National Association of Benefits and Insurance Professionals
NABIP
Shaping the *future* of healthcare

March 19, 2024

The Honorable Virginia Foxx
Chair, House Committee
on Education and the Workforce
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Robert C. Scott
Ranking Member, House Committee
on Education and the Workforce
2328 Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Foxx and Ranking Member Scott:

I am writing on behalf of the National Association of Benefits and Insurance Professionals (NABIP), formerly known as NAHU, which is an association representing over 100,000 licensed health insurance agents, brokers, general agents, consultants, and employee benefits specialists. We are pleased to have the opportunity to provide comments in response to the Committee on Education and Workforce's recent request for information (RFI) regarding the Employee Retirement Income Security Act of 1974 (ERISA). In light of ERISA's 50th anniversary later this year, we very much support your quest to consider reforms to this landmark law geared at increasing the affordability and quality of employer-sponsored health insurance plans.

The members of NABIP work daily to help millions of individuals and employers purchase, administer, and utilize health insurance coverage. Ensuring market stability and competition, as well as improving health coverage affordability, are among our top goals. Many members of our association specialize in helping employers of all sizes design and maintain their group health benefit plan arrangements, including assisting them in complying with ERISA and all of its related amendments and regulations. A working group of these individuals, which includes attorneys, other compliance professionals, and licensed health insurance producers dedicated their time and decades of expertise in the industry to preparing the following responses to the questions outlined in your January 22 RFI. Our responses are broken down by topic, and when relevant to our areas of direct knowledge, by the direct questions posed by your committee.

ERISA Preemption

1. *The Committee broadly seeks feedback on ways to strengthen and clarify ERISA preemption. Should the Committee consider legislation or taking other actions to help create more clarity regarding and strengthening ERISA preemption to ensure plan sponsors are able to design, offer, and administer uniform benefits and programs pursuant to ERISA's purposes? If so, what legislation or other actions, and why?*

   NABIP members appreciate the Committee's dedication to creating more clarity surrounding ERISA's preemption of state laws and regulations. We also welcome your commitment to strengthening that preemption through legislative action if appropriate.

Our membership believes the ERISA preemption is more critical to employers who offer group health benefit plans to employees than ever before due to our globally connected world. Due to the COVID-19 pandemic, employers of all sizes and structures moved to fully remote and partially remote workplaces, and all indications show the demand for such workplaces to persist. The result is more employers than ever before with multiple employees living in different states, making ERISA's preemptive protections essential to plan sponsors nationwide.

As your committee begins to consider updates to ERISA, we believe it would be wise to take heed of the most significant current federal legal challenge to the strength of the law's preemptive standard—*PCMA v. Mulready*. In an August 2023 ruling, the 10th Circuit Court of Appeals found that an Oklahoma state law regulating pharmacy benefit managers (PBMs) violates both ERISA and Medicare Part D's preemptive standard, so Insurance Commissioner Glen Mulready may not enforce it. The Oklahoma Insurance Department is preparing to appeal this ruling to the Supreme Court of the United States (SCOTUS), and it is currently unknown if SCOTUS will grant certiorari. However, based on SCOTUS' unanimous 2020 decision in *Rutledge v. PCMA*, which held that certain state-based regulation of PBMs is permissible under ERISA, it seems likely that SCOTUS will want to weigh in on the reach of their decision during its 2024-2025 session.

The Committee may want to act relatively quickly to shore up the strength of ERISA's preemptive standard before any potential SCOTUS action on *Mulready*. The Committee may also want to act in response to future SCOTUS decisions addressing the law's preemptive standard. NABIP members argue that doing both would be the wise course of action.

2. ***To what extent do state laws prevent or purport to prevent multistate employers from offering a uniform set of benefits across state lines? Please list the specific state laws which pose or may pose barriers to offering uniform benefits.***

Each year, state-level legislation is introduced, and sometimes enacted, which presses the bounds of the ERISA preemption. Given the changes to the health insurance marketplace, the structure and roles of group health benefit plan arrangements, and the rise and change in the role of service providers who are not always directly covered by the ERISA preemption over time, this type of legislation is to be expected. Some examples of recently enacted state laws that raise preemption issues include Oklahoma's *Patient's Right to Pharmacy Choice Act*, the Florida *Prescription Drug Reform Act*, the Indiana *All Payer Claims Database Law*, and New Jersey's *Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act*. Furthermore, following the *Rutledge* decision, almost every state has engaged in legislative and/or regulatory activity to in some way place requirements on PBMs.

Besides these actions, our association sees several areas of overall state-level policy activity that can impede an employer's ability to cost-effectively and fairly implement group health plans that stretch over the bounds of multiple states. The most significant are state-level privacy and cybersecurity requirements. These confusing, onerous, and overlapping laws require compliance from group health plan sponsors who are already subject to the federal Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Clinical Health Act (HITECH) privacy and data security rules, either as covered entities or business associates, depending on the funding status of the plan.

