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HHS Issues Proposed Rules Implementing the Individual Health Insurance Agent & Broker Fee Disclosure Requirements

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As we discussed in our earlier summary, the Consolidated Appropriations Act, 2021, Public Law 116-260 ("CAA"), signed into law by the President on December 27, 2020, imposed new compensation disclosure requirements upon brokers and consultants to group health plans covered by the Employee Retirement Income Security Act of 1974. In addition, the CAA added new required disclosures related to agent and broker compensation to the Public Health Service Act ("PHSA") that apply to the individual market. The Department of Health and Human Services ("HHS") has issued a set of proposed rules implementing these requirements titled Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement ("Proposed Rules"), 86 Fed. Reg. 51,730 (September 16, 2021), available here. HHS also issued a Paperwork Reduction Act ("PRA") package, which includes the proposed required data elements for the reporting. These reporting requirements do not apply to health insurance obtained by or through an employer group health plan and only apply to policies purchased by individuals in the individual market. In this summary, we focus on the agent and broker compensation disclosure requirements established by the Proposed Rules, including disclosures that must be made to policyholders ("Policyholders") and reports that must be made to HHS.

Comments on the Proposed Rule are due to HHS by October 18, 2021.

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I. The Who, What, When and How of the Proposed Rules' Two Disclosure Requirements

a. Who?

The Proposed Rules require health insurance issuers to disclose specific information to Policyholders and to HHS. For the purpose of the Proposed Rules, a "policyholder" means the individual who purchases individual health insurance coverage or short-term, limited-duration insurance and who is responsible for the payment of premiums. In cases where an issuer has contracted with an agent or broker, the disclosures are permitted to—and practically speaking likely must—come from the agent or broker in order to meet the requirement that prospective purchasers receive the disclosure before finalizing their policy decision.

b. What?

The Proposed Rules include two separate requirements. *First*, issuers must disclose information to Policyholders regarding direct and indirect compensation provided by the issuer to an agent or broker, associated with enrolling individuals in coverage. Issuers' disclosure of such information must distinguish between commission payments associated with new enrollments and such payments for renewed enrollments if the issuer differentiates compensation for those two types of enrollments. The disclosure must likewise contain an explanation of qualifying thresholds for the payment of indirect compensation to an agent or broker. The purpose of the disclosure is to allow the Policyholder to evaluate whether the agent or broker may have conflicts of interest in the policies that it recommends based on commissions and other expected payments.

Second, issuers must report specific information directly to HHS in a "backward-looking" annual report filed on an HHS electronic system, the Health Insurance Oversight System ("HIOS"), after payments have been made to agents and brokers. Per the Proposed Rules, HHS intends to collect data from issuers that is similar to the data collected by the Department of Labor on compensation of insurance producers for group health plans subject to the Form 5500 (Schedule A) reporting requirement. The Proposed Rules specify that for each payment recipient and intermediary organization in a specific month of the reporting year, a single row of data in comma-separated values ("CSV") format containing the following fields/columns must be provided:

1. Payor Federal Tax ID Number ("FTIN");
2. Recipient Identifier Type ("NPN" for writing agents or "FTIN" for payments made to intermediaries);
3. Recipient Identifier Value (the actual number);
4. The date on which the payment was made to the payment recipient;
5. Direct Compensation, expressed as a dollar amount (the commission);
6. Indirect Compensation, expressed as a dollar amount, if any (if Indirect Compensation payment amount was made in that month, for example, a bonus was paid out; bonuses for annual

performance are accounted for in December of the reporting year rather than disaggregated into 12 parts for each month);
7. the basis for indirect compensation – a text field allowing entry of what the grounds for the indirect compensation were (bonus, incentive, etc.); and
8. other information specified by the Secretary, which may include, for example, distinguishing between individual health insurance coverage and short-term, limited-duration insurance, listing the appointment arrangement duration, and providing the number of plans the agent sold.

