TUGGLE DUGGINS

ATTORNEYS AT LAW

Kenneth M. Johnson
336-271-5264
kjohnson@tuggleduggins.com

February 11, 2008

Via E-mail: e-ORI@dol.gov
Office of Regulations and Interpretations
Employee Benefits Security Administration
Room N-5669
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Attn: 408(b)(2) Amendment

Re: Proposed Regulation:
Reasonable Contract or Arrangement Under Section 408(b)(2)

Dear Ladies and Gentlemen:

I appreciate the Department's efforts in addressing fee disclosure. Bringing transparency in fees will be especially appreciated by fiduciaries for small and mid-sized 401(k) plans who often find it difficult to make informed choices in provider selection. My comment, however, relates to welfare plans. I would request clarification of the following statement made in the preamble of the proposed regulation:

> However, if a fiduciary contracts on behalf of a welfare plan with a medical provider network, for example an HMO, a doctor that is part of the network and that has no separate agreement or arrangement with the plan would not be a service provider to the plan; the doctor merely provides medical benefits to the plan's participants and beneficiaries.

I understand that in this situation a doctor would not be performing the services that are enumerated in sections (c)(1)(i) (A)-(C) of the proposed regulation and therefore, would not be bound by that regulation's disclosure obligation. I am however, concerned

that the statement might be construed by some to mean that it is the Department's view that welfare plan transactions with medical benefit providers are immune from ERISA's prohibited transaction provisions.

Plan participants are becoming increasingly responsible for medical costs under their group medical plans not only in terms of increased participant contributions but also by increased deductibles, co-insurance and co-pays. Medical provider selection and compensation is, therefore, becoming an increasingly important issue to welfare plan participants and beneficiaries. The Department's prior position has been that as long as plan assets are involved (such as with participant contributions) such selection is subject to ERISA's prohibited transaction provisions. In a February 1998 Information Letter to Diana Orantes Ceresi, the Department stated:

> When the selection of a health care provider involves the disposition of employee benefit plan assets, such selection is an exercise of authority or control with respect to the management and disposition of the plan's assets within the meaning of section 3(21)(A) of ERISA, and thus constitutes a fiduciary act subject to the general fiduciary responsibility standards **and prohibited transaction provisions of ERISA.**

An information letter is only issued when it concerns a "well-established interpretation or principle of [ERISA]". That the plan contracts with a network or managed care provider who, in turn, contracts with a medical provider should not change this analysis. First by picking the network the plan fiduciaries are actually selecting the medical providers and how much they will be compensated by the plan. Second, §406(a) applies to direct or indirect transactions. Indeed the Department has granted an individual prohibited transaction exemption with regard to payments to medical benefit providers through networks such as PTE 93-62 involving Emory Hospital. Pharmacies also "merely provide medical benefits to participants" but payments by welfare plans to those pharmacies (contracted through a pharmacy network) have also been subject to a prohibited transaction analysis by the Department in several prohibited transaction exemptions. Indeed the two most recent of these exemptions arose out of the Department's investigation and apparent direction to the welfare plans that they needed to seek such an exemption. See the application for individual exemptions 2007-07 and

2006-12. See also individual exemptions 2002-05, 2000-44, and 95-61.[1] The Department has also taken the position in litigation that payments to medical providers can be prohibited transactions. McLaughlin v. Bendersky 705 F.Supp. 417 (N.D. Ill. 1989) (seeking to enforce a subpoena for documents from a dental provider arguing that payments to that provider from a welfare plan may have been prohibited transactions).

Again, this comment merely seeks clarification that the reference to medical services in the preamble is not intended to express the Department's view that selection and payment of medical providers by welfare plans is exempt from a prohibited transaction analysis. Rather we seek confirmation that it is just the Department's view that there is no disclosure obligation under the proposed regulation because such arrangements are not among the enumerated services specified in Section (c)(1)(i) (A)-(C) of that regulation.

Very truly yours,

Kenneth M. Johnson

KMJ:ktc

[1] The fact that there are more exemptions for payments to pharmacies rather than for doctors or hospitals is probably due to the fact that the doctors and hospitals believed the §408(b)(2) statutory exemption applied while pharmacies, since they were not providing a service, could not use the statutory exemption.