Another is state-level reporting requirements utilized to enforce state-level mandates for individuals to hold health insurance coverage. These requirements are both costly and complicated for employers who offer group coverage to employees in California, Massachusetts, New Jersey, Rhode Island, and the District of Columbia. Given the nature of remote work these days, group plans of all sizes and locations are affected by these measures. Unlike the federal ACA reporting requirements, these state measures apply to small employers too and can involve different reporting dates, forms and formats, and submission processes than the federal requirements.

Other state-specific reporting measures can also cause complications for employers all over the country. For example, the *New York Healthcare Reform Act* requires certain third-party payors and providers of health care services, including self-funded and level-funded medical plans covering New York residents, to both pay assessments and complete extensive annual (and in some cases, quarterly) reporting. A 2020 Michigan auto insurance law has required every group health plan with Michigan employees to revise their plan documents and summary plan descriptions (SPDs) to address coordination with this measure.

Another example of state-level laws that cause benefit plan confusion and cost-increases are the multitude of state measures on co-payment accumulator programs which conflict with federal regulatory guidance for group health plan sponsors. These laws are currently creating uncertainty and conflict for both employers and plan participants in affected states. Meanwhile, the federal essential health benefit (EHB) rules, which allow for states to establish their own base benchmark plans and allow national self-funded plans to select any state's EHB benchmark plan as their standard, has resulted in an overwhelming number of employer group plans opting to use the State of Utah's benchmark plan. Since Utah's plan is known for being the least robust of all states, self-funded plan participants in all states get the lowest common denominator when it comes to the standard of group benefits.

Fiduciary Requirements

1. *The Committee broadly seeks feedback on the definition of fiduciary, its use, and fiduciary obligations under ERISA as they pertain to health benefits.*

   NABIP feels strongly that each health and welfare plan must have a single entity that has primary, or fiduciary responsibility over plan decision-making, and the primary fiduciary should be the employer. As the chief payer, and the organization closest to the plan participants, the duty and role of the employer plan sponsor must be paramount.

   However, the complexities of designing, implementing, and maintaining a group health plan have increased exponentially since ERISA was enacted almost 50 years ago. The roles of certain plan service providers, such as network providers, utilization management entities, third-party administrators, pharmacy benefit managers (PBMs), and others are dramatically different today than they were even 20 or 10 years ago, let alone 50. Many service providers essential to health plan administration today either did not exist when ERISA came into being, or they played very different and reduced roles. The responsibilities of each plan's health insurance agent, broker, or consultant have vastly evolved too.

   As the complexities of health and welfare plan administration have grown and changed, so has the power of technology and the data health plan service providers control in the marketplace. Vertical integration and market consolidation have further compounded the authority and influence of healthcare-specific service providers in the market. The result is a significant power imbalance between the employer plan sponsors (as well as the agents, brokers, and consultants who serve as the plan's advocates) and each plan's service provider. The discord between these entities serves as a breeding ground for bad actors, poor service, high fees, and lack of plan sponsor access to their own plan data.

   To address this matter, we propose two specific ideas:

   First, we strongly suggest that Congress adjust the definitions of fiduciary and service provider within ERISA to create specific definitions for health and welfare plans (as opposed to the single definition for both retirement and health and welfare plans). For example, NABIP suggests adjusting the definition of the term fiduciary which is specific to health and welfare plans. The definition should specify that health and welfare plan fiduciaries may contract out specific plan services to vendors who make day-to-day care and coverage decisions on behalf of the plan, and these entities will be classified as associate fiduciaries (see our second recommendation below).

We also suggest Congress add definitions of agents, brokers, and consultants who specifically serve health and welfare plans (as opposed to the catch-all 'broker-dealer' term today that does not apply in health and welfare plans). The health and welfare plan definitions should also outline the role that health insurance agents, brokers, and consultants play for their group health plan sponsor clients. While the names of the person and/or firm serving in this role vary based on compensation structures and industry colloquialism, the common thread for all of these entities is that they hold state-level insurance producer licenses and serve as an advocate for the health plan sponsor.

Second, we would also propose the creation of a new definition and standards for those entities who are today considered to be merely service providers under the law, but truly provide direct healthcare and health coverage services to health and welfare plans. NABIP suggests these entities be classified as associate health and welfare plan fiduciaries. (Our association believes that a parallel to consider would be the role of a business associate to a covered entity under the HIPAA and HITECH privacy and data security rules, with similar levels of care and responsibility when it comes to enforcement.)

