

TESTIMONY ON

HEARING ON REASONABLE CONTRACTS OR ARRANGEMENTS
UNDER ERISA SECTION 408(b)(2) – FEE DISCLOSURE

By

Stephanie Kanwit
Special Counsel
On behalf of
AMERICA'S HEALTH INSURANCE PLANS

Before the
UNITED STATES DEPARTMENT OF LABOR
EMPLOYEE BENEFITS SECURITY ADMINISTRATION

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Good afternoon. My name is Stephanie Kanwit and I am Special Counsel for America's Health Insurance Plans (AHIP). I would like to thank the Employee Benefits Security Administration (EBSA) for the opportunity to discuss our concerns regarding the Proposed Rule that would significantly expand disclosure requirements on service providers that enter into contracts and arrangements with ERISA employee benefit plans. AHIP is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans. Our members offer a broad range of products in the commercial marketplace including health, long-term care, dental, vision, disability, and supplemental coverage. Almost all of AHIP's members provide insurance coverage to or administer benefits on behalf of employee health and welfare benefit plans.

AHIP submitted extensive written comments to the Department of Labor regarding the Proposed Rule, and fully supports its goals: to assure that plan fiduciaries have sufficient information about the cost and quality of services provided to the plan to make prudent decisions and fulfill their fiduciary responsibilities, as ERISA requires. Such "transparency" mandates, however, must be meaningful, and impose requirements that in fact assure that helpful information is supplied at appropriate junctures to plan fiduciaries.

To accomplish the laudable purpose of the Proposed Rule, we believe that it must be withdrawn and revised to more accurately address the specific needs of health and welfare plan fiduciaries for two key reasons:

- First, we do not believe deficiencies exist in disclosures to plan fiduciaries that would warrant imposition of such sweeping requirements. In fact, plan fiduciaries already receive or can request from their service providers a comprehensive laundry list of information related to cost as well as type and quality of services;

- Second, the disclosure requirements in their current form will impose additional costs on health plans and their service providers, while at the same time failing to provide any additional material information useful to health and welfare plan sponsors and simultaneously creating the risk of disrupting the current highly competitive marketplace.

1. The Proposed Rule in the context of health and welfare plans purports to fix a nonexistent problem.

The provisions of the Proposed Rule as currently drafted are ill-suited to the real world in which health and welfare benefit plans operate. In fact, we understand that most of the concerns leading to the Rule pertain to how service providers to *pension plans* are compensated -- in particular, defined contribution arrangements such as 401(k) retirement plans -- and as a result the provisions of the Proposed Rule reflect that pension-related focus.

The ERISA Working Group cites no evidence that plan sponsors of health and welfare plans are somehow lacking material information. In fact, service providers to self-funded health and welfare plans disclose an extensive amount of information about their services and prices at multiple stages of the contracting process -- for example, in response to requests for proposals issued by the fiduciary; as part of the contract negotiations; in the services contract documents; and in post-contract reporting and auditing requirements that are included in many service provider agreements. The contracts are typically renewed on an annual basis, giving fiduciaries the ability to change service providers if the cost and quality of administrative services do not meet the needs of the plan and its beneficiaries.

In addition, a plan sponsor is always free to request information from its health insurance plan, and that plan will provide sufficient information to reasonably allow a fiduciary to determine (for example) whether a service provider's compensation or fees are reasonable for the services performed. The only information service providers such as

health plans do not routinely share is sensitive, proprietary information such as rates paid to physicians and other health care providers pursuant to their contracts, but even in the case of such proprietary information, the plan sponsor or its consultant or auditor has access to selected information for auditing purposes.

Nor does it benefit the plan sponsor or its participants and beneficiaries to have access to all such proprietary information for two reasons: first, such information is not needed by the sponsor to evaluate the reasonableness of costs; second, public disclosure of that information would be anticompetitive and ultimately result in higher costs. For example, certain information about prices or fees paid to the service provider, such as amounts received from wellness program vendors or withholds related to risk sharing arrangements with physician groups, should not need to be disclosed since they do not directly impact the fees, but serve in the aggregate to lower future insurance premiums or administrative services fees.

At bottom, what is missing from the Proposed Rule is the recognition of the empowerment of plan sponsors, an empowerment born of the highly competitive and vigorous price competition that exists in the marketplace for health and welfare benefit plans. As the Federal Trade Commission has noted on multiple occasions, health and welfare plan fiduciaries have a clear choice among an enormous variety of administrative service and benefit designs and financial arrangements from multiple plans and service providers, allowing them enormous flexibility to obtain services that meet the needs of their particular participants and beneficiaries.

That flexibility is pro-competitive, resulting in lower premiums or other improved terms for the plan sponsor. As the FTC has noted, “vigorous competition...is more likely to arrive at an optimal level of transparency than regulation of those terms.”

II. The Proposed Rule’s breadth will impose additional costs on health plans and their service providers, while at the same time disrupting a system that works well for plan sponsors.

As noted above, the current system works well, with plan sponsors able to access exactly the kind of information they need when they need it from their service providers. The breadth of the language of the Proposed Rule, however, and the inapplicability of certain sections to health and welfare plans, will impose unnecessary and sometimes costly administrative burdens on health insurance plans which service these ERISA plans-- costs that ultimately will be passed on to plan sponsors. The Rule as drafted would mandate the disclosure and provision of reams of unnecessary information, including (for example) information pertaining to vaguely worded requirements such as "direct" and "indirect" compensation received in connection with the provision of services and to "potential conflicts of interest."

Generally, because of the penalties imposed for violation, plan fiduciaries will need to demand reams of information from their service providers – even information they may not need or want – and service providers will be forced to produce similarly massive amounts of information no matter how tangentially related to the core elements of their agreements. The result will be that plan service providers as well as fiduciaries will find themselves drowning in a sea of information that will not only be costly to produce, but will confer little value on the participants and beneficiaries.

One specific example of inefficiency likely to be caused by the Proposed Rule that will almost certainly result in unnecessary expenditures is its possible application to insurance products, rather than solely to self-funded health and welfare plans. Yet insurance carriers that sell health, disability, long-term care, supplemental or other insurance to a fully-insured ERISA plan already assume the *full risk for the coverage* provided to plan participants and beneficiaries.

We believe the broad state oversight already applicable to fully-insured arrangements provides sufficient assurance that relevant information is disclosed -- including state review and approval of policy forms and premiums. The Proposed Rule as currently drafted would force insurers to include additional and duplicative language in the policy

forms, including resubmitting already-approved forms to state insurance regulators for approval – an expensive and time-consuming process.

Conclusion

AHIP fully supports the principle of providing plan sponsors and fiduciaries with all the requisite material information to enable them to make informed decisions in transactions with their service providers. But the Proposed Rule is counterproductive to that goal, and meets neither the needs of the health and welfare plan fiduciaries intended to be benefited, nor the ultimate participants and beneficiaries who depend on them for health and welfare coverage.

AHIP recommends that the Department withdraw the Proposed Rule with respect to health and welfare benefit plans and conduct an additional investigation to determine: (a) whether specific issues exist with respect to the adequacy of disclosures made to health and welfare plans fiduciaries; (b) whether there are “gaps” in existing requirements for disclosure, including ERISA disclosure requirements such as the annual Form 5500 reports; and (c) how meaningful transparency of material information useful to plan sponsors can best be provided to them without at the same time requiring the disclosure of competitively sensitive information that will raise costs for all.

Thank you for your consideration.