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MEMORANDUM

REGARDING HEALTH INSURANCE COMPENSATION DISCLOSURE REQUIREMENTS

Recent amendments to ERISA impose broad compensation disclosure requirements on agents and brokers in connection with group health plans

The requirements are in addition to any existing state law disclosure requirements that may already apply

Agents and brokers may need to comply with the requirements before additional guidance is issued

The Comprehensive Appropriations Act of 2021 was signed into law by President Donald Trump in the final days of 2020. Congress finalized the nearly six thousand pages of text supporting $2.3 trillion in spending and passed it on December 21, 2020. Section 202 of the act amends and expands Section 408(b)(2) of the Employment Retirement Income Security Act of 1974 (ERISA), which already requires similar compensation disclosures relating to retirement plans.

This new provision will have a significant impact on health insurance agents, brokers and consultants because it requires them to disclose compensation and other information to sponsors of group health plans subject to ERISA. The act also requires health insurers to disclose to individual health insureds the compensation paid to the agent or broker involved in the coverage selection and enrollment. While that part of the requirements does not directly apply to agents or brokers, carriers may require agents and brokers to make disclosures on their behalf. The new requirements will take effect on December 27, 2021, and the full text can be found HERE.

The Department of Labor has not yet published guidance or regulations implementing the relevant law requiring agents and brokers to disclose compensation related to group health plans. The law will go into effect on December 27, 2021. This memo will be updated to reflect further developments.

GROUP HEALTH PLAN REQUIREMENTS

WHO IS SUBJECT TO THE DISCLOSURE REQUIREMENTS?

The new disclosure requirements broadly apply to any person (referred to as a "covered service provider") that:

- Reasonably expects to receive at least $1,000 (an amount that may be adjusted to account for inflation) in direct or indirect compensation in connection with the services provided pursuant to the arrangement or contract with a group health plan.
- Provides brokerage or consulting services (including providing such services via an affiliate or subcontractor) to a group health plan.

The statute identifies a wide range of brokerage or consulting services that trigger the disclosure obligations, and the list includes the following:

- Selection of health insurance products (including vision and dental plans)
- Development or implementation of plan design
- Medical and disease management services
- Recordkeeping services
- Stop-loss insurance
- Compliance services
- Pharmacy benefit management
- Medical management vendor
- Benefits administration and benefits administration selection
- Wellness design and management services
- Transparency tools and vendors
- Employee assistance programs
- Third party administration services
- Group purchasing organization preferred vendor panels, agreements and services

The definition of a group health plan is similarly broad and includes any group plans subject to ERISA, including but not limited to Health Reimbursement Arrangements (HRAs), Individual Coverage HRAs (ICHRAs), Flexible Spending Accounts (FSAs) or other types of group health plans, except for Qualified Small Employer HRAs (QSEHRAs). Due to the low $1,000 threshold, the requirement will likely be applicable in most contexts other than for the smallest of group plans.

A broker need only provide the disclosures to the client's responsible plan fiduciary, not the Department of Labor (DOL). If the broker fails to provide appropriate disclosures, however, the DOL could assess penalties, and such penalties are unlikely to be covered by the broker's E&O policies. Thus, compliance is important to the extent these requirements apply to a broker's business.

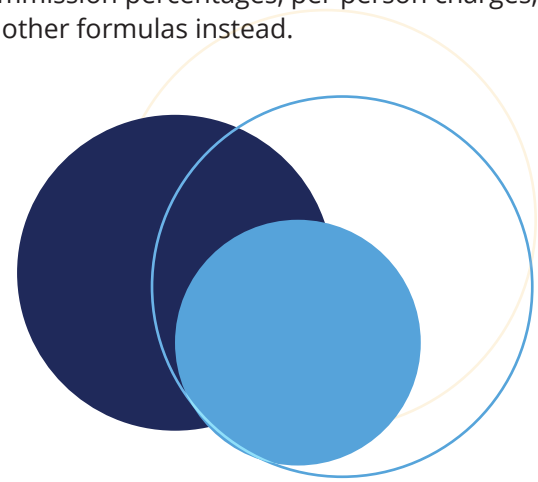
WHAT MUST BE DISCLOSED?

Any insurance agent, broker, consultant, or other covered service provider subject to the requirements must disclose the following to a responsible plan fiduciary:

- A description of the services to be provided to the group health plan;
- A description, either in the aggregate or by service, of all direct compensation (i.e. compensation received from the plan directly) the service provider or its affiliates or subcontractors reasonably expect to receive;
- A description of all indirect compensation (i.e. compensation received from any source other than the plan or its sponsor), either in the aggregate or by service, that the service provider or its affiliates or subcontractors reasonably expects to receive in connection with the services;
- The identity of any entity paying indirect compensation and a description of the arrangement that exists between that entity and the service provider and the services for which the indirect compensation will be received;
- A description of any compensation that will be paid among the service provider, an affiliate, or a subcontractor in certain instances if the compensation is determined on a transaction basis (e.g. commissions);
- A description of the manner in which any such compensation will be received;
- A description of any fees payable relating to termination, including a description of how any prepaid amounts may be calculated and refunded (if applicable); and
- A statement that the broker expects to provide services to the plan as a fiduciary, if applicable (which is unlikely under most circumstances).

The disclosure requirement is quite broad and potentially burdensome as it covers nearly all forms of compensation, including fees, bonuses or other incentives that may not be easily calculable in advance of a plan year. Compensation, however, is defined by the law not to include non-monetary compensation valued at $250 or less in the aggregate during the term of the contract or arrangement.

The statute also provides some flexibility in how compensation may be described and disclosed, and it permits it to be expressed as "a monetary amount, formula, or a per capita charge per enrollee." It is important to note that precise dollar amounts are not required, and brokers are permitted to provide commission percentages, per person charges, or other formulas instead.



In instances in which compensation or cost cannot be reasonably expressed as a monetary amount, formula, or per enrollee charge, the statute permits disclosure to be made "by any other reasonable method."

This includes instances where "additional compensation may be earned but may not be calculated at the time of contract if such disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate" if the broker "cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate.

While not yet stated for these purposes, the Department of Labor has also previously opined in the context of retirement plans that "disclosure of expected compensation in the form of known ranges can be a 'reasonable' method" for achieving compliance if the ranges provided are "reasonable under the circumstances surrounding the service and compensation arrangement at issue." Overall, the disclosure will need to identify each specific payer, the services for which the broker is paid as well as describe each arrangement with sufficient detail to allow the client to evaluate the "reasonableness" of the compensation.

WHEN AND HOW MUST THE DISCLOSURES BE MADE?

These disclosures must be made in writing and "reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed." Any changes in the information disclosed must be updated "as soon as practicable" and no later than 60 days from when the service provider becomes aware of the change. Any inadvertent errors or omissions in disclosures must be corrected within 30 days of discovery. Additionally, service providers must respond within 90 days when a responsible plan fiduciary or plan administrator requests other compensation-related information that is required by the plan to comply with its own reporting and disclosure obligations. If the broker fails to provide the disclosure, the employer must request disclosure in writing and then submit notice to the DOL within 30 days if the broker fails to respond.

It is important to note that these new disclosure requirements are separate from annual Form 5500 reporting and are forward-looking. The new requirements do not expressly define the period of time to determine the $1,000 threshold. They also do not state what qualifies as an extension or renewal of an arrangement such that disclosures may be required for existing arrangements after December 27, 2021. Commentators have suggested the final regulations will likely apply on a plan year basis.

Also note that the new requirements are in addition to, and do not supersede, existing state disclosure laws which may already apply to agents and brokers (unless the state requirements somehow prevent the disclosures required under federal law). In states that prohibit the charging of a fee for placement-related services, it may be especially important to update existing disclosures to list the specific services for which fees are being charged for clarity.

INDIVIDUAL MARKET REQUIREMENTS

There are also new disclosure requirements that apply to health insurers offering individual coverage or short-term limited duration insurance coverage. Once the provisions take effect, they will require carriers to disclose "the amount of direct or indirect compensation provided to an agent or broker in connection with plan selection and enrollment." The disclosure must be made to an enrollee prior to plan selection and be included in any documentation confirming enrollment. The law directs the Department of Health and Human Services (HHS) to initiate a formal rulemaking process before the notice obligations take effect.

On September 10, 2021, HHS published its proposed rule, which would require disclosure of compensation for all potential and new policies, as well as upon renewal of existing policies. While it does not impose direct requirements on agents and brokers, the proposed rule anticipates the possibility of an agent or broker providing a commission schedule and other compensation information in satisfaction of the insurer's requirements. In particular, it states:

> "HHS expects that issuers subject to the requirements of this section would integrate this new disclosure requirement into their existing compliance operations. An issuer's obligation could be satisfied by the agent or broker making the required disclosure on the issuer's behalf. For example, issuers may provide agents or brokers who have an appointment arrangement with the issuer printed versions of the commission schedule and other documentation disclosing direct and indirect compensation, if applicable, to attach to enrollment materials or may provide a link to an online version of the document. This would equip agents and brokers with the information necessary to ensure that consumers would be aware of any compensation being paid by the issuer to the agent or broker prior to enrolling."

This may prompt carriers to require agents and brokers to make the necessary client disclosures on their behalf. In addition to these direct disclosures, insurers would also be required to submit annual disclosure reports to HHS prior to open enrollment.

NEXT STEPS

The Government Affairs team has worked closely with other organizations in seeking additional clarity and guidance from federal regulators concerning compliance with these new and extensive disclosure obligations. The Big "I" and certain other major producer groups have met with DOL officials and submitted a joint comment letter, but no regulatory guidance from the Department has been issued to date.

While we hope to receive additional guidance, particularly as to what a disclosure form should look like, it is currently unclear whether regulators will act prior to December 27, 2021. Thus, agents and brokers who handle group health care plans subject to the new ERISA requirements will need to attempt to comply with the broad provisions of the act unless and until more detailed guidance is provided or enforcement is delayed.

QUESTIONS?

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