

**FIELD ASSISTANCE BULLETIN NO. 2021-03**

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MEMORANDUM FOR: MABEL CAPOLONGO, DIRECTOR OF ENFORCEMENT
AMY TURNER, DIRECTOR OF FIELD ADMINISTRATION
REGIONAL DIRECTORS

THROUGH: TIMOTHY D. HAUSER
DEPUTY ASSISTANT SECRETARY FOR PROGRAM OPERATIONS

FROM: JOHN J. CANARY
DIRECTOR OF REGULATIONS AND INTERPRETATIONS

SUBJECT: TEMPORARY ENFORCEMENT POLICY REGARDING GROUP HEALTH PLAN
SERVICE PROVIDER DISCLOSURES UNDER ERISA SECTION 408(b)(2)(B)

This memorandum announces the Department of Labor's (Department) temporary enforcement policy for group health plan service provider disclosures under ERISA section 408(b)(2)(B). Section 202 of Title II of Division BB of the Consolidated Appropriations Act, 2021 (CAA) amended section 408(b)(2) of ERISA to require certain service providers to group health plans, as defined in section 733(a) of ERISA, to disclose specified information to a responsible plan fiduciary about the direct and indirect compensation that the service provider expects to receive in connection with its services to the plan. The new disclosure requirements in ERISA section 408(b)(2)(B) apply to persons who provide "brokerage services" or "consulting" to ERISA-covered group health plans who reasonably expect to receive \$1,000 or more in direct or indirect compensation in connection with providing those services. The information required to be disclosed under ERISA section 408(b)(2)(B), which includes both direct and indirect compensation that is expected to be received in connection with a contract or arrangement between a covered service provider and a covered plan, generally must be disclosed reasonably in advance of the parties entering into such contract or arrangement. The required disclosures are intended to provide the responsible plan fiduciary with sufficient information to assess the reasonableness of the compensation to be received and potential conflicts of interest that may exist as a result of a covered service provider receiving indirect compensation from sources other than the plan or the plan sponsor. The CAA provides that the ERISA section 408(b)(2)(B) amendments apply beginning one year after the date of the CAA's December 27, 2020 enactment, *i.e.*, December 27, 2021.

TEMPORARY ENFORCEMENT POLICY

The Department is not issuing regulatory guidance at this time. However, the Department is aware that service providers and group health plan fiduciaries have questions about certain provisions of the new law. The Department is providing the following guidance and temporary enforcement policy to address such questions.

The Department understands that group health plan service provider arrangements and compensation structures are not uniform, often complicated, and frequently structured to reflect state law. Accordingly, the Department expects that covered service providers will adopt various methods to make the required disclosure regarding their services and compensation in a way that complies with ERISA section 408(b)(2)(B). For purposes of analyzing the application of ERISA section 408(b)(2)(B) to a service contract or arrangement, the Department is of the view that a significant goal of the new disclosure requirements is to enhance fee transparency, especially for service arrangements that involve the payment of indirect compensation as defined in ERISA section 408(b)(2)(B)(ii)(I)(dd)(CC).¹ For example, service providers previously may not have disclosed compensation that they reasonably expected to receive from a third party provider in return for referring group health plan clients to such provider (*i.e.*, indirect compensation), because such compensation was not paid directly by the group health plan. The statute now unambiguously requires covered service providers to disclose indirect fees and compensation. When analyzing a covered service provider's efforts to comply with the requirements, the Department will consider whether the provider's disclosure of information is reasonably designed and implemented to provide the required information and transparency.