Associate fiduciary responsibility should be assigned to those plan service providers whom the plan directly engages with to provide care, claims, or coverage-related services on a day-to-day contract basis for the plan sponsor and thereby make daily administrative decisions within their sphere on behalf of the plan. Examples would include a self-funded plan's network, utilization management vendors, PBMs, and issuers in a fully insured plan. These entities could be assigned a level of responsibility and liability that is lower than the level of the named plan fiduciary, but one that still requires them to consider the needs of the plan and its beneficiaries as they relate to the services that the entity provides to the plan.

Meanwhile, the definition of plan service provider should be clarified and limited so that it only applies to those plan vendors who do not provide direct care and coverage services to plans, such as a mailing service or internet provider. This would also exclude agents, brokers, and consultants since their role is similar to other advisors providing advice or guidance on issues, with the Plan Administrator(s) making the ultimate decision.

In summary, making these changes to ERISA should lift protections for plan participants and ensure the appropriate level of accountability and liability for decision-making is assigned to the responsible entity.

2. *How can Congress build upon ERISA regarding the fiduciary obligations of plan sponsors, administrators, and trustees in the management of health benefit plans?*

NABIP believes that Congressional action to ensure that sponsors of ERISA and health and welfare plans take their fiduciary responsibilities as seriously as retirement plan sponsors is long overdue. By more clearly delineating the responsibilities of plan fiduciaries and assigning appropriate standards and duties of care to entities that contract with plans to provide care, claims, and/or coverage services, Congress will go a long way towards ensuring all protections are being provided to health and welfare plan beneficiaries.

3. *How can Congress clarify the extent to which fiduciary responsibilities are applied to insurance companies, insurance agents, broker-dealers, third-party administrators (TPAs), PBMs, or other service providers? Please specify the following:*
    - *A description of the changes proposed and rationale for their adoption. Any practical or legal risks or challenges to making such changes to the administration of plans and delivery of benefits.*
    - *Whether the fiduciary duties would apply to the plan sponsor or the plan beneficiary, and if so, why?*
    - *Whether the fiduciary duties should be determined by the function performed by the entity.*
    - *How the Department of Labor (DOL) should implement enforcement over any additional statutory fiduciaries.*
    - *The complexity of clarifying fiduciary responsibilities and how Congress should approach examining such clarifications.*

As outlined in our answer to question one, we suggest an amendment to ERISA to create an associate level of fiduciary duty for certain entities that are today considered to be merely plan service providers. This associate fiduciary status should be applied to those entities who provide care and/or coverage services to the plan directly on a day-to-day basis. Associates should be assigned a level of care and liability that is lower than the level of the named fiduciary, which should be the employer plan sponsor or lead entity assuming plan sponsor responsibility in a multi-employer welfare arrangement. However, the designation of associate fiduciary should still require consideration of the needs of the plan and its beneficiaries to a greater degree than a service provider that does not provide direct health care or coverage services to the plan.

NABIP believes that if the Committee used similar language to what was used in the HIPAA and HITECH privacy and data security rules to establish the relationship and standard of duty a business associate has to a covered entity, it would be an appropriate parallel. The DOL could then use similar methods of enforcement to ensure compliance from associate fiduciaries. Given that this standard of care and responsibility has been in place in this same market space for almost two decades to address privacy and data security without significant issue, our membership feels it would be an entirely

appropriate methodology to use in addressing other fiduciary duties needed to ensure the protection of health and welfare plan beneficiaries.

4. *Are there specific areas where fiduciary responsibility should be more clearly defined to ensure the best interests of plan participants and beneficiaries?*

As we have noted above, NABIP believes the definition of a plan fiduciary needs to be revisited, and it would be beneficial to all if a subsidiary level of fiduciary responsibility is assigned to those plan service providers that have the ability to make day-to-day care and contracting decisions on behalf of a plan. In addition to that, our membership feels it would be beneficial if Congress were to revisit all of the definitions in ERISA related to health and welfare plans and to consider adding new ones to reflect the dramatic changes in the marketplace that have occurred since 1974. There are several new entities that should be clearly defined.

5. *Do the liabilities placed on plan fiduciaries create burdens on small businesses providing health coverage? If so, how?*

Yes. Businesses large and small face significant compliance responsibilities, costs, and burdens as sponsors of group health plans. Even when the duty of compliance with specific requirements can be transferred to a health insurance carrier (as is the case for many Consolidated Appropriations Act of 2021 or CAA requirements for fully insured group plans), it is still a significant burden and requires the plan sponsor to obtain annual consent that their health insurance issuer will assume responsibility for each applicable requirement. Plus, that assumption of liability represents a cost to issuers, and those costs are ultimately reflected in fully-insured plan premiums.

In self-funded plan arrangements, fiduciary liability and compliance responsibility ultimately rests with the ERISA plan sponsor, even though it is the plan's service providers who almost always hold or control all the data and or day-to-day decisions involved with the compliance requirements and not the plan sponsor. If Congress were to take action on our associate fiduciary proposal outlined above, and/or our recommendations regarding reporting and disclosure requirements outlined in the Reporting Requirements section of our letter, that action would reduce the plan fiduciary liabilities and concerns significantly.

6. *The Committee seeks feedback on the fiduciary's duty to monitor and how it impacts small businesses.*

Health plan sponsors have limited ability to exercise their fiduciary duty to effectively monitor and control the conduct of its service providers who provide healthcare and

coverage-related services to their plan, which is a significant concern. This problem affects businesses of all sizes, not just small businesses. NABIP members serve Fortune 100 clients, micro-businesses, and everything in between. When it comes to health plan administration, the business owner is never the entity making day-to-day care, contracting, and claims decisions. Those functions are almost unilaterally outsourced to service providers, even in the limited number of self-administered Taft-Hartley plans. NABIP members can attest that even the largest of employer clients are subject to contracts where the language is dictated by service providers with little recourse for change. For anything other than very large employers, health plan service provider contracts are ones of complete adhesion. Therefore, in many cases, it is impossible for plan sponsors to truly exercise their fiduciary duties to effectively monitor plan service providers, let alone curb and control problematic service provider behavior.

Regarding a plan fiduciary's duty to monitor the actions of their service providers, ERISA dictates that cost-effectiveness should be the fiduciary's primary concern. While costs might be the driving factor for retirement plan sponsors, NABIP members believe this standard should be modified for health and welfare plans. Instead, plan fiduciaries should require reasonable costs from their service providers and associate fiduciaries, while also taking into account the value each of these entities brings to the plan as a whole, in terms of meeting direct needs, responsiveness, service, and other needs of both the plan sponsor and plan participants alike.

7. *What federal case law would be informative to the Committee to help circumscribe the fiduciary responsibilities in the statute?*

NABIP acknowledges the importance of specific federal case laws in shaping the understanding and application of fiduciary duties under ERISA. We recommend that the Committee examine cases such as *Lewandowski v. Johnson & Johnson* to glean insights into fiduciary responsibilities and obligations. However, we note that the case law is limited in this area because of standing issues—it is rare to find employees willing to sue their current employer/insurer regarding benefits that they need, creating a set of incentives that make lawsuits less likely.

8. *What are the appropriate boundaries of fiduciary obligations to ensure appropriate and optimal resource allocation, to recognize control and agency of all stakeholders?*

It is NABIP's observation that the DOL believes appropriate fiduciary prudence must be demonstrated through process. When measuring fiduciary adequacy, the focus seems to be on determining if the plan's decision-making processes are fair and if the fiduciary is acting prudently and in the best interest of the overall plan. NABIP supports this approach, but we note that this does not always yield the optimal result for some

individual plan participants. Accordingly, overall prudence can be a difficult concept for some employers to accept, especially in smaller businesses or when the employer plan sponsor has a strong personal connection to an affected plan participant. Similarly, much of the existing ERISA case law involves the needs of one individual plan participant, which are not always the same as what might be in the best interest of the whole plan. Additional federal education and clarifying guidance as to why employer plan sponsors must use the overall best interest of the plan and its participants as the defining boundary of fiduciary duty, rather than the interests of one (or a small group of) plan participant(s) would be helpful for employer plan sponsors.

9. *The Committee broadly seeks feedback on what Congress and DOL can do to help plans better understand their fiduciary duties.*

The DOL already has an excellent publication available on the fiduciary responsibilities of health plan sponsors. However, additional federal guidance, examples, templates, seminars, and other educational materials designed to elevate the importance of fiduciary duty in health plans, as well as the boundaries of fiduciary duty, would always be helpful to both plan sponsors and their advisors.

Reporting Requirements

1. *The Committee broadly seeks feedback on ways to streamline reporting and disclosure requirements.*

When ERISA was enacted almost 50 years ago, there were no federal group health plan reporting requirements. Today, group health plan sponsors must annually deal with ACA individual and employer mandate reporting requirements relative to coverage offers and coverage status, the Medicare prescription drug creditable coverage calculations and disclosure to CMS, the claims data and pricing machine-readable file posting and maintenance requirements, online advance EOBs for plan participants and real-time cost transparency tools, the prescription drug data collection reporting (RxDC) requirements, the gag clause attestations, broker and consultant compensation disclosure failure reporting, PCORI fee calculations and payments, Form 5500 reporting, the MHPAEA NQTL and QTL analyses requirements, and more. The resulting monetary costs and human capital burdens on employer group health plan sponsors cannot be understated.

One of the most significant strains on employer group plan sponsors when it comes to almost all of their federal reporting burdens is their lack of autonomy. Due to the role healthcare service providers play in plan administration, and the plan data they hold, plan sponsors cannot independently complete large aspects of almost every reporting obligation. While ERISA assigns the plan sponsor the responsibility (and in most cases

ultimate liability) for their reporting and disclosures being done on-time, accurately, and correctly, without the cooperation of their service providers, in many cases the plan sponsor's hands are tied.

