Published on *The National Law Review* https://natlawreview.com

Department of Labor Issues Advice on Broker and Consultant Compensation Disclosures Under the Consolidated Appropriations Act, 2021

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In Field Assistance Bulletin 2021-03, the Department of Labor (the "Department") announced a temporary enforcement policy relating to the rules enacted in Division BB of the Consolidated Appropriations Act, 2021 (the "Act") requiring the disclosure of direct and indirect compensation paid to brokers and consultants who advise group health plans. (We reported on these rules in a previous post.) This post summarizes the key features of the new guidance.

Background

Division BB of the Act broadly addresses surprise medical billing and health plan transparency. Section 202 of Division BB (the "Provision") establishes rules governing the disclosure of direct and indirect compensation paid to brokers and consultants who advise group health plans. The Provision applies to contracts or arrangements executed or entered into on or after December 27, 2021. Specifically, the Provision amends the prohibited transaction exemption provisions in ERISA section 408(b)(2) that govern service provider arrangements with ERISA plans. The amendments require persons providing "brokerage services" or "consulting" to ERISA-covered group health plans to disclose detailed information to plan fiduciaries about the compensation that providers expect to be paid in connection with their services to the plan.

The Act's broker and consultant compensation rules are modeled on similar disclosure requirements that have applied to pension plan service providers since 2012. The Field Assistance Bulletin tracks and cites the pension disclosure rules while also providing transitional flexibility that individuals and entities subject to the rules act reasonably and in good faith. Field Assistance Bulletin 2021-03 is organized as a set of questions and answers that, according to the Department, "are designed to explain the department's view about what constitutes a good faith, reasonable interpretation of the statute with respect to several key issues that had been raised by stakeholders."

Field Assistance Bulletin 2021-03 Highlights

- *Noting that the disclosure requirements added by the Act are substantially similar to the Department's pension disclosure rules, the Department advises that it 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."

The pension disclosure rules apply to covered service providers. A "covered service provider" is a service provider that expects to receive at least $1,000 in direct or indirect compensation in connection with the service engagement. The term includes investment advisors, record keepers, and brokers and consultants, among others. A covered service provider who is providing recordkeeping services must also disclose all direct and indirect compensation that an affiliate or subcontractor expects to receive in connection with such services. Thus, the pension rules are similar to the Provision. According to the Department, "much of the terminology and many of the requirements in [ERISA] 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." The consequences of this approach will be particularly important when determining whether compensation paid to a broker or consultant is "indirect" (a topic that we plan to address in a future post).

- *The new rules cover both insured and self-insured group health plans.*

Based on what appears to be a plain reading of the definition of what constitutes "group health plan" under ERISA, the Department concludes that the term includes both insured and self-insured group health plans, including grandfathered health plans. However, "because ERISA section 733(a)(1) expressly excludes qualified small employer health reimbursement arrangements from the definition of group health plan," these arrangements are not subject to the disclosure rules.

- *Plans that provide "excepted benefits," such as limited scope dental and vision benefits, are subject to the disclosure rules.*

While noting that certain benefits are not subject to certain requirements of Part 7 of ERISA if offered separately, including limited scope dental or vision benefits, the Department nevertheless expresses the view 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 Department goes on to say, correctly, that 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)."

- *Whether or how a broker or consultant is licensed, or how the services are marketed, is not relevant. The terms "broker" and "consultant" are defined in relation to a list of sub-services that constitute the subject matter of the brokerage services or consulting with respect to categories of advice.*

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.

The Department separately addresses bundled services, saying:

[I]n 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. Pending further guidance, the Department’s enforcement policy will apply to parties who reasonably and in good faith determine their status as a covered service provider under section 408(b)(2)(B).

- *Reporting of “amounts that cannot be known in advance, before a contract or arrangement is entered into with a group health plan.”*

Recognizing that covered service providers may be unable to state with precision the amount of compensation they expect to receive for services, the Department endeavors to provide some flexibility. The statute itself (ERISA section 408(b)(2)(B)(ii)(II)) states that the required description of compensation or cost:

“[M]ay 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.”

Therefore, pending further guidance, 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. The Department cautions, however, that such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue. It also expresses a preference for information that is more specific, rather than less specific, whenever it can be furnished without “undue burden.”

- *Contracts to which the new rules apply.*

According to the statute, “[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. No contract executed prior to December 27, 2021 is subject to the Provision. Thus, as a practical matter, January 1, 2022 renewals should not be subject to the rule.

The Department separately adopts a clarification that applies to “broker of record” (“BOR”) agreements under which the date the contract or arrangement will be considered entered 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.”

- *The disclosure rules apply to both large and small group health plans.*

The Department clarifies that the new compensation disclosure rules apply 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.

- *The Department does not plan to issue regulations under the Provision.*

Observing that the “CAA does not require the Department to issue regulations” under the provision, the Department does not plan to do so (“[T]he Department does not believe that comprehensive implementing regulations are needed.”). The Department does, however, intend to continue monitoring feedback from stakeholders to assess whether, and if so what, additional guidance may be necessary.

National Law Review, Volumess XII, Number 5