assets" for most welfare plans further justify a different treatment of pension plans and welfare plans.

When selecting health plan service providers, plan fiduciaries are most interested in their services capabilities (e.g., call centers, medical management, claims processing times, and error rates), the per member per month fee, and the health care provider networks they make available (including the breadth of the network and the amount of discounts that have been negotiated with providers). These issues are negotiated in detail when hiring a TPA and the information needs are fairly straightforward and made available by a service provider prior to the engagement as part of the agreed contract. In addition, these services relationships are frequently subject to ongoing audits rights during the contract term.

AHIP and BCBSA believe that the cost of services impacts pension plan participants and benefits in a far more direct way than welfare plans and that welfare plan fiduciaries have access to needed information regarding plan services. The EBSA should carefully consider the differences between service arrangements involving pension and those involving welfare plans in developing any new disclosure requirements for welfare plan fiduciaries and providers.

Recognizing Implementation Challenges

Health insurers are currently implementing significant administrative and operational changes required by the ACA. As a part of these efforts, health insurance plans are modifying claims and administrative procedures, implementing new information technology systems, revising provider contracts and consumer disclosure materials, adopting new underwriting and pricing standards, and responding to increased oversight by state and federal regulators. Health insurance plans are expending extensive resources to satisfy these new requirements. Sponsors of self-insured health plans are also being subject to significant new compliance burdens.

Based on the section 408(b)(2) rule that applies to pension plans, subjecting health and welfare plans to a new disclosure rule could involve insurers providing new disclosures and contract supplements to thousands of in-force TPA agreements with plan sponsors. Plan sponsors will have a fiduciary duty to review and understand the new disclosures and contractual changes. These same insurers and employers are already faced with significant ACA implementation challenges and costs in the short term and long term. The EBSA should evaluate the burdens on health insurers and employers before moving forward with new section 408(b)(2) disclosure requirements.

If the EBSA moves forward with new regulations, AHIP and BCBSA believe that the process followed for the pension plan rule is a good roadmap to follow. EBSA originally released a Proposed Rule and Proposed Class Exemption in the *Federal Register* on contracts between service providers and plan fiduciaries on December 31, 2007.[5] In consideration of the Proposed Rule, the EBSA conducted two rounds of public comments as well as conducted a hearing to solicit input from interested parties. After consideration of the extensive stakeholder input, the EBSA issued an Interim Final Rule (IFR) on July 16, 2010 applicable to pension plans.[6] In recognition of the implementation challenges, pension plan fiduciaries and service providers are given 12 months, until July 16, 2011, to come into compliance with the Interim Final Rule and the EBSA solicited additional public comments regarding the IFR.

If the EBSA chooses to adopt new disclosure requirements for welfare plans, it should issue a Notice of Proposed Rulemaking allowing stakeholders to review and provide input on the efficiency and impact of the provisions. In addition, EBSA should recognize the demands already imposed on health insurance plans by the ACA and other state and federal mandates. Welfare plans and fiduciaries should be given sufficient time to implement any new requirements to minimize the administrative burdens and potential coverage disruptions.

[5] 72 Fed. Reg. 70988.
[6] 75 Fed. Reg. 41600.

AHIP and BCBSA recommend that the EBSA release any new information disclosure regulations as a Notice of Proposed Rulemaking and give interested parties the opportunity to provide meaningful input. In addition, any final rules must give welfare plan fiduciaries and service providers sufficient time to implement the changes in a manner that does not result in undue burdens or costs.

Excluding Insurance Coverage

To the extent that the Department decides to develop rules in this area, it is critical that any such guidance clearly exclude insured welfare plans. Almost half (41%) of workers receive health coverage through a fully-insured plan.[7] In general, small employers (those with up to 199 workers) are fully-insured, while larger firms are self-funded.[8] As the Department has recognized, the issuance of an insurance contract does not constitute the provision of services to a welfare plan and, as a result, an insurance carrier is not a "service provider" for purposes of section 408(b)(2).[9] Moreover, DOL has specifically excluded the payment of insurance premiums from the Schedule C reporting requirements, acknowledging that such payments typically do not involve payments for "services."[10]

New disclosure requirements are not needed for insured plans since existing state and federal oversight already provides significant protections to fully-insured welfare plans.
All states provide extensive oversight of entities that sell insurance, including: (a) financial solvency standards; (b) licensure of insurance carriers and producers; (c) consumer protections and disclosure requirements; (d) mandated access to medical services and health care providers; and (e) approval of insurance rates and forms. As a result of such laws, state regulators typically will engage in the following oversight:

- review the content and form of insurance agreements and reject any term or condition of the agreement which is unreasonable or contrary to state requirements;
- review the amount of group health insurance premiums in relation to medical expenses and reject rates which are excessive, discriminatory or otherwise not actuarially justified; and

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[7] Kaiser Family Foundation and Health Research & Education Trust, *Employer Health Benefits: 2010 Annual Survey.*

[8] According to the KFF/HRET survey, 83% of small employers fully-insure their health coverage while 84% of larger employers are self-funded.