To address this issue and provide much-needed relief to employer plan sponsors, Congress should ensure that the entity holding the information or the entity responsible for its determination should be the one responsible for any federal reporting or data compilation requirement. To put it another way, any amendments to ERISA the Committee considers should guarantee whoever holds the data is responsible for reporting and disclosing that data to either policymakers, the plan sponsor, or plan participants as appropriate. It is unfair and unreasonable to hold the employer responsible and liable for reporting information they cannot control. Even if an employer plan sponsor had better access to their plan-level data, the entity serving the plan in this capacity related to the requirement should be the entity to do the work and the reporting because they are the ones taking the related claims, care, and coverage decisions on a day-to-day level. At a minimum, Congress should create an enforcement safe harbor for those plan sponsors who can document they are doing their best to obtain accurate and timely data from their service providers, but could not obtain full cooperation from a service provider.

Another concern is the multitude of reporting "systems" with disparate processes. The federal government requires employers to report data electronically through the AIRS system for ACA reporting, the E-Fast system for Forms 5500, and three different versions of the HIOS system for RxDC, Creditable Coverage, and Gag Clause Attestations. Notably the different HIOS platforms vary tremendously in terms of ease-of-use for the plan sponsor, ranging from a user-friendly online form that requires no login and can be accessed instantaneously, to a multi-week process including multiple verifications and complicated questions to just obtain login credentials.

Related to disclosure improvements, NABIP members feel that virtually all existing ERISA documents, disclosures, and templates could benefit from some improvements. The only required disclosure templates that NABIP members consistently cite as well-designed and very useful are the HIPAA notices of privacy practices. It is our understanding that both focus groups of potential notice recipients and design contests were used to develop them, which likely accounts for their usability. NABIP strongly suggests that the Committee consider action to require the Department of Labor's Employee Benefits Security Administration (EBSA) to utilize both of these practices to improve and streamline all existing and any new ERISA disclosures.

NABIP also recommends legislative action to require the DOL to annually review all ERISA-disclosure requirements and issue guidance each year for content, readability, and

relevance. This review and release of any updated guidance and document templates should come at a set time each year, well in advance of the fourth quarter, when many group benefit plans conduct open enrollment and make required ERISA disclosures.

Taking that idea further, it is NABIP's view that the number of separate ERISA notice requirements and the complexity of content required for many notices are critical concerns. So are the broad range of notice distribution due dates, as well as various delivery mechanisms and formats for disclosure (e.g., as part of the SPD, separate notice, disclosure that can be part of the SPD or delivered distinctly). All of these factors are confusing to employers and employees alike.

Accordingly, we encourage the committee to consider amending existing notice requirement provisions that are not participant- or plan-specific and replacing them with a single consolidated ERISA health and welfare plan notice that the DOL would be required to update annually. Employers that distributed this notice annually could be deemed to meet a compliance safe harbor. Businesses often make notice disclosure compliance mistakes unintentionally, and employees do not benefit from a multitude of paper notices provided at different points during the plan year. NABIP also believes consolidating all ERISA general notices and required distributions into a single annual notice would increase the likelihood that plan participants read and digest the material contained in the common notice.

While many ERISA documents are both too voluminous and complex to provide meaning to the typical ERISA plan beneficiary, NABIP members believe that the SPD is probably the most important document in this category. The SPD provides a critical legal framework for any benefit plan, and it should always be available as a valuable resource for plan beneficiaries upon request. However, right now, the lack of official templates, compliance resources, and education about SPD requirements hurts both employees and business owners. Participants suffer because the resulting materials that are intended to provide them with information and protections are often confusing, incomplete, duplicative, or not available. Group plan sponsors struggle because they are rudderless when it comes to appropriate SPD development and maintenance; thus, they are forced to rely on expensive service providers for these duties.

To address some of these issues, NABIP suggests a new SPD distribution requirement safe harbor for employer plan sponsors who create and annually distribute an SPD highlight document. The SPD highlight document would be a new concise reference tool for employees, highlighting all of the employer-plan-specific components of the SPD. This recommendation is like one contained in the 2017 ERISA Advisory Council report titled "Reducing the Burden and Increasing the Effectiveness of Mandated Disclosures with Respect to Employment-Based Health Benefit Plans in the Private Sector." An SPD

highlight document could complement the summaries of benefits and coverage (SBC) and follow the same distribution rules and timeframes. It could also drastically increase overall SPD requirement compliance.

A highlight document could be required to follow a federal template relative to content and design. Any legislation establishing the use of a highlight document and a related employer-plan safe harbor could require the DOL to utilize focus groups and current ERISA plan participant surveys to develop the template for plan sponsors to utilize and determine which SPD elements to summarize and include. Additionally, from NABIP's perspective, any highlights document would need to contain "key" elements that are specific to the employer plan, including plan contact information and eligibility criteria. It should also include language to guide participants and beneficiaries to appropriate detailed source materials to answer any questions regarding the plan's contents, their rights, and additional relevant information.

