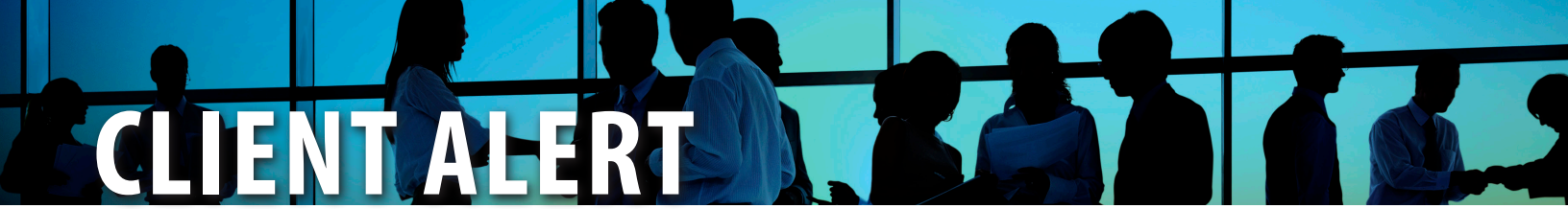





## FEE DISCLOSURES COMING FOR GROUP HEALTH PLANS

*By Cynthia A. Moore*

The Consolidated Appropriations Act ("CAA") includes a number of provisions enhancing transparency in the operation of group health plans. One of those provisions will require brokers and consultants to make fee disclosures to a responsible plan fiduciary if the broker or consultant qualifies as a covered service provider.

### Background

In general, certain transactions between an employee benefit plan and a party-in-interest, including a service provider, are prohibited transactions under ERISA. However, ERISA Section 408(b)(2) provides that a contract between a plan and a service provider is not a prohibited transaction if reasonable compensation is paid for necessary services under a reasonable contract.

In 2012, the Department of Labor ("DOL") issued final regulations requiring covered service providers to provide fee disclosures to a responsible plan fiduciary in advance of entering into a contract for services with respect to a retirement plan. The purpose of the disclosures was to give the fiduciary information to determine whether the fees to be paid were reasonable and to assess the impact of any potential conflict of interest. If the fiduciary did not receive the fee disclosures, the contract would be deemed not "reasonable," and the fiduciary would have engaged in a prohibited transaction. The DOL considered extending the fee disclosure rules to welfare benefit plans but decided to reserve that rule-making for a future date.

The CAA amends ERISA Section 408(b)(2) to require, by statute, that certain service providers make fee disclosures to group health plans. These disclosures must be made in order for the contract with the service provider to be "reasonable" and thus exempt from the prohibited transaction rules. The amendment is very similar to, and appears to be largely modeled after, the retirement plan fee disclosure rules. Therefore, if an employer is familiar with the retirement plan 408(b)(2) fee disclosure rules, the new rules for group health plans will not contain many surprises.

### Effective Date

The effective date of the group health plan disclosure rules is December 27, 2021 (one year after the date of enactment of the CAA). The amendment applies to any contract executed after that date (including an extension or renewal of an existing contract).

### Plans That Are Subject to the Fee Disclosure Rules

An ERISA-covered "group health plan" is subject to the fee disclosure rules. This includes any plan, whether insured or self-insured, that provides medical care to employees or their dependents. The rules would apply to any:

- Major medical/prescription drug plan
- Dental plan
- Vision plan
- Health flexible spending account
- Health reimbursement arrangement (other than a qualified small employer health reimbursement arrangement or QSEHRA.)

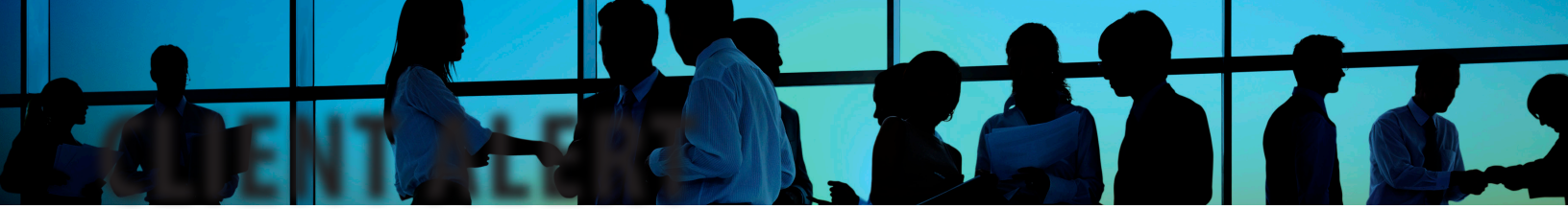
There is no exception for a small plan covering fewer than 100 participants with fully insured or self-funded benefits. Thus, a small group health plan will be subject to the fee disclosure rules even if it is exempt from Form 5500 filing.

### Covered Service Providers

A covered service provider is a service provider that enters into a contract with a group health plan and reasonably expects to receive $1,000 or more in direct or indirect compensation in connection with the following services:

- Brokerage services for the selection of insurance products, recordkeeping services, medical management vendor, benefits administration, stop-loss insurance, pharmacy benefit management services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or third party administration services.
- Consulting services relating to the development or implementation of plan design, insurance or insurance product selection, recordkeeping, medical management, benefits administration selection, stop-loss insurance, pharmacy benefit management services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or third-party administration services.