[9] *See* DOL Advisory Opinion 76-36 (Jan. 15, 1976) (clarifying that an insurance company that sells a group insurance policy to an ERISA plan is not a party in interest to the plan based on the sale of the insurance policy alone).

[10] *See* 2009 Form 5500 Instructions p. 23 ("The … payment of premiums for insurance contracts, however, are not in and of themselves payments for services rendered to the plan for purposes of Schedule C reporting… .")

- prohibit or restrict the manner in which any of the premium may be rebated to or shared with unlicensed individuals or entities.

In addition, health insurance plans must file financial and other annual reports with state insurance regulators and are subject to market conduct and financial examinations. Health insurance plans also provide information to welfare plans for use in the annual Form 5500 reporting (including Schedule A "Insurance Information" and Schedule C "Service Provider Information") that is made to EBSA.

The ACA added new insurance regulations including restrictions on medical underwriting, improved consumer disclosures, limits on "unreasonable" rates, and minimum medical loss ratio (MLR) standards.[11] These provisions are intended to provide consumers and employers with a choice of affordable health coverage and actionable information about cost, benefit options, and quality of service. The ACA also increases the oversight of health insurers by state and federal regulatory agencies. These consumer protections and expanded disclosures give welfare plan fiduciaries and participants and beneficiaries added assurance that they are receiving appropriate insurance coverage at the right cost.

AHIP and BCBSA recommend that the EBSA make clear that health insurance coverage is exempt from any new disclosure requirements of ERISA Section 408(b)(2).

EBSA's Special Treatment of Welfare Plans

EBSA has historically recognized that welfare plans merit different regulatory treatment under ERISA. For example, EBSA has had a consistent policy of extending special treatment to welfare plans utilizing cafeteria plans within the meaning of Code section 125 since 1988. Technical Release 92-01 specifically states that ERISA's trust requirement would not be enforced with respect to these welfare plans (assuming no other trust or source of segregated assets is maintained in connection with the plan).[12] The Technical Release also gives large plans that use cafeteria plans and other contributory plans meeting its conditions relief from engaging an independent auditor and filing a financial schedule (such as Schedule H) with the plan's annual Form 5500. The EBSA also considers these plans to be "unfunded" for purposes of ERISA's bonding rules.[13] Just recently, the EBSA relieved welfare plans that utilize cafeteria plans meeting the conditions of Technical Release 92-01 from the Schedule C reporting

[11] The MLR standards assure employer purchasers that at least 85% of premiums (80% in the case of small employers) will be spent on claims and on activities that improve health care quality.
[12] *See* Technical Release 92-01, 57 Fed. Reg. 23272 (June 2, 1992) (clarifying and extending relief provided under DOL Technical Release 88-01).
[13] *See* DOL Field Assistance Bulletin 2008-04, Q-13 (Nov. 25, 2008).

requirements.[14] These rules would otherwise require large plans to report detailed information regarding service provide compensation to the government.

The fact that welfare plans utilizing cafeteria plans are exempt from the new Schedule C requirements suggests that welfare plans generally should be exempt from any enhanced disclosure requirements under section 408(b)(2). At a minimum, welfare plans utilizing cafeteria plans should be exempt from any new 408(b)(2) requirements.

AHIP and BCBSA recommend that the EBSA consider its guidance regarding cafeteria plans meeting the conditions of Technical Release 92-01 as a basis for exempting welfare plans from any new disclosure requirements of ERISA Section 408(b)(2).

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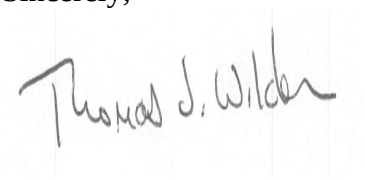
AHIP and BCBSA appreciate the opportunity to provide our views with respect to the provision of services to welfare plans by our members. We believe that arrangements for services to welfare plans are fundamentally different from pension plan services arrangements and the rationale for imposing new disclosure requirements on pension plans does not apply to welfare plans. Should the EBSA consider adoption of additional requirements that apply to welfare plans, we stand ready to work with the agency to implement the new standards in a way that protects the interests of fiduciaries and plan beneficiaries and participants and does not increase the cost or complexity of welfare plans.

Please contact Tom Wilder, AHIP at (202) 778-3255 or twilder@ahip.org or Justine Handelman, BCBSA at (202) 626-4801 or justine.handelman@bcbsa.com if you have any questions.

Sincerely,



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[14] *See* 2009 Instructions to the Form 5500 p. 2, 22.