To meet the SPD highlight document safe harbor, NABIP proposes that an employer would have to have an updated SPD on-hand (a compliance obligation the vast majority of employer group plans, notably smaller group health and welfare plans and fully insured health and welfare plans of all sizes are not meeting). Employers would have to make the full SPD available upon request and we suggest, for this safe harbor, reducing the SPD distribution timeframe from the current 30 days. In today's world, an updated SPD can be delivered to any plan participant much more quickly upon request. Furthermore, to meet the safe harbor, the plan sponsor should need to update the new SPD highlight document annually and distribute it to plan participants annually, on request, and within 60 days of a material plan modification, just like the plan's SBC.

Along with this idea, NABIP suggests any amendment language to ERISA require the DOL to produce more official compliance resources for employers to use relative to SPD development and updates. Employers often do not comply or fully comply with SPD rules due to a lack of understanding and appropriate resources. Businesses also often contract out their SPD development process, and they have no efficient and cost-effective means to measure the quality of the documents they purchase, often at great expense.

1. *The Committee seeks comments on ways Congress can better support electronic disclosure and when electronic disclosures are beneficial to the plan participant.*

The ERISA electronic distribution requirements and the related safe harbor date back more than two decades. Since then, technology has changed significantly in terms of ease of use and extensive access to devices that can access information. Accordingly, NABIP believes an update to ERISA's electronic distribution rules would benefit all stakeholders. Allowing more efficient use of online distribution resources and employee benefit

administration systems will reduce the costs of mailing, distribution, and printing that many businesses endure. Enhanced online delivery methods will also be advantageous for beneficiaries, as they can make critical documents easy to find and easy to search when needed. Furthermore, searchable electronic notices are significantly more meaningful than often discarded printed notices.

The Committee should seriously explore replicating retirement electronic disclosure safe harbors for health and welfare plans. We also recommend allowing delivery of required disclosures through other means than traditionally printed notices that are mailed or hand-delivered, or notices that appear in written form through electronic devices or on websites. It could be particularly beneficial to allow those notices that are not participant- or plan-specific to be delivered through videos, PowerPoint slides, or other visual means.

However, if the Committee does opt to address electronic disclosure improvements, we would suggest a focus on being as evergreen and flexible as possible. Any legislative changes should ensure regulators will have the ability to update best practices through guidance as technology evolves. NABIP recommends shying away from references to specific types of electronic technology and allowing employees and plan participants to self-certify that they have access to an appropriate device and online connectivity. Also, our membership supports the use of an opt-out standard relative to electronic delivery so that modern processes will be the default. Finally, NABIP believes that any legislative change should stipulate that printed versions of any/all disclosures must always be made available to plan participants within a reasonable timeframe upon request.

Prohibited Transactions

1. *The Committee broadly seeks feedback on how vertical integration and consolidation in the healthcare sector impact ERISA's prohibited transactions.*

Vertical integration and consolidation amongst large and common health plan service providers is an issue that drives up costs for plan sponsors. It can also lead to service providers engaging in practices that are counter to the best interests of their group health plan clients and/or obtaining undisclosed compensation at the expense of plan sponsors and plan participants. For example, several of the nation's largest health insurers have shared ownership with the country's largest PBMs. These entities also own TPAs, utilization management entities, healthcare clearinghouses, providers, networks, data analytics providers, and more. The duty that these health plan vendors exhibit towards each other, and their subsidiaries often prevails above all else, most especially over the needs and financial interests of a plan sponsor client and the beneficiaries of such a plan.

The power imbalance between employer plan sponsors and some of their most significant service providers should be something the Committee is aware of and considers action to address. NABIP realizes that if our associate fiduciary responsibility standard were to be adopted, the conflicting interests of plan service providers will likely be forced to a head. However, this issue will only exacerbate itself if not addressed in short order, so our association strongly recommends that the Committee consider addressing it now.

2. *The Committee broadly seeks feedback on how changes in transparency affect how plan sponsors determine whether spending and costs are reasonable and necessary.*

NABIP strongly supports increased price and quality information transparency in healthcare, as evidence for our support of transparency measures currently being considered by both houses of Congress. We believe while recent policy changes in this area created by the ACA Transparency in Coverage final rules and the transparency provisions in the CAA will provide plan sponsors with much-needed information to make spending and cost-saving decisions long-term, the fruits of these legislative and regulatory requirements are not yet fully actualized. The requirements that providers, health insurers, and group health plan sponsors publicly post machine-readable files containing deidentified and aggregated claims and negotiate rate data are a good example of this phenomenon. The availability of the MRF information in the marketplace will significantly increase plan sponsor access to comparative price data and bring down costs over time, particularly if these requirements were strictly and uniformly enforced. However, right now, enforcement (and thereby compliance) is inconsistent, and the data analytics being performed by third parties on available MRF information is just at its beginning stages. So, its utility to plan sponsors making cost determinations and product evaluations is still limited.

Even when analytical cost information from MRF data becomes more widely available, one problem with the data currently required to be made publicly available is that it does not deal with its volume. For example, perhaps a carrier has negotiated a volume-based rate on a service and a low volume of claims makes the negotiated price higher. In that case, how would analysis of MRF claims and pricing data make the volume-based payment structure clear? A recently passed New Jersey law requiring PBM price transparency does consider volume when it comes to reporting and calculating price data. Even though that law likely should not stand in light of the ERISA federal preemption standard, it could still be used as a model when it comes to proposing meaningful adjustments to existing federal price transparency requirements.

3. *Should DOL update its prohibited transaction exceptions, and if so, how?*

ERISA section 406(b) generally prohibits a plan fiduciary from (1) dealing with the assets of a plan in their own interest or for their account, (2) acting in any transaction involving the plan on behalf of a party whose interests are adverse to those of the plan or its participants and beneficiaries, or (3) receiving any consideration for their own personal account from a party dealing with the plan in connection with a transaction involving plan assets, unless an exemption specifically applies to such conduct. Existing statutory exemptions include retirement plan loans to participants and contracting or making reasonable arrangements with a party in interest for office space, or legal, accounting, or other services necessary for the establishment or operation of the plan if no more than reasonable compensation is paid for services rendered. In addition, the law gives the DOL the authority to grant individual plan sponsors an exemption on an application-basis.

NABIP members do not have any specific suggestions as to additions or modifications to the existing prohibited transactions, as they currently generally relate more to retirement plans. However, accordingly, we do not believe that many health and welfare plan sponsors have a great understanding of prohibited transactions and how they may relate to health and welfare plans. The most significant and new way that prohibited transactions affect them is the role the prohibited transaction requirements play in the compensation disclosure requirements created by the CAA. As we note in the Direct and Indirect Compensation section of this response, NABIP members do not believe employer plan sponsors fully understand their role in reporting and enforcing the provision of correct disclosures and the prohibited transaction consequences that may befall them if they do not fulfill their responsibilities correctly. As such, more guidance in this area would be appreciated.

4. *How do different payment and contracting models, such as direct contracting, concierge services, wellness centers, on-site clinics, and capitated payments, affect dynamic fiduciary duties, prohibited transactions, and other ERISA requirements?*

While dynamic payment and contracting models are gaining more marketplace traction with every given year, the percentage of group health plan sponsors who engage in these practices increases. However, these arrangements still represent a small fraction of the overall group health plan marketplace. These arrangements have gained almost no penetration in the fully-insured market space, and even with self-funded and level plans, the overall number of group plans with these features is very limited. Based on observation only, NABIP members do not believe that ERISA issues are the cause, but we also do not believe that a significant enough amount of data exists to make a determination.

Data Sharing

1. *The Committee broadly seeks feedback on ways to improve data sharing between employer-sponsored plans and contracted entities.*

   NABIP believes it would be very helpful if the Committee would consider legislative action to address the reluctance many service providers have in sharing what is truly the plan's own data back with employer group plan sponsors. By deeming these entities associate fiduciaries who have a legal obligation to assist plan sponsors with upholding their fiduciary duties and hold a level of care and responsibility to serve the overall best interests of their customers, Congress would ensure the automatic enforceability of data sharing, thereby improving the level of cooperation between service providers and their group health plan clients.

2. *The Consolidated Appropriations Act, 2021 (CAA) prohibited provisions in health plans that prevent plan fiduciaries from accessing quality and cost information, known as "gag clauses." However, plan fiduciaries still struggle to receive this information from TPAs. How can Congress strengthen the prohibition on gag clauses to ensure that plan fiduciaries have access to this data?*

   While NABIP members understand the impetus behind the CAA's gag clause prohibition, it did not have the intended impact on the marketplace. Not only do employer plans not understand the requirement, but they also have no means of enforcing it. Plan sponsor contracts with health plan service providers are almost exclusively those of adhesion. They do not have the ability to dictate contract terms, nor do they have access to service provider contracts, so Congress should consider action to assign responsibility for gag clauses directly to those service providers who craft the contracts that may be of concern.

   However, NABIP also believes the premise about TPAs limiting access to quality and cost information is not fully accurate, particularly when it comes to independent TPAs and those managed by smaller health insurers. TPAs routinely provide their clients with reporting data on plan claims and costs as part of their standard ASA contracts. Additionally, TPAs may pair with firms that specialize in data analytics to provide plan sponsors with more predictive data based on their medical claims and other census information. The provision of such data from the TPA to the plan is routinely part of TPA ASA agreements with plan sponsors.

   Where gag clauses did often come into play between TPAs and plan sponsors prior to the enactment of the gag clause prohibition were ASA provisions concerning direct access to

all claims data and files to perform audits. Prior to the ban, TPAs would often allow plans to audit all of their claim files, but the contract provisions addressing audits often came with all kinds of limitations, such as charging for this access, requiring significant notice from plan sponsors, and/or only allowing such access once during the plan year. Due to the gag clause prohibition, most TPAs removed gag clauses such as these from their base ASA agreements.

Additionally, when it comes to price information, while the TPA holds medical claims and costs data, the prescription drug cost and pricing data comes from the Plan's PBM, even if a TPA or a carrier providing ASO support white-labels Rx management services offered by a PBM. In our experience, even when PBMs and TPAs or carriers performing ASO support plans all share common ownership, the PBM data and contracts are controlled by the PBM entity only, and the TPA or applicable issuer has limited control over the distribution of prescription drug pricing and related information to the plan sponsor.

When it comes to quality data, the TPA is generally not the source of such information. Instead, quality data would stem from service providers offering provider network and utilization management services. However, this data is not typically provided to plan sponsors, and it is unclear what data is even routinely and consistently collected by such entities, or even what appropriate and the most useful quality measures for plan sponsors might be. While there have been many state and federal-level healthcare price transparency efforts supported by NABIP both under consideration and adopted as policy, efforts to promote and require transparency of quality data for plan sponsors and plan participants have lagged behind. Our association has long encouraged state and federal policymaking efforts to make healthcare quality data more visible and useful to both plan sponsors and plan participants, and we urge the committee to take up this issue now.

3. *The CAA requires plans to attest that their contracts do not contain these gag clauses. Is this requirement effective?*

No, the attestation requirement is not effective. While it is the employer plan sponsor's responsibility to attest, and theoretically, they are liable to ensure all of their service providers do not have these clauses in downstream contracts related to their health plan, in reality, employers have no knowledge of contracts that are negotiated and held by their service providers and then used for health plan implementation purposes. For example, a group plan sponsor would never be privy to the plan network's contracts with individual providers. So, for the attestation requirement, plan sponsors are being required to vouch for contracts they did not negotiate, did not sign, and cannot review. These plan sponsors are entirely reliant on generic statements their service providers have given them claiming that their agreements do not include gag clauses.

If a gag clause did in fact exist in a downstream service provider contract, the plan sponsor would have no way of knowing it. Even if a plan sponsor was made aware of a gag clause, the sponsor would have no real recourse or leverage to ensure that it was removed. Therefore, it is critical those negotiating these agreements be held fully accountable for their contents.

It is also unclear to NABIP why, if gag clauses are now prohibited by federal law, there need to be annual attestations. The initial gag clause attestation process, which was completed by December 31, 2023, should have been enough to raise awareness amongst plan sponsors and their service providers that all gag clauses must be removed and kept out of any future agreements. The additional annual reporting requirement only adds expense and administrative burden to the employer community.

If continued reporting is necessary, then it should be required of the entities who negotiate contracts on behalf of the plan, and it should only apply to new contracts. A simple legislative change to shift the burden away from employers who are subject to contracts of adhesion with their service providers, and place the responsibility with the entities who truly have control over such matters, would be a huge help to group plan sponsors. It would also likely increase compliance with the gag clause ban moving forward.

4. *What are the implications of treating data as a plan asset under ERISA?*

NABIP supports the idea of establishing that a group health plan's data is considered to be a plan asset under ERISA and thereby applying all of the protections and responsibilities that come along with such consideration.

5. *TPAs commonly restrict the extent to which a plan sponsor can direct the service provider to share data with other service providers and how that data can be used. How do these restrictions affect value-based payments, measuring quality, and the freedom of employers to design innovative payment models? How do these restrictions discourage service providers from creating innovative solutions to measure quality? The Committee seeks feedback on how to improve data sharing between plan sponsors and service providers.*

In NABIP's experience, the premise behind these questions is not fully accurate, especially when it comes to independent TPAs and those owned and operated by smaller and regional health insurance plans. Actually, as business associates of the group health plan, TPAs routinely obtain authorization to share information with other business associate service providers of their group health plan clients. These authorizations,

known as data use agreements, dictate that all parties are business associates of the group health plan and that they both have duty and liability under HIPAA and HITECH to protect the security of protected health information (PHI) and to use it appropriately.

What NABIP members have identified as a true concern is the unwillingness of plan service providers to share with the plan sponsor what is ultimately the plan's own data. In some cases, plan service providers, such as networks, PBMs, and utilization management vendors are unwilling to provide plan-level back to even the TPA, despite the existence of HIPAA/HITECH data sharing agreements. Given that in a self-funