June 4, 2021

The Honorable Xaviar Becerra
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

The Honorable Martin Walsh
Secretary, Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

Re: Section 202 of the No Surprises Act

Dear Secretaries Becerra and Walsh,

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefit specialists, regarding Section 202 of the No Surprises Act portion of the Consolidated Appropriations Act of 2021.

The members of NAHU are primarily state-licensed health insurance producers who work daily to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Our members and the employer group health plan sponsors they serve are very eager to understand the implementation plan for this section of the law. Further, we believe that additional guidance is warranted concerning how you anticipate some of the provisions of this section will work in practice. As you work to implement Section 202, we hope that you will keep these thoughts, which stem directly from a representative sample of our members who work as brokers and other types of health plan service providers likely to be subject to this section of the law.

Overview

Our understanding of Section 202 of the No Surprises Act is that agent, broker and consultant compensation related to all group health plans and individual health insurance policies be disclosed for arrangements entered into, renewed or extended on or after December 27, 2021. This law requires agent, brokers and/or consultants (and their subcontractors) to disclose their compensation to plan fiduciaries. Specifically, any covered service provider that receives compensation in excess of $1,000 annually must provide this disclosure. The disclosure must include amounts paid directly and those received indirectly related to group and individual health plans. This requirement applies to contracts with both fully insured and self-funded group health plan arrangements.

Brokers and other service providers must disclose the required information prior to the date the contract or arrangement is entered into, extended or renewed. Covered entities must disclose compensation changes within 60

days of being informed of the change and correct inadvertent errors and omissions within 30 days of discovery. If the covered services provider fails or refuses to disclose the required compensation information, then the employer must request disclosure in writing. If the broker fails or refuses to respond to the written request, the client must submit a formal notice to the Department of Labor within 30 days.

If the plan fiduciary does not report the covered entity's failure to disclose to the DOL on time, then the plan fiduciary is subject to enforcement action. Furthermore, the broker is liable under Section 502(i), which allows the DOL to assess penalties against service providers whose arrangements result in prohibited transactions.

Areas Where Additional Implementation Guidance Is Necessary

Section 202 includes a great deal of information about how the compensation requirements will work, but as our membership prepares to make them operational, they still have many unresolved questions. NAHU members believe additional Section 202 implementation guidance in the following areas would be extraordinarily helpful to agents and brokers, other health plan consultants and plan fiduciaries.

Timing and Precision of Disclosures

All parties would benefit from additional information about the timing of disclosures. The law states full disclosure is due by a date that is "reasonably in advance of the date on which the contract or arrangement is entered into, and extended or renewed." Service providers subject to Section 202 frequently present various product options to plan fiduciaries, and ultimate compensation will vary based on the options selected. It would seem that the compensation disclosures should be made in advance of group health plan year renewal dates. If so, should disclosures include compensation levels relative to each option presented to the plan fiduciary? Or, if the intent is for the disclosure to reflect the actual contract, should a service provider wait until the group makes a purchasing decision to make its disclosure? The preference of the broker community would be to provide the calculation and disclosure when a purchasing decision is made in order to reduce the administrative burden and chance of error when providing calculations based on multiple options. However, even when providing a disclosure at the point of purchasing, there may still be other factors left to be determined that could affect compensation.

The NAHU membership would also be very appreciative of guidance addressing the precision of advance disclosures. For agents, brokers and other service providers, compensation arrangements are often based on the number of employees who actually enroll in a group plan. In addition, employer groups frequently make plan-design and other changes before finalizing service agreements that can affect overall premium rates and pricing. Furthermore, the choices employees make when enrolling in coverage, such as picking one plan option over another, affect their premiums, which can have an impact on compensation. These enrollment decisions often take place well after the contract effective date. In the case of electronic employee enrollment (something that happens more and more), brokers will not know what their compensation for a group will truly be until they receive their first commission payment, which may be up to two months after the contract goes into effect. As such, there is only so much accuracy possible in an advance disclosure.

