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Health Plan Broker & Consultant Service Provider Fee Disclosure

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The Consolidated Appropriations Act, 2021, Public Law 116-260 ("CAA"), signed into law by President Trump on December 27, 2020, imposes new compensation disclosure requirements upon brokers and consultants to group health plans covered by the Employee Retirement Income Security Act of 1974. Additionally, new disclosures in the individual market related to compensation were added to the Public Health Service Act. This alert summarizes these new disclosures and highlights important considerations for both plans and service providers.

If you have any questions, please do not hesitate to contact your regular Groom attorney or the authors listed below:

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I. Group Health Plans

In general, ERISA section 408(b)(2) permits plans to enter into reasonable plan service arrangements for reasonable compensation. The CAA amends ERISA section 408(b)(2) ("Amendment") to require certain "covered service providers" to ERISA-covered group health plans to provide written information about their fees and services to a "responsible plan fiduciary." The "responsible plan fiduciary" is a plan fiduciary with authority to cause a plan to enter into, extend, or renew a contract or arrangement for plan services. Failure to comply with the disclosure requirements means that the service arrangement is not reasonable and is therefore a prohibited transaction to which the statutory ERISA section 408(b)(2) exemption does not apply.

This Amendment incorporates into ERISA many of the disclosure requirements set forth in Department of Labor ("DOL") regulation, 29 C.F.R. 2550.408b-2, which currently applies only to certain service providers to ERISA-covered retirement plans. Many of the definitions and provisions of the Amendment repeat, in some cases on a word-for-word basis, provisions currently applicable to retirement plan service providers under 29 C.F.R. 2550.408b-2. Accordingly, many interpretive questions that arise under the Amendment may be informed by the DOL's parallel regulation for retirement plan service providers and associated guidance (and we expect any implementing regulations will be similarly so informed).

A covered service provider ("CSP") is defined by the types of services provided and compensation received. A CSP is a service provider that reasonably expects to receive $1,000 or more in total direct or indirect compensation from the plan in connection with providing a "covered service" to an ERISA-covered group health plan. Compensation received by the CSP's affiliate or subcontractor is taken into account for purposes of applying the $1,000 minimum threshold. In general, "indirect compensation" is compensation received by a provider from a source other than the plan, plan sponsor or the CSP, while "direct compensation" is that paid by the group health plan itself. Service providers that are paid entirely from the plan sponsor's assets and no other sources would not be subject to the new disclosure requirements.

A. Service Providers Covered

CSPs, for purposes of group health plans, are limited to providers of certain brokerage and consulting services.

Brokerage services provided to a covered plan are those with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendors, benefits administration (including vision and dental), 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 are those related to the development or implementation of plan design, insurance or insurance product selection (including vision and dental), recordkeeping, medical management, benefits administration selection (including vision and dental), 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.

B. Disclosure Contents

The Amendment states that the disclosure must contain a description of the services to be provided, a statement of the entity's fiduciary status, and a description of "compensation" received by the CSP for services. The term "compensation" is defined broadly to include anything of monetary value except for non-monetary compensation valued at $250 or less throughout the term of the arrangement.

For indirect compensation, the disclosure must describe: the payer of the indirect compensation; the amount (or formula or estimate) of the indirect compensation; the services for which the indirect compensation will be paid; and the arrangement between the CSP (or its affiliate or subcontractor), who receives the fees and the payer of the indirect compensation. Importantly, indirect compensation is defined as including compensation paid by a vendor to a brokerage firm based on a structure of incentives not solely related to the contract with the covered plan.

Additionally, the disclosure must contain a description of compensation paid among the CSP, its affiliates and subcontractors if it is set on a transaction basis. Transaction-based compensation would include commissions, finder's fees or other incentive-based compensation related to the contract for services. The disclosure must describe the services for which such "shared compensation" is paid, and identify each payer and recipient (including status of recipient as an affiliate or subcontractor).

In addition, the disclosure must describe any compensation expected to be received in connection with the termination of the contract or arrangement as well as the manner in which compensation will be received.

C. Disclosure Timing

The disclosure must be made reasonably in advance of the date that the contract or arrangement for brokerage or consulting services is "entered into, extended or renewed." Additionally, if the information contained in the disclosure changes over time, an update must be provided within sixty-days unless extraordinary circumstances beyond the CSP's control apply, in which case the disclosure must be provided as soon as reasonably possible.

D. Disclosure Failures

An arrangement will not fail to be reasonable if the CSP acts in good faith with reasonable diligence to provide an accurate disclosure even if an error or omission occurs. The CSP will need to correct the error or omission as soon as possible, but no later than 30 days after discovery of the error or omission.

The Amendment includes a provision that is designed to insulate an innocent plan fiduciary from liability for engaging in a prohibited transaction if the fiduciary does not receive the disclosures that the Amendment requires a service provider to make. A plan fiduciary may avoid liability if certain conditions are complied with, including notifying the Secretary of Labor of the disclosure failure and considering terminating the provider.

E. Consequences of Disclosure Failures for Providers and Plan Sponsors

If a CSP fails to make the disclosures required by the Amendment, consequences arise under ERISA both for the plan's fiduciary as well as for the service provider. First, the services arrangement would no longer qualify for the statutory exemption under ERISA section 408(b)(2) and would result in a prohibited transaction under ERISA. Under ERISA, the plan's fiduciary may be held liable for any losses to the plan that result from the prohibited services arrangement. In addition, the service provider faces its own potential for liability under ERISA's civil enforcement provisions that allow for the imposition of equitable relief against a service provider for knowingly participating in a prohibited transaction. Second, ERISA section 502(i) permits the Secretary of Labor to assess civil penalties against a service provider whose arrangements result in a prohibited transaction. Finally, ERISA section 502(l) requires the Secretary of Labor to assess an additional 20% penalty on the amount recovered in either a settlement agreement with the Secretary of Labor, or a court judgment in a case brought by the Secretary of Labor, in connection with a prohibited transaction.

In addition, we note that in our experience working with retirement plans, the DOL requests the plan's 408(b)(2) disclosures during routine plan sponsor audits. We believe the DOL will likewise begin to request these disclosures from both group health plan sponsors as well as brokers and consultants in the group health plan space as soon as these new requirements become effective. While brokers and consultants should take care to ensure that their disclosures meet the new requirements, plan sponsors should also consider establishing a process for reviewing and retaining the disclosures and asking any follow up questions.

II. Individual Market Coverage

A health insurance issuer offering individual health insurance coverage or a health insurance issuer offering short-term limited duration insurance coverage must make disclosures to enrollees in such coverage and reports to the Secretary regarding direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

The disclosures made to enrollees should be made prior to the person finalizing the plan selection and also included on any documentation confirming the person's enrollment. The disclosure made to the Secretary of Health and Human Services should be made annually prior to the beginning of open enrollment.

Notice and comment rulemaking regarding the timing, form, and manner of the disclosures is required to be finalized by December 27, 2021.

III. Effective Dates

The Amendment is effective beginning on December 27, 2021, and requires disclosures related to contracts for covered services executed after that date. Arrangements entered into prior to that date are not subject to the disclosures unless or until a renewal occurs. The requirements for the individual market coverage also go into effect on that date.