GROOM INSIGHT: This reporting requirement is a "backward-looking" report that will disclose actual dollar amounts of compensation paid. It is intended to be broader in scope than the disclosures made to Policyholders, for example, it includes payments to intermediaries like General Agents or Insurance Marketing Organizations even though HHS states that the Policyholder need not receive that information.

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c. When?

The Proposed Rules address the timing of when disclosures must be made to Policyholders and HHS. The Proposed Rules require disclosure to Policyholders:

1. For disclosures related to initial policy enrollments: prior to when a potential policyholder finalizes their plan selection and in any documentation confirming the initial enrollment;
2. For renewals: disclosure must accompany the plan renewal notice; and
3. If there are no state or federal law or other requirements regarding new policy or renewal notices, the disclosure must be provided with the invoice for the first premium payment for the initial coverage term and for each renewal period.

The report must be submitted to HHS on a calendar year basis. It must be submitted no later than the last business day of July and must reflect payments made during the prior calendar year.

GROOM INSIGHT: Although the reporting to HHS is made on an annual basis, the report to HHS breaks down agent and broker compensation information by month.

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d. How?

The Proposed Rules address the manner of disclosure. The Proposed Rules note that an issuer's disclosure obligation could be satisfied by the agent or broker making the required disclosure to the Policyholder 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*.

86 Fed. Reg. 51,742 (emphasis added).

The Proposed Rules also specify that in making disclosures to Policyholders, issuers must conform with accessibility requirements (including, for example, providing disclosures in multiple languages, accommodating individuals who are blind or require large type) *if* those requirements otherwise apply to the policies sold.

Despite the specifications noted above, the Proposed Rules do not prescribe a specific format for issuers' commission schedules or other documents that detail the applicable direct or indirect compensation in disclosures to Policyholders.

The Proposed Rules contemplate that the "backward-looking" report to HHS would be made through an online system. The PRA package states that HHS will use the HIOS system for the issuer reporting.

II. Penalties for Failure to Make the Required Disclosure

Generally, states have primary enforcement authority under the PHSA with respect to issuers in the individual market. Nonetheless, in the preamble, HHS noted its concern that states would not enforce the requirement of issuers to provide annual reports to HHS regarding agent and broker compensation. Therefore, HHS proposes to retain direct enforcement authority over the requirement for issuers to report annually to HHS (unless a State notifies HHS of its intent to enforce these requirements directly). Enforcement could involve investigations and market conduct examinations by CMS, as well as the assessment of civil monetary fines.

III. Applicability Date

Interestingly, HHS proposed a transition rule that effectively delays the applicability date of the new disclosure and reporting requirements, in some cases significantly. Specifically, the disclosure and reporting requirements would apply with respect to contracts executed *between an agent or broker and a health insurance issuer* on or after December 27, 2021. For the purpose of determining the date of contract execution, the execution of contractual addenda or revisions to the material terms of a pre-existing contract is deemed the execution of a new contract. In other words, the transition rule appears to exempt from disclosure commissions and other amounts paid to agents and brokers under a contract executed with an issuer prior to December 27, 2021, unless an addenda or amendment to that contract is entered into after December 27, 2021. Thus, if an issuer has executed appointment contracts with

agents and brokers prior to December 27, 2021, it may not have a disclosure obligation until later in 2022 at the earliest.

IV. Exclusions

Certain types of plans are excluded from the new agent and broker compensation disclosure and reporting rules. Specifically, coverage that consists solely of excepted benefits (as described in section 9832 of the Code, section 733 of ERISA, and section 2791 of the PHS Act) is not subject to the reporting requirements in the Proposed Rules. The same is true of individual coverage health reimbursement arrangements and other account-based plans that qualify as excepted benefits.

GROOM INSIGHT: Although the reporting to HHS is made on an annual basis, the report to HHS breaks down agent and broker compensation information by month.