A related issue is how covered service providers should handle disclosures when changing employee counts or premium volumes result in varying compensation. Does the use of simple formulas, ranges and/or percentages in the initial

disclosure address that possibility sufficiently? These percentages would not change and would likely be quite simple for plan fiduciaries to understand. However, they would not necessarily accurately reflect ultimate compensation, which might not be known until well into a contract period or change over a contract period. Our membership believes that covered entities should be able to opt for this means of disclosure, given that the language of Section 202 clearly was designed to provide flexibility and ease to covered entities when calculating compensation disclosures.

However, this method raises some other questions. If service providers convert their compensation from a per-employee-per-month rate or other variable rate to a fixed percentage, at what point should this conversion be made? With a group health plan, broker compensation changes slightly almost every month because every time someone adds a baby or has a birthday, an employer adds a location, or an employee moves to a different rate region, etc., the group's overall premiums change, and the resulting compensation changes with them. So keeping the conversion accurate will always be a challenge.

A related question is how much latitude will be extended should a covered service provider need to make corrections. Is there a safe harbor for a covered service provider that makes a mistake? Given the range of minor compensation changes that can occur for health insurance agents on a month-to-month basis due to slight changes to group demographics, could there be a disclosure safe harbor for a small range of compensation changes?

NAHU members also have questions about health insurance agents and brokers who receive commission statements from insurance companies or third-party administrators detailing their compensation. If a commission statement includes the required data elements for a disclosure to a plan fiduciary, would simply providing them with a copy be sufficient? What if a health insurance carrier discloses an agent's commission, including all of the data elements required by Section 202, on its monthly invoice to plan fiduciary? Would such an invoice satisfy the disclosure requirement for the agent? Alternatively, would it be a sufficient way to notify a plan fiduciary of a compensation change, given that for most group health plan products, the amount of compensation paid to the agent will change slightly every single month as new people join the plan, others leave, people age, etc.? For some markets and covered service providers, broker disclosure through carrier or TPA invoicing might be the easiest option. For others, it may not even be a possibility to rely on a third party. However, understanding if it is an option would be helpful for our members.

Another area where additional information would be helpful is how to handle disclosures with multi-year contracts. Is disclosure in this situation related simply to changes to the contract a service provider has with the plan fiduciary, or is it related to underlying service provider changes? For example, a broker might have a multi-year contract with a large self-funded employer group plan that does not change over its lifespan. However, the plan may have annual arrangements with the PBM or the rental network that renew on the basis of the group's plan year. Will employer fiduciaries expect to receive a disclosure every year? Or is a new disclosure only necessary if the compensation arrangement changes mid-contract? The way our membership understands Section 202, a second disclosure would only be required if the compensation arrangement changed mid-stream. However, there could be unintended consequences should plan fiduciaries think that they are due an annual disclosure.

Changes to Compensation Disclosures

The law states that any compensation changes must be disclosed as soon as practicable but not later than 60 days from the date on which the covered service provider is informed of the change. However, there is an exception to the 60-day rule for extraordinary circumstances beyond the covered service providers' control. More clarification about what this means and how to document it is needed. For example, if brokers are unsure of their true level of compensation until the receipt of their first compensation statement, would that circumstance qualify for the exception?

Additionally, how are employers with reporting responsibilities expected to know if they are due an updated disclosure and how does a compensation change impact employer's reporting requirements should they not get an updated disclosure on a timely basis?

Disclosure Documentation
Section 202 specifies covered service providers must provide comprehensive descriptions of their compensation agreements. While the statute does list required elements, NAHU members would appreciate additional details and examples of sufficient disclosures before they need to implement the requirements. Do your Departments intend to provide covered entities with a model disclosure form? Our membership believes that a model that covered entities could use would be very helpful.

