External FAQs: Broker and Consultant Compensation Disclosure to Group and Individual Clients

Updated August 29, 2022

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Consolidated Appropriations Act FAQ for Group Clients

Please note this is general information. You should consult with your legal counsel for determining the application to a specific situation.

Who must provide the required disclosure?

Covered Service Providers (and their affiliates or subcontractors) providing specified brokerage or consulting services to ERISA-governed group health plans who reasonably expect to receive at least $1,000 in direct or indirect compensation for those services. Covered Service Providers are individuals and entities who provide brokerage and consulting services to group health plans.

What are brokerage and consulting services for purposes of the reporting requirements?

Covered service providers that must provide disclosures includes those offering brokerage and consulting services. This is not limited to service providers who market themselves as brokers or consultants, but rather includes anyone who offers brokerage (selection) and consulting services (development, implementation, design, and selection) for any of the following:

- Brokerage services respect to selection of:
    - o Insurance products (including vision and dental)
    - o Recordkeeping services
    - o Medical management vendor
    - o Benefits administration (including vision and dental)
    - o Stop-loss insurance
    - o Pharmacy benefit management services
    - o Wellness services
    - o Transparency tools and vendors
    - o Group purchasing organization preferred vendor panels
    - o Disease management vendors and products
    - o Compliance services
    - o Employee assistance programs
    - o Third party administration services

- Consulting services related to the development or implementation of:

- o Plan design
- o Insurance or insurance product selection (including vision and dental)
- o Recordkeeping
- o Medical management
- o Benefits administration selection (including vision and dental)
- o Stop-loss insurance
- o Pharmacy benefit management services
- o Wellness design and management services
- o Transparency tools
- o Group purchasing organization agreements and services
- o Participation in and services from preferred vendor panels
- o Disease management
- o Compliance services
- o Employee assistance programs
- o Third party administration services

What is the difference between direct and indirect compensation?

Direct compensation is compensation paid directly from a group health plan, while indirect compensation is compensation received from a source other than the group health plan, the plan sponsor, or the covered service provider.

If a broker earns non-monetary incentives such as through a points system, does that need to be disclosed?

Yes, if this is tied to a service for a group health plan these incentives would likely need to be disclosed. The exact value of these incentives is not required to be disclosed if, for example, a reasonable estimate or range is provided. The Department of Labor provides several alternative approaches that could be used for disclosure in place of exact amounts.

What qualifies as a "group health plan"?

For purposes of the disclosure rules, "group health plan" is defined broadly to include any employee welfare benefit plan (insured, self-insured, and grandfathered) that provides medical care, including but not limited to:

- • Major medical plans
- • Vision plans
- • Dental plans
- • Health Reimbursement Arrangements (HRAs), except Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)
- • Individual Coverage Health Reimbursement Arrangements (ICHRAs)
- • Flexible Spending Accounts (FSAs)

Does the disclosure requirement apply to both small and large group health plans?

Yes. Brokers and consultants must provide disclosures to both small and large group health plans. There is no exception for small plans covering fewer than 100 participants. In addition, a small group health plan is subject to the disclosure requirements even if the plan is exempt from filing a Form 5500 annual report because it is fully insured, unfunded, or a combination of fully insured and unfunded.

When must a broker or consultant provide a disclosure to a group health plan?

The disclosures must be provided reasonably in advance of a service agreement being executed. Brokers and consultants must disclose anticipated direct or indirect compensation to plan fiduciaries sufficiently in advance of the date they enter into, extend or renew a contract to ensure the plan fiduciary has time to evaluate the disclosures.

In addition to the initial disclosure, brokers and consultants must:

Notify the plan fiduciary of compensation changes within 60 days of being informed of the change;

- Correction of inadvertent errors and omissions within 30 days of discovery; and,
- Respond to any written request made by the client within 90 days.

How does this requirement affect the obligation for disclosures on Form 5500?

These new disclosure requirements do not affect existing Form 5500 reporting requirements. There are different intents with these two disclosures: Form 5500 is retrospective and for tax and industry monitoring purposes, while the new disclosure requirements are prospective and are designed to provide transparency prior to a final contracting agreement.

We currently make available to brokers and consultants ERISA Form 5500 reports that outline their compensation and which they can share with their clients. We will continue to offer access to these reports to assist brokers and consultants in providing required disclosures to clients. If you need additional information, contact your Account Executive.

How should brokers and consultants handle compensation that is not certain at the time of disclosure?

The Department of Labor is aware that group health plan service provider arrangements and compensation structures vary widely, may be complex, and may not be certain at the time of disclosure.

The agency recognizes that covered service providers may be unable to state with precision the amount of compensation they expect to receive for services, because the methodology by which certain components of their compensation is determined will depend on decisions or variables that are not known before, or even at the time, the contract or arrangement is entered into and, in fact, may change over the term of the contract or arrangement.

For this reason, the standard for disclosure is good faith. This good faith disclosure may include estimates or formulas that would govern any anticipated compensation.

Is the federal government providing any forms or templates that brokers and consultants can use for their disclosures?

No. Given the diverse service and compensation structures that exist in the group health plan marketplace, the Department of Labor is not providing a model form or specific directions on how to disclose all components of every service provider's potential compensation.

However, the law permits a variety of disclosure formats. For example, compensation or cost may be expressed as a monetary amount, formula, or a per capita charge for each enrollee. Or, if those approaches are insufficient, 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).

Additionally, disclosure of compensation in ranges may be reasonable in circumstances when the service provider's compensation may vary within a projected range. However, such ranges must be reasonable under the circumstances surrounding the service and compensation arrangement at issue.

How can a broker and consultant determine if their disclosures are sufficient to meet this new legal requirement?

No matter the methodology used to disclose compensation, the disclosure should provide the responsible plan fiduciary with sufficient information about the compensation to allow the fiduciary to evaluate the reasonableness of the compensation in light of the services provided and the severity of any associated conflicts of interest. What constitutes adequate disclosure for a specific compensation arrangement will depend on the facts and circumstances of the service contract or arrangement.

To ensure that covered service providers communicate meaningful and understandable compensation information, the Labor Department cautions that more specific, rather than less specific, compensation information is preferred whenever it can be furnished without undue burden.

What are the disclosure requirements for an agent versus a general agent? Does the agent only have responsibility for disclosing the payments they receive directly and then the general agent has their own requirements to disclose the compensation they receive?

Generally, the requirement anticipates that the disclosure would be provided by the specific service provider who is entering into the contract and receiving compensation. Thus, the agent should disclose their direct and indirect compensation and the general agent should disclose their direct and indirect compensation.

Multiple service providers that furnish services pursuant to a single contract or arrangement with a covered plan may agree among themselves who will enter into the contract or arrangement with the covered plan and be the covered service provider. The other service providers may be affiliates of or subcontractors to the covered service provider; and covered service providers' disclosures would reflect their status.

Agents may or may not have knowledge of agency level specialty bonus payments and/or specialty primary overrides. What is the rule around this? Are agencies expected to disclose this?

See the discussion above regarding general agent disclosures. The agent should also consider what services and products are generating the specialty bonus payments. Some products that are not medical benefits (e.g., life insurance or disability insurance) are not covered under this requirement, while, for example, as specified in the Department of Labor guidance, dental and vision benefits are.

The new requirements apply beginning on December 27, 2021. Does this applicability date include service contracts or arrangements that have already been executed?

The new disclosure requirements apply only to contracts which are entered into, extended, or renewed on or after December 27, 2021. The date on which a contract or arrangement is entered into between an agent/broker and a plan fiduciary will be considered the date the contract or arrangement was "executed."

Example: If a plan fiduciary enters into a new agreement with an agent/consultant on December 15, 2021, for the plan year beginning on January 1, 2022, the agreement will be treated as having been "executed" on December 15, 2021, which is prior to December 27, 2021, so the agreement will not be subject to the new compensation disclosure requirements. However, if the fiduciary and agent/consultant renew or extend the agreement or sign a new agreement on or after December 27, 2021, the disclosure requirements do apply.

Also, pending further guidance, in the case of an agent or broker that enters into a contract or arrangement with a plan fiduciary through use of a "broker of record" (BOR) agreement, the date of the agreement 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.

Are there penalties to a covered service provider for failing to disclose compensation?

If a Covered Service Provider fails to comply with a written request for disclosure of compensation information within ninety (90) days, Plan Fiduciaries are required to determine whether continuing the contract with the Covered Service Provider is consistent with the Plan Fiduciaries' obligations under ERISA Sec 404. If the failure to provide requested information relates to future services, the Plan Fiduciary is required to terminate the contract as expeditiously as possible. Additionally, Plan Fiduciaries are required to provide the name, address, phone number and if known, the employer identification number of Covered Service Providers who fail to provide requested compensation information upon request to the Secretary of Labor. This notice should include a description of the services provided by the Covered Service Provider, a description of the information requested from the Covered Services Provider, the date the information was requested in writing, and a statement as to whether the Covered Service Provider continues to provide services to the Group Health Plan.

Additional Information
NAHU: Broker Compensation Disclosure Requirements under the CAA, 2021—Group Health Plans **(November 2021)**

Consolidated Appropriations Act FAQ for Individual Clients

Will Anthem prepare disclosure documents for direct and indirect compensation that brokers earn on group business?

No. The Consolidated Appropriations Act (CAA) requires brokers to provide the commission disclosure on their group business.

Who is responsible for communicating agent and broker compensation information to members for Anthem Individual and Anthem Enhanced Choice coverage?

Anthem is responsible for providing this information when a consumer is shopping, when they enroll, and upon renewal. Our quote tools and applications, new member welcome kits and renewal letters will include a link to the applicable disclosure. Brokers are responsible for providing the disclosure to the consumer during the shopping experience if our tools are not being used.

Does a broker need to post this on their website?

No, the CAA does not require brokers who sell individual medical insurance or limited duration health plans to post this on their website. The updated information will always be available on our website. The requirements for group medical insurance are different.

Where can I learn about disclosures for groups?

The National Association of Health Underwriters (NAHU) has prepared templates, FAQs, and other resources to help brokers understand their disclosure responsibilities.