Consistent with the scope of the prohibited transaction relief provided by ERISA section 408(b)(2), and pending further guidance, in the case of a person who is a covered service provider under ERISA section 408(b)(2)(B) by reason of providing brokerage services or consulting to a group health plan, the Department will not treat that person as having failed to make required disclosures to a responsible plan fiduciary under ERISA section 408(b)(2)(B) as long as the person made disclosures in accordance with a good faith, reasonable interpretation of ERISA section 408(b)(2)(B). Further, ERISA section 408(b)(2)(B)(viii) provides conditional relief for responsible plan fiduciaries in connection with disclosure failures by covered service providers. The Department will interpret and apply ERISA section 408(b)(2)(B)(viii) in light of the enforcement policy for covered service providers set forth above. In general, pending future guidance or rulemaking, covered service providers and plan fiduciaries are expected to implement the ERISA section 408(b)(2)(B) requirements using a good faith, reasonable interpretation of the law.

GUIDANCE ON GOOD FAITH AND REASONABLE INTERPRETATIONS

Q1: The section 408(b)(2)(B) disclosure requirements added by the CAA are substantially similar to the Department's ERISA section 408(b)(2) regulation governing covered service provider disclosures to responsible plan fiduciaries of pension plans. See 29 CFR § 2550.408b-2(c). In attempting to comply with the new CAA requirements for group health plans, may covered service providers look to prior Departmental guidance developed for service providers of pension plans?

Yes. Even though certain provisions in ERISA section 408(b)(2)(B) are not identical to the pension plan disclosure provisions in regulation 29 CFR § 2550.408b-2(c), the Department would view it as a good faith and reasonable step for a group health plan service provider to take into account the Department's guidance on its regulation for pension plans in connection with the similar disclosure requirements under section 408(b)(2)(B) for group health plan service providers.

¹ The Department pursued a similar goal when issuing its final regulation requiring enhanced fee disclosures for pension plan service providers, ensuring comprehensive disclosure of compensation to be received by covered service providers, whether directly from the plan or indirectly from third parties. See 29 CFR § 2550.408b-2(c); see also the Department's explanation for adopting this regulation, at 77 FR 5632 (Feb. 3, 2012).

A considerable amount of information about the Department's views on the similar disclosure requirements for ERISA pension plans is available in the Notices published in connection with the Department's 2012 final rule governing pension plan disclosures. Although group health plan compensation arrangements may differ from pension plan compensation, much of the terminology and many of the requirements in section 408(b)(2)(B) as added by the CAA and the Department's regulation on pension plan disclosure are identical, such that the Department's explanations of such terminology and requirements may be useful when analyzing the new provisions in ERISA section 408(b)(2)(B). See 29 CFR § 2550.408b-2(c); 77 FR 5632 (Feb. 3, 2012), *Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure* (Final Rule), <https://www.govinfo.gov/content/pkg/FR-2012-02-03/pdf/2012-2262.pdf>; and 75 FR 41600 (July 16, 2010), *Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure* (Interim Final Rule), <https://www.govinfo.gov/content/pkg/FR-2010-07-16/pdf/2010-16768.pdf>.

Q2: Does ERISA section 408(b)(2)(B) cover insured and self-insured group health plans?

ERISA section 408(b)(2)(B) applies to group health plans as defined in ERISA section 733(a). ERISA section 733(a) defines a "group health plan" as "an employee welfare benefit plan to the extent that the plan provides medical care ... to employees or their dependents ... directly or through insurance, reimbursement, or otherwise." This term includes both insured and self-insured group health plans, including grandfathered health plans, as defined in section 1251(e) of the Patient Protection and Affordable Care Act. Because ERISA section 733(a)(1) expressly excludes qualified small employer health reimbursement arrangements from the definition of group health plan, such arrangements are not subject to these provisions. Compliance with the disclosure requirements in ERISA section 408(b)(2)(B) is a condition, among others in ERISA section 408(b)(2), for covered service provider arrangements to be exempt from the prohibited transaction provisions in ERISA section 406(a)(1)(C) and (D).²

Q3: Is a plan that provides only "excepted benefits," such as limited scope dental and vision benefits as defined in ERISA section 733(c)(2), a "covered plan"?