Many of our members use disclosure templates that have been accepted as a standard business practice in the industry. NAHU can provide these templates to the Departments as examples of what the current practice is or as a model for any future templates the Departments choose to develop. A streamlined template approved by the Departments would be useful not only for guiding brokers to comply with the law, but also to provide a uniform disclosure device for brokers who may have clients in multiple states with varying rules of their own.

Do your Departments plan to issue guidance regarding the presentation of disclosures? For example, will there be requirements about using plain language? What about a requirement to display this information prominently? Does it need to be presented to a plan fiduciary in a separate disclosure or may it be combined with other documents? What will constitute acceptable delivery methods? Will electronic delivery be acceptable? If so, under what terms? Additionally, our membership would benefit from more guidance from the Department about what constitutes indirect compensation for both group and individual markets. If such guidance could include multiple examples, it would be very beneficial to all covered service providers. NAHU believe additional information from your Department addressing these questions and any other disclosure documentation and delivery rules is warranted.

Indirect Compensation Issues
The way compensation flows to covered entities is another issue where more clarification is needed. For example, brokers regularly receive indirect compensation from health insurance carriers based on a book of overall business, not on a plan-specific basis. Sometimes this indirect compensation is paid to an entire firm, and sometimes it might be to an individual producer within a firm. Often, the amount of this compensation is unknown until over a year after a broker contracts with a related group. How does the producer or agency allocate compensation to specific plans in these situations? Also, this compensation is often awarded on a contingency basis, and the amount of an award could easily be $0, so it will be impossible to completely disclose compensation upfront. The level of compensation an agency might receive is based on incredibly complex formulas so would it be sufficient to acknowledge the existence of this type of

compensation in an initial disclosure and provide ranges of potential awards? This would probably be the easiest type of disclosure for a plan fiduciary to understand and would remain static no matter what the level of award (if any). Or does the compensation need to be divided on a prorated basis among groups that contribute to a potential award? If so, what formula should be used?

Similarly, brokers often are paid joint compensation for different types of insurance products sold to the same plan. There will often be instances where some of those fall into the realm of products where compensation must be disclosed. For example, compensation from the group's medical plan will need to be disclosed, but compensation for their short-term disability coverage will not. The compensation flow from the payer may not necessarily break down easily by product. How is compensation disclosure handled in these circumstances?

Employer Responsibilities

Section 202 places significant responsibilities and liability on plan fiduciaries. Our members work with employer group health plan sponsors on a daily basis, and it is our observation that virtually no employers understand or are even aware of their new responsibilities. Is there a plan to educate plan fiduciaries about their new compliance responsibilities and liabilities?

Another consideration is the resources that will be required of plan fiduciaries to complete their Section 202 requirements. The resources that will be required to track disclosures and report to the DOL if needed are not insignificant. Neither are the fines associated with a prohibited transaction under ERISA should they fail to meet Section 202's requirements. Businesses, particularly small businesses and those that have been hardest hit by pandemic-related economic issues, do not necessarily have the bandwidth to handle more costs and complications related to their group health insurance offerings. Our membership is concerned that some employers may view the Section 202 requirements as a penalty for offering health insurance to their employees.

Given the challenges Section 202 disclosures may present to business owners, will your Departments make resources available to group plan sponsors regarding the management of their compensation disclosures? Will the Departments provide a model form for plan fiduciaries to assist them with their reporting obligations? Based on our discussions with employer group clients to date, none were aware of this new requirement prior to being informed by their NAHU member health insurance broker. More direction for plan fiduciaries is a critical need.

In certain cases, depending on how your Department interprets the applicability of these requirements, employer group plan sponsors may be due disclosure documentation from covered service providers who profit off of their group health plan but, due to the service provider's behind-the scenes role, the fiduciary might be unaware of their work. How do you plan to ensure that employers are informed of all entities that need to provide them with disclosures? If a plan fiduciary does not receive a disclosure notice from a consultant and is unaware that it was due, will there be a safe harbor relative to the plan fiduciary's responsibility to notify the DOL? Also, if covered entities know that a plan fiduciary is not expecting a disclosure from them due to the behind-the-scenes nature of their work, could such covered entities evade disclosure easily?

