From: Anne Lennan [mailto:anne@spbatpa.com]
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To: EBSA, E-ORI - EBSA
Subject: Second Comments 408(b)(2)

April 21, 2008

Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5655
US Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

ATTN: 408(b)(2) Amendment

Dear Ladies and Gentlemen:

The Society of Professional Benefit Administrators (SBPA) appreciates the invitation to submit supplemental comments on the proposed regulation for amendment of ERISA section 408(b)(2) as a follow up to our earlier comments sent to the Department of Labor on February 6, 2008.

SPBA is the national association of Third Party Administration (TPA) firms that are hired by employers and employee benefit plans to provide outside professional management of their employee benefit plans. It is estimated that 55% of US workers in non-federal health coverage are in plans administered by some form of TPA. The clients of TPA firms include every size and format of employment, including large and small employers, state/county/city plans, union, non-union, collectively bargained multiemployer plans, as well as plans representing religious entities. Most of these clients are ERISA self-funded plans and sponsors, but our member TPAs are also providing services to all other types of plans, such as insured, HMO, etc. Our comments reflect this wider perspective.

SPBA's comments draw on insights and feedback from the broad employee benefit community: plan sponsors, plan trustees, plan participants and administrators. In light of the comments received by the Department of Labor and the comments expressed during the hearing on the 408(b)(2) proposed rules, SPBA offers some additional real-world examples and insights that, we believe, will broaden further the Department's perspective.

SPBA's comments will focus exclusively on health plans.

First, we believe the Department's motivation for the proposal, as expressed in the preamble is valid with respect to health plans. The Department recognizes that the increasing complexity in the way service providers are compensated makes it challenging for plan sponsors to understand when the plan actually pays for specific services and whether compensation arrangements pose any potential conflicts of interest.

Current Practices of Health Plan Disclosure

Self-Funded Plans

It is our understanding that disclosure of service provider fees varies widely in the health plan services industry and we surmise that this is a result of the general nature of the ERISA

fiduciary disclosure rules that have not provided many details on how fees should be disclosed, other than on the 5500 Form and in the limited prohibited transaction exemptions (e.g. PTE 84-24).

Our member TPA firms that administer self-funded plans typically provide a detailed list of all the administration fees upfront, before a plan sponsor signs a service contract with the TPA. These fees usually include: medical plan administration, vision plan administration, Stop Loss commission, Stop Loss override commission or bonus, COBRA notification services, disease management services, utilization review services, to name a few.

Often, if a broker has brought the plan to a TPA for administration, the broker requests that the TPA add X dollars per employee per month to the medical plan administration fee. This has the effect of hiding the broker fee in the TPA administration fee. The plan fiduciary has no idea how much the broker is being paid and how much the administrative cost has been increased for this payment. TPAs would prefer to break out the broker fee as a separate line item, but the DOL guidelines, prior to the new proposed rules, did not specifically address broker fees and consequently the TPA, not wanting to alienate the broker, had no specific guidance to show the broker and always lost out to the demands of the broker. Due to the lack of direction from DOL, the plan sponsor has no knowledge of the "real" cost of the medical plan administration vs. the cost of the broker placement fee. The plan sponsor remains in the dark. Note: Please see SPBA's February 6, 2008 comments for details on the self-funded broker issue.

It is our understanding in the TPA self-funded world that pre-contract disclosure is prevalent, with the exception of the broker component. The proposed rule, in our opinion, would not require dramatic changes in current disclosure practices of TPAs administering self-funded plans and would bring important, useful information to plan sponsors with respect to broker fees. We disagree with those commenters on the proposed regulation who argued that the application of the proposed rule to health and welfare plans is misplaced and that they are not aware of a need to increase transparency of fees related to health plans. Transparency of fees does not currently exist with respect to broker fees.

Fully Insured Plans

One industry group noted in their written comments to the Department that most insurance carriers contractually require broker disclosure in the pre-contract stage and therefore the proposed rule is not needed. SPBA member TPA firms vociferously disagree with this statement. According to our member TPA firms, the meaningful disclosure of broker fees for placing fully insured policies is rarely given in the pre-sale stage. Brokers often tell TPAs administering self-funded plans how much more money they will make if they steer the plan sponsor to a fully insured arrangement, even if they know the TPA self-funded format would be the most prudent for the plan. The new proposed rules are needed to ensure that plan sponsors are given broker fee information before entering service contracts. Note: Please see SPBA's February 6, 2008 comments for details on the fully insured broker issue.

Unmerited Objections to the Proposed Rule

Other benefit trade groups asserted that the proposed rules were unnecessary for fully insured health plans because adequate disclosure under ERISA already exists; they claim that the Form 5500 Schedule A is sufficient. Other groups argued that fully insured plans should be exempted from the disclosure rules for numerous reasons: The DOL has long treated fully insured arrangements differently from other plans, including special treatment for annual reporting purposes on the Form 5500; Insurance products are highly regulated by State insurance laws and do not require further regulation; There are a number of existing

disclosure requirements that are common with respect to insurance, including Class Exemption 84-24.

Below we will address each of these objections and offer the Department a more balanced view on the need for disclosure oversight.

Is the Schedule A Sufficient?

No. The Schedule A of the 5500 Form does not serve the goals of section 408(b)(2): to provide useful information to plan sponsors when entering service contracts to enable them to assess the reasonableness of the fees paid for services and the potential for conflicts of interest that may affect a service provider's performance. 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. According to our TPA members, most plan sponsors ignore the Schedule A since they are typically focused on what is happening with the plan today and not what happened in a prior plan year.

Form 5500

Should special treatment for fully insured plans under the 5500 Form translate into an exemption of fully insured plans from the new proposed regulations? No. As you know, there are special exceptions for filing a fully insured 5500 Form for plans with under 100 participants, as well as special exceptions for obtaining an accountant's opinion for plans with 100 or more participants. The reasons for this special treatment under the 5500 Form are irrelevant for the purposes of 408(b)(2). In fully insured plans, plan sponsors do not need to know about the financial management of the plan assets since the insurance company is taking on the risk. However, plan sponsors of fully insured plans absolutely need to know about the fees associated with selecting a particular plan since this impacts the cost borne by the plan sponsor and the plan participants.

State Insurance Laws

Should fully insured plans be exempted from the 408(b)(2) proposed rules because fully insured plans are subject to State insurance laws? No. It is our understanding 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 they are loosely enforced, if at all, given that fully insured plans are currently less compliant with the spirit of 408(b)(2) than self-funded plans.

PTE 84-24

Are the existing disclosure guidelines, such as PTE 84-24 sufficient? No. As noted earlier, in both the self-funded and fully insured worlds there is no specific guidance with respect to the pre-contract disclosure of broker fees, as one example. The ERISA fiduciary rules are too vague to provide any consistent and uniform disclosure in the health care market.

Products Use Varying Terminology

An estimated 25% to 30% of plans are reportedly "minimum premium" or "experience rated" plans under which the plan sponsor's final payment is based on the experience of the plan at the end of the year. In some of these plans, if claims are higher than expected, the insurance company absorbs the loss; in other plans, the plan sponsor is asked to pay more and handle the risk. Over the years, the insurance industry has arbitrarily declared these plans to be insured one year and then called them self-funded the next year. If special

treatment were given to fully insured plans, a segment of the market could use creative interpretations to avoid the consumer-protective disclosure rules under 408(b)(2).

Key Point: Fully insured plans should NOT be given special exemptions from the 408(b)(2) regulations.

Conflict of Interest Disclosure

Some industry commenters argued that the proposed rule imposes overly broad conflict of interest disclosure obligations on ERISA plan service providers and significant burdens on plan fiduciaries to obtain and evaluate the information. Health insurance industry representatives who testified at the hearings on the proposed rule believed that a "sea of information" would be needed to satisfy the rule. While we do not believe a "sea of information" is needed, or desired by the Department, we agree that the rule should be clarified and an effort made to provide a comfort level to the industry so that the insurance carriers with extensive legal teams will not feel compelled to flood plan fiduciaries with a torrent of indecipherable information.

One possible solution to provide a comfort level would be to present an example of how the Department envisions a potential conflict of interest to be disclosed. We offer the below example for your consideration.

Example: A TPA has a partial ownership interest in a disease management company, whose services are offered to the plan fiduciary through the TPA. On the list of the administration fees provided to the plan fiduciary, a one-sentence explanation alerting the plan fiduciary to the existence of the partial ownership would suffice.

Inadvertent Mistakes

SPBA shares the concerns of other industry groups about the potential penalties for inadvertent mistakes and believes that the requirement to disclose "to the best of the service provider's knowledge" may be a standard of diligence that is too high for a service provider to satisfy given the complex mergers, acquisitions and constantly changing ownership arrangements of health care entities. We agree that a "good faith" standard of care would be preferable.

We look forward to answering any questions you may have on this submission or current health plan industry disclosure practices.

Respectfully submitted,

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