ERISA section 733(a) defines a "group health plan" as "an employee welfare benefit plan to the extent that the plan provides medical care ... to employees or their dependents ... directly or through insurance, reimbursement, or otherwise." ERISA section 733(c)(2) provides that certain benefits are not subject to certain requirements of Part 7 of ERISA if offered separately, including limited scope dental or vision benefits. Service providers for, and issuers of, dental and vision coverage have asked the Department whether plans providing only these "excepted benefits" are "covered plans" for purposes of the new disclosure requirements in ERISA section 408(b)(2)(B).

The view of the Department is that limited scope dental and vision plans, although excepted from certain requirements in Part 7 of ERISA, are "covered plans" subject to the requirements of ERISA section 408(b)(2)(B). The definition of a "covered plan" in ERISA section 408(b)(2)(B) refers to ERISA section 733(a), without any indication that the definition is further limited by ERISA section 733(c)(2). That conclusion is further supported by the definition of a "covered service provider" in ERISA section 408(b)(2)(B)(ii)(I)(bb), which states that covered brokerage services in subparagraph (AA) include such services rendered to a "covered plan with respect to the selection of insurance products (*including vision*

² This Bulletin does not address any prohibited transaction issues that may arise under ERISA section 406(b). Compliance with ERISA section 408(b)(2) does not provide any relief for ERISA section 406(b) fiduciary self-dealing prohibited transactions. See 29 CFR 2550.408b-2(e). See also Advisory Opinion 82-26A; Advisory Opinion 83-44A; Information Letter to Richard E. Dolan from Bette J. Briggs (December 17, 1990).

and dental)” and that covered consulting services in subparagraph (BB) include services “related to the development or implementation of plan design, insurance or insurance product selection (*including vision and dental*)[.]” [Emphasis added.]

Neither the text of the statutory amendment to ERISA section 408(b)(2), nor the legislative history of the CAA, evidences any intent to exclude contracts or arrangements involving excepted benefit plans from the new disclosure requirements. The fact that they are excluded from some of the requirements of Part 7 of ERISA (such as the portability and nondiscrimination provisions of the Health Insurance Portability and Accountability Act, the mental health and substance use disorder parity provisions, the Affordable Care Act market reforms, and certain other provisions of the No Surprises Act) does not, in the Department’s view, result in a different conclusion. Rather, the policy basis for the treatment of excepted benefits under those Part 7 provisions is not analogous to the policy underlying the new 408(b)(2)(B) service provider disclosure requirements, which, in the Department’s view, applies equally to limited scope dental and vision coverage as it does to other group health coverage.

Q4: ERISA section 408(b)(2)(B) defines “covered service providers” to include providers of brokerage services and consulting to group health plans, but does not define these services. Is the definition limited to service providers who are licensed as, or who market themselves as, “brokers” or “consultants”?

No. ERISA sections 408(b)(2)(B)(ii)(I)(bb)(AA) and (BB) describe two categories of “covered service providers” to whom the new disclosure requirements apply – the first being providers of “brokerage services” and the second “consulting” services.³ Neither term is defined in ERISA section 408(b)(2)(B), and the categories may overlap in some circumstances. Rather, each of these terms is described in relationship to a list of sub-services that constitute the subject matter of the brokerage services or consulting. Service providers have considerable discretion over how they describe and market their services and label their fees. The fact that a service provider does not call itself a “consultant” or charge a “consulting” fee is not dispositive, for example, as to whether the provider is “consulting” for purposes of section 408(b)(2)(B). Further, in some cases “bundled” services are provided to a group health plan for one fee, without any separate charge disclosed for a specific service. The nature of compensation received by a service provider also is not a basis for defining or differentiating brokerage services from consulting.⁴ Pending further guidance, the Department’s enforcement policy will apply to parties who

³ Specifically, *brokerage services* “provided to a covered plan with respect to selection of insurance products (including vision and dental), recordkeeping services, medical management vendor, 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” or *consulting services* “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.”

⁴ Historically, consultants tended to work on a fee-for-service basis, and brokers worked for commissions. However, many brokers now work on a fee-for-service basis, and many consultants work for commissions. The legislative history to the amendments adding ERISA section 408(b)(2)(B), and prior drafts of the legislation, make note of referral fees as an example of indirect compensation that must be disclosed, though the Department does not view ERISA section 408(b)(2)(B)(ii)(I)(bb)(BB) as limited to compensation received for service referrals. See, e.g., House Report 116-615 (Dec. 2, 2020), p. 48, www.congress.gov/116/crpt/hrpt615/CRPT-116hrpt615.pdf and House Ways and Means discussion at waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/OMNISurpriseBillingPublicHealthFDA_FINAL3.pdf.

reasonably and in good faith determine their status as a covered service provider under section 408(b)(2)(B).

Whether a person acts reasonably and in good faith depends on the facts of the particular situation. As noted above, the Department is of the view that a significant goal of the new disclosure requirements is to enhance fee transparency, especially for service arrangements that involve the receipt of indirect compensation as defined in ERISA section 408(b)(2)(B)(ii)(I)(dd)(CC). Accordingly, in light of this goal and taking into account the prohibited transaction consequences of a disclosure failure, service providers who reasonably expect to receive indirect compensation from third parties in connection with advice, recommendations, or referrals regarding any of the listed sub-services in section 408(b)(2)(B)(ii)(I)(bb) of ERISA, should be prepared, if the Department is auditing their 408(b)(2)(B) compliance, to be able to explain how a conclusion that they are not covered service providers is consistent with a reasonable good faith interpretation of the statute.

Q5: How should a covered service provider disclose compensation amounts that cannot be known in advance, before a contract or arrangement is entered into with a group health plan? For example, compensation ultimately received often will depend on a number of variables, such as participants' actual benefit elections, changes to elections, and usage rates.

ERISA section 408(b)(2)(B) requires covered service providers to make the required disclosures to responsible plan fiduciaries reasonably in advance of the date they enter into a contract or arrangement with a covered group health plan. The statutory provision expressly acknowledges that this may involve disclosures of estimates or formulas that would govern any anticipated compensation. The Department recognizes that covered service providers may be unable to state with precision the amount of compensation they expect to receive for services, because the methodology by which certain components of their compensation is determined will depend on decisions or variables that are not known before, or even at the time, the contract or arrangement is entered into and, in fact, may change over the term of the contract or arrangement.

Section 408(b)(2)(B) explicitly provides covered service providers with considerable flexibility in how they disclose the compensation that they reasonably expect to receive. Given the diverse service and compensation structures that exist in the group health plan marketplace, it is not feasible for the Department to provide a model form or specific directions on how to disclose all components of every service provider's potential compensation. However, the statutory provision permits a variety of disclosure formats that specifically address many of the fact patterns raised by stakeholders.

Subparagraph 408(b)(2)(B)(ii)(II) states that the required description of compensation or cost "may be expressed as a monetary amount, formula, or a per capita charge for each enrollee or, if the compensation or cost cannot reasonably be expressed in such terms, by any other reasonable method, including a disclosure that additional compensation may be earned but may not be calculated at the time of contract if such a disclosure includes a description of the circumstances under which the additional compensation may be earned and a reasonable and good faith estimate if the covered service provider cannot otherwise readily describe compensation or cost and explains the methodology and assumptions used to prepare such estimate."

Pending further guidance, the Department takes the view that disclosure of compensation in ranges may be reasonable in circumstances when the occurrence of future events or other features of the service arrangement could result in the service provider's compensation varying within a projected range. In

that regard, the following language in the preamble to the Department’s final regulation for covered service provider disclosures to pension plan fiduciaries is germane: “However, such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue. To ensure that covered service providers communicate meaningful and understandable compensation information to responsible plan fiduciaries whenever possible, the Department cautions that more specific, rather than less specific, compensation information is preferred whenever it can be furnished without undue burden.” See 77 FR 5632, at 5645.

