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408(b)(2) for Health Plans

This column explains the new rules that extend Section 408(b)(2) of ERISA to health plans under the Consolidated Appropriations Act.

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In the Consolidated Appropriations Act, 2021 (CAA) [P.L. 116-260, December 27, 2020], Congress amended the Employee Retirement Income Security Act of 1974 (ERISA) to define health plans as “covered plans” subject to Section 408(b)(2) of ERISA. The new law takes effect with respect to contracts with “covered service providers” that are entered into, extended, or renewed on or after

December 27, 2021. These new rules are in addition to disclosures that are required on Form 5500 and applicable state law disclosure rules.

Background

Under ERISA, any payment for services with respect to an ERISA plan is a “prohibited transaction” unless it meets an enumerated exemption. [ERISA §§ 406-408] ERISA exempts payment for services if the payment is for services that: (1) are necessary for the establishment or maintenance of the Plan, (2) are provided under a contract, the terms of which are “reasonable,” and (3) no more than “reasonable compensation” is paid for such services. [ERISA § 408(b)(2)] Any fiduciary that enters into a contract that does not meet all three requirements has committed a *per se* fiduciary breach for which they may be personally

liable. [ERISA § 406] Specific disclosures regarding compensation to service providers has been required for retirement plans under ERISA for many years. [29 CFR § 2550.408b-2] Similar rules are now being extended to health plans.

New Fee Disclosure Requirements

Under the new law, “covered service providers” that enter into a contract (or arrangement), provide “brokerage or consulting” services to “covered” plans, and reasonably expect that compensation to exceed at least \$1,000 (adjusted for inflation), must disclose all compensation, either direct or indirect, received in relation to such brokerage or consulting services for a health plan. [ERISA § 408(b)(2) as amended by the CAA] Note: There is no requirement that the contract be in writing. Oral agreements and arrangements are subject to the new rule. Both insured and self-insured plans are subject to the new rule. [All references herein are to Section (b)(2) of ERISA as amended by the CAA].

Covered plans include group health plans as defined in Section 733(a) of ERISA. So, plans, such as governmental plans or voluntary plans which are exempt from Title I of ERISA, are not group health plans for this purpose and are not subject to the new rule. Likewise, a welfare benefit plan that does not provide for medical care, such as a life insurance plan, is not subject to the new rule because it is not a group health plan.

The new rules require a covered service provider to disclose, in writing, the following information to a “responsible plan fiduciary” (that is, a fiduciary with authority to enter into the contract):

- A description of the services to be provided to the covered plan under the contract or arrangement and whether such services are fiduciary in nature.
- A description of all direct compensation and all indirect compensation the service provider (or an affiliate or covered subcontractor) reasonably expects to receive in connection with the provision of services (including incentives paid to a brokerage firm not solely related to the contract with the covered plan), a description of the arrangement with the payer if indirect compensation is received, and the identity of the payer of the indirect compensation.
- Compensation includes cash and non-cash amounts (unless the value of the non-cash compensation does not exceed \$250 over the entire life of the contract).
- Direct compensation includes amounts paid directly by the plan. Indirect compensation includes amounts received from third parties (that is, not from the plan, the employer, the covered service provider or its affiliates and covered subcontractors).
- To the extent compensation is paid among a service provider, the service provider’s affiliate, or the service provider’s covered subcontractor on a transaction basis (such as commissions or finder’s fees), a description of any such arrangement and identification of the payers and recipients of such compensation (including the status of a payer or recipient as an affiliate or covered subcontractor).
- A description of any compensation that the service provider (or an affiliate or covered subcontractor) reasonably expects to receive in connection with the termination of the contract or arrangement, and how any prepaid amounts will be calculated and refunded upon such termination.
- A description of how any direct or indirect compensation will be received by the service provider (or an affiliate or covered subcontractor).

This information must be disclosed to the responsible plan fiduciary before the contract or arrangement is entered into, extended, or renewed. In addition, the service provider has an affirmative obligation to notify the responsible plan fiduciary of any change to the required disclosures as soon as practicable, but generally no later than 60 days from the date the service provider is informed of the change.

As is the case under the retirement plan disclosure regulations, a health plan fiduciary will satisfy the prohibited transaction exemption if the plan fiduciary relied in good faith on a service provider’s disclosures that later turned out to be incomplete or inaccurate. In such a case, the plan fiduciary must take reasonable steps to obtain the missing or incorrect information upon discovery, must inform the Department of Labor (DOL), and must consider whether to terminate or continue the arrangement if the service provider fails to comply with a request for information within 90 days.

Next Steps for Plan Fiduciaries

Plan fiduciaries will need to request these disclosures, review them to be sure they accurately reflect both the services to be provided and the agreed on

amount of compensation as reflected in any written service contract. The plan fiduciary may want to make sure that compliance with these rules is covered in the applicable service contract. Next, the plan fiduciary should compare the actual fees paid to the contract and disclosures to be sure they are consistent. Finally,

the plan fiduciary should keep copies of the disclosures for an appropriate period. Going forward, the DOL is expected to provide additional guidance regarding these requirements. In the meantime, employers and plan administrators are subject to a good faith standard. ■

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