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2008 Joint Fall CLE Meeting

San Francisco, California
September 11 to 13, 2008

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Impact on Welfare Benefit Plans of Proposed EBSA Regulation on Reasonable Contracts or Arrangements Under Section 408(b)(2)

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Introduction

The Department of Labor's proposed regulation issued December 13, 2007 (72 Fed. Reg. 70988) entitled "Reasonable Contract or Arrangement Under Section 408(b)(2) (the "Proposed Regulation") would amend 29 C.F.R. 2550.408b-2(c) to provide that a "'reasonable contract or arrangement" under ERISA § 408(b)(2) must include, among other things, certain disclosures concerning service provider compensation and conflicts of interest. While the Proposed Regulation is principally intended to address concerns relating to 401(k) plans, its scope is not so limited. Instead, as currently constituted, it applies to all ERISA-covered pension and welfare benefit plans.

The Proposed Regulation is part of a larger, laudable effort by the Department of Labor to ensure that fiduciaries and plan participants have access to information relating to fees paid by plans to services providers. The other parts of this effort include expanded Schedule C reporting of both direct and indirect service provider fees, and rules relating to the information concerning fees that must be supplied to participants. (The Proposed Regulation addresses the information that the service provider must provide to the plan's fiduciaries.)

ERISA § 408(b)(2) and 29 C.F.R. 2550.408b-2 provide relief from the prohibited transaction rules for service contracts or arrangements between a plan and a party in interest if the contract or arrangement is reasonable, the services are necessary for the establishment or operation of the plan, and no more than reasonable compensation is paid for the services. While perhaps little noticed, there is a battle begin waged in the comments and elsewhere over proper scope of disclosure rules. The possibilities include the following:

(i) Apply a single set of disclosure standards to all ERISA-covered plans;

(ii) Adopt one set of rules for ERISA-covered pension plans and another for ERISA-covered welfare plans; and

(iii) Adopt a rule similar to item (ii) but further subdivided the pension universe into self-directed arrangements and non self-directed arrangements.

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While compelling cases can be made for each approach, the statute itself makes no distinction.

Application to Welfare Plans

Set out below are some of the key disclosure issues that apply to welfare plans:

(a) *Insured Welfare Benefit Plans*

Insured welfare benefits plans—e.g., group medical plans, group insurance programs, and long and short-term disability arrangements—are highly regulated under state insurance laws. Thus, the argument has been advanced that carriers selling group insurance products, and vendors providing services, to these plans should be exempt from additional disclosure rules. The counter argument is that state insurance codes and regulations are directed at the integrity of the underlying insurance products. Separately, it may be argued that the Department's rules relating to the disclosure of direct and indirect service provider fees on Form 5500 Schedule C should vitiate the need to any further disclosure. But Schedule C disclosure does not include conflicts-of-interest, nor does it ensure that information about fees and conflicts is available in advance.

(b) *Self-Funded Medical Plans*

Self-funded medical plans, particularly large self-funded medical plans, rely on a host of service providers to operate. These include actuaries, accountants, lawyers, third-party claims administrators, pharmacy benefits managers, COBRA administrators, and stop-loss carriers/re-insurers, among others. (Pharmacy benefits managers raise a series of unique issues that are treated separately below.)

Unlike insured plans, where the commissions are integral to furnishing plan benefits, it is impossible to distinguish the costs of plan administration from the costs of providing benefits. Each dollar that the plan sponsor spends on service providers represents a dollar that is not available to pay benefits. Many if not most of these plans require employee contributions. Thus, fee and conflicts disclosures like those suggested in the Proposed Regulations would seem important.

(c) *Pharmacy Benefits Managers.*

Pharmacy benefits managers (or "PBMs") wield considerable influence over all aspects of the prescription drug supply chain, and their buying power gives them the power to demand steep discounts from the pharmaceutical manufactures. Certain practices engaged in by PBMs pose conflicts-of-interest risks. There are many opportunities for PBMs to demand and receive indirect compensation that are not required to be disclosed under current law. For example:

- PBMs can realize significant profits from discounts of the "average wholesale place" ("AWP") of a drug. Thus, for example, a self-funded group health plan might negotiate AWP less, say 15%, but the PBM might pay the manufacturer

AWP less18%, thereby pocketing the 3%. Under current law, the PBM is not required to disclose the additional savings.

- PBMs routinely qualify for rebates from the pharmaceutical manufacturers based on volume, and they often aggregated claims data to manufactures, thereby reaping additional revenues. While common sense dictates that these amounts ought to be disclosed, there is no current requirement to that effect.

- Mail order programs have become a common cost-cutting technique, and many PBMs also own, control, or are affiliated with mail-order vendors. When a PBM fills a mail order prescription, it gets a fee for dispensing the drug and a fee for processing the claim. Current law does not require the disclosure of these arrangements.

These and other PBM practices would need to be disclosed under the Proposed Regulations. Some commentators have argued that PBMs need no further regulation citing their compliance with rules issued by other Federal agencies, such as the HIPAA privacy rules issued by the U.S. Department or Health and Human Services. This is certainly accurate as fare as it goes. A basic purpose of ERISA, however, is to protect the rights of participants and beneficiaries in pension and welfare benefits and to impose rigorous requirements on plan fiduciaries and others in pursuit of that goal. The HIPAA privacy rules have different goals and purposes. Thus, it is not clear that compliance with the HIPAA privacy rules, among others, is relevant to the purpose and goals of the Proposed Regulation.

It has also been urged that subjecting PBMs to the Proposed Regulations would force the disclosure of confidential and sensitive pricing information which would interfere with the marketplace. This is a compelling argument to be sure, and one that can only be considered and disposed of at the level of policy. Which is more important, preventing the disclosure of market information, which may be harmful to PBMs, or providing enhanced disclosure of costs to plan sponsors and fiduciaries? One wonders in this regard why a similar issue does not arise in the 401(k) marketplace, which is highly competitive despite its relative generous fee transparency under SEC rules.

Conclusion

On balance, both because the statute makes no distinction between pension and welfare plans for purposed of the service provider exception to prohibited transaction rules, and because ERISA requires fiduciaries to be informed about service provider fees, it appears that the better view would be for the same rules to apply irrespective of plan type. But ERISA does not exist in vacuum, and, in establishing the proper scope of the disclosure rules, the Department of Labor will need to think about and balance competing considerations.