No matter the methodology used to disclose compensation, the adequacy of the disclosure should be measured against a principal objective of the statutory provision – which is to provide the responsible plan fiduciary with sufficient information about the compensation to be received by covered service providers to allow the fiduciary to evaluate the reasonableness of the compensation, and the severity of any associated conflicts of interest. The duties of prudence and loyalty in ERISA section 404 apply to a responsible plan fiduciary’s decisions to hire service providers and to ongoing monitoring of service provider arrangements. What constitutes adequate disclosure for a specific compensation arrangement will depend on the facts and circumstances of the service contract or arrangement.

Q6: ERISA section 408(b)(2)(B)(i) states that “[n]o contract or arrangement for services between a covered plan and a covered service provider, and no extension or renewal of such a contract or arrangement, is reasonable” unless the disclosure requirements of section 408(b)(2)(B) are met. The new requirements apply beginning on December 27, 2021. Does this applicability date include service contracts or arrangements that have already been executed?

The CAA provides that the amendments to ERISA section 408(b)(2), including the new disclosure requirements for covered service providers to group health plans, “shall apply beginning 1 year after the date of enactment of [the CAA].” Accordingly, the requirements apply to covered service providers and covered plans beginning on December 27, 2021.

The CAA also provides a transition rule, which clarifies that “no contract executed prior to [December 27, 2021] by a group health plan subject to the requirements of section 408(b)(2)(B) of [ERISA] ... shall be subject to the requirements of such section 408(b)(2)(B) ...[.]”⁵

Therefore, only contracts or arrangements for services that fall within the scope of ERISA section 408(b)(2)(B) which are entered into, extended, or renewed on or after December 27, 2021 are required to comply with the disclosure requirements in section 408(b)(2)(B).

The date on which a contract or arrangement is entered into between an agent or broker and a plan fiduciary will be considered the date the contract or arrangement was “executed.” For example, if a plan fiduciary enters into a new service contract with an agent on December 15, 2021, for the plan year beginning on January 1, 2022, the service contract will be treated as having been “executed” on December 15, 2021, which is prior to December 27, 2021, so that the contract will not be subject to the new compensation disclosure requirements, but the disclosure requirements would apply if the contract is renewed or extended, or a new contract is executed, on or after December 27, 2021.

Also, pending further guidance, in the case of an agent or broker that enters into a contract or arrangement with a plan fiduciary through use of a “broker of record” (BOR) agreement, the date the

⁵ See Section 202(d) of Title II of Division BB of the CAA.

contract or arrangement will be considered entered into for purposes of section 408(b)(2)(B) is the earlier of the date on which the BOR agreement is submitted to the insurance carrier or the date on which a group application is signed for insurance coverage for the following plan year provided that the submission or signature is done in the ordinary course and not to avoid disclosure obligations under ERISA section 408(b)(2)(B).

Q7: Does the law apply to both large and small group health plans?

Yes, ERISA section 408(b)(2)(B) applies to group health plans regardless of size. There is no exception for small plans covering fewer than 100 participants. A small group health plan is subject to the disclosure requirements even if the plan is exempt from filing a Form 5500 annual report under 29 CFR 2520.104-20 because it is fully insured, unfunded, or a combination of fully insured and unfunded.

Q8: Does the Department intend to issue regulations on these statutory disclosure requirements?

The CAA does not require the Department to issue regulations under ERISA section 408(b)(2)(B), and, as noted above, the statutory provisions borrow heavily from and mirror a long-standing Department regulation governing service provider disclosures for pension plans. Accordingly, the Department does not believe that comprehensive implementing regulations are needed. The Department does intend to continue monitoring feedback from stakeholders and from the Department's enforcement activities to assess whether, and if so what, additional guidance may be necessary to assist covered service providers and responsible plan fiduciaries in complying with the new disclosure requirements. The Department is particularly interested in input as to whether particular elements of the ERISA section 408(b)(2)(B) statutory provisions would benefit from notice and comment regulations, and, if so, what the Department should consider including in any such proposed regulations.

FOR FURTHER INFORMATION

Questions concerning this memorandum may be directed to the Employee Benefits Security Administration's Office of Regulations and Interpretations at (202) 693-8500.