In determining whether the $1,000 threshold is exceeded, the covered service provider would consider services performed by – and payments received by – an affiliate or a subcontractor.





A covered service provider does not include an insurer. Presumably, this is because health insurers are subject to rigorous regulation by states, including the calculation of premiums.

**Compensation Taken Into Account**

Both "direct" and "indirect" compensation is taken into account for this purpose.

- Direct compensation is compensation received directly from the group health plan.
- Indirect compensation is compensation received from any source other than the group health plan, the plan sponsor, the covered service provider, or an affiliate.

**Information to be Disclosed**

The covered service provider must disclose, in writing, the following information to a responsible plan fiduciary:

- A description of the services to be provided under the contract.
- Whether the services will be provided in a fiduciary capacity.
- A description of all direct and indirect compensation that the covered service provider reasonably expects to receive, which may be expressed as a monetary amount, formula or a per capita charge for each enrollee, or by any other reasonable method. If applicable, the description should include a disclosure that additional compensation may be earned with a description of the circumstances under which the additional compensation will be received with a good faith estimate of the additional compensation.
- With respect to indirect compensation, the disclosure should (1) include compensation paid by a vendor to a brokerage firm based on incentives not solely related to the contract with the plan (such as contingent compensation paid based on a broker's overall book of business with a carrier); (2) describe the arrangement between the payer and the covered service provider pursuant to which the indirect compensation is paid; (3) identify the services for which the indirect compensation will be received; and (4) identify the payer of the indirect compensation.
- A description of any compensation that will be paid among the covered service provider, an affiliate or a subcontractor, if such compensation is set on a transaction basis (such as commissions, finder's fees or similar incentive compensation based on business placed or retained).
- A description of any compensation that the covered service provider, affiliate, or subcontractor reasonably expects to receive in connection with the termination of the contract.

The disclosure must include a description of the manner in which the direct and indirect compensation will be received by the covered service provider (for example, paid by the plan or plan sponsor or in the form of commissions paid by an insurance carrier).

**Timing of Fee Disclosures**

The covered service provider must make the required disclosures to the responsible plan fiduciary reasonably in advance of the date on which the contract or arrangement is entered into and extended or renewed. In the retirement plan rules, the DOL declined to specify a date by which the disclosures must be made. Remember that the purpose is to give the responsible plan fiduciary sufficient time to review the disclosures in compliance with his/her ERISA fiduciary duties, including determining that the compensation is reasonable in relation to the services to be provided. Therefore, the responsible plan fiduciary should request that the fee disclosures be provided in advance of the date expected to sign the contract with sufficient time to review them and ask any questions or request further explanation or supplemental information.

**Errors in Fee Disclosures**

The contract will not fail to be reasonable if the covered service provider notifies the responsible plan fiduciary within 30 days of discovering an error or omission in the disclosed information.

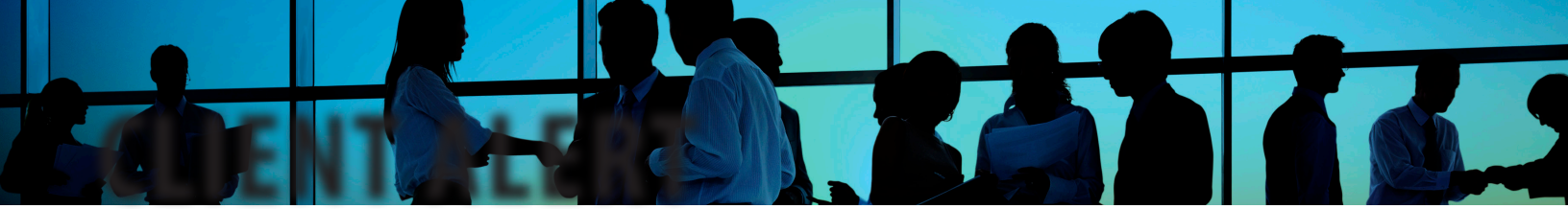
**Failure to Receive the Required Fee Disclosures**

The responsible plan fiduciary will not be deemed to have engaged in a prohibited transaction if it reasonably believed that the covered service provider had made the required disclosures and, upon discovery of the failure, takes the following steps:

- Requests in writing that the covered service provider furnish the fee disclosures.
- If the covered service provider refuses or fails to furnish the fee disclosures within 90 days of the request, notifies the DOL of the failure or refusal.
- Evaluates whether to terminate the contract, consistent with the duty of prudence. If the contract relates to future services and the disclosure is not furnished promptly after the 90-day period, the contract must be terminated as expeditiously as possible.

**Next Steps**

Savvy plan sponsors are already asking brokers and consultants to provide robust fee disclosure whenever they enter into a new contract for a group health plan. The new rules will formalize this process. Obtaining and reviewing fee disclosures should be added to a plan sponsor's annual checklist.





It is less clear how plan sponsors should determine whether fees for group health plans are "reasonable." For commissions on insurance products, plan sponsors are generally informed that "these are standard commission levels." Currently, the benchmarking tools that exist for retirement plans are not as readily available for welfare benefit plans. It will be interesting to see whether benchmarking tools are developed for group health plans and whether these tools will begin to affect fees.

If you have any questions about the new fee disclosure rules, please contact Cynthia A. Moore or any other member of Dickinson Wright's Employee Benefits and Executive Compensation Group.

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