Finally, plan fiduciaries that have been informed of their new responsibilities under Section 202 by their NAHU member brokers have already started asking how they will be expected to provide notification of non-disclosure to the DOL. Will there be an electronic portal for them to transmit information? An address to send written documentation? Also, how long should employers retain records on the disclosures by covered service providers?

Applicability to the Individual Market

The No Surprises Act specifies that a health insurance issuer offering individual health insurance coverage or short-term limited duration insurance coverage must also disclose direct or indirect compensation information to enrollees. Issuers also must provide the Department of Health and Human Services with compensation data. The law stipulates that this process will be outlined through rulemaking within a year.

NAHU members request that your Departments begin the regulatory process regarding individual-market compensation disclosures as soon as possible. It would be very helpful to get additional guidance regarding individual-market disclosures, including the types of coverage affected by the requirements and any related agent or broker responsibilities, as soon as possible.

A particular concern for our members is their potential role regarding disclosures for products that touch both the group and individual markets. There are many products that could be considered either group or individual coverage, or both. For example, employers may offer Individual Coverage Health Reimbursement Accounts to employees. An ICHRA is technically a self-funded group health plan, and brokers may receive a commission from the ICHRA administrator for managing the group aspects of this plan option. However, the broker may also receive some commissions on individual coverage that employees buy using ICHRA funds if the employee works through the same broker and the individual carrier pays commission on the related product (which is not guaranteed in many states). In this situation, who is responsible for disclosures and who is the party to whom the information should be disclosed?

Similarly, what happens when an employer offers a Qualified Small Employer Health Reimbursement Arrangement, which is not actually a group health plan arrangement, even though a broker typically works with the employer to establish and administer the arrangement and may receive compensation for doing so? Are disclosures by the broker involved necessary? Or is this part of the individual carrier's responsibility? If so, who receives the disclosure --the employee or the employer?

Other products that may skirt the line of group and individual coverage when it comes to disclosure include individual products that are sold through a group, such as long-term care or accident coverage or coverage that is list-billed but technically an individual arrangement. If coverage is payroll-deducted, does that make the coverage group coverage even though it might involve individual coverage? Would COBRA or state continuation coverage be considered to be group or individual coverage? Who ultimately determines if these are group insurance or individual insurance? Will it be HHS, the DOL, the state Departments of Insurance or the covered service provider? What happens if there is confusion or disagreement?

NAHU members believe that guidance clearly defining what is to be considered individual coverage and what will be considered group would be very helpful. Additionally, guidance about what would happen should covered entities and plan fiduciaries disagree about what disclosures are due to whom and when would be appreciated.

Conclusion

NAHU appreciates your willingness to engage with our members concerning the implementation of this important requirement. Our members believe in transparency and consumer protection is paramount in our business. Additional guidance about the questions and issues we've raised will help our members with their own disclosures and compliance with Section 202, and it will help them educate the employer community about this process and their responsibilities.

Ultimately, though, the most helpful thing for employers and covered entities alike would be more guidance from your Departments about enforcement and the assurance, at least for the initial years of implementation, that a good-faith compliance standard will apply. As consumer-facing entities agents and brokers work to ensure that consumers in all markets enroll in coverage that is best suited for them. Any disruption or additional administrative burdens placed on agents and brokers could disrupt this service to consumers and result in some level of market disruption. Implementation of Section 202 is coming up quickly, on the heels of a global pandemic and economic downturn. Providing safe harbors to both employers and covered entities that do their best to comply would be in the best interest of all affected parties.

If you have any questions about our comments, or you would like more information, examples, or the ability to speak to covered service providers and employers directly engaged in the implementation process, please do not hesitate to contact me. I may be reached at (202) 595-0639 or jtrautwein@nahu.org.

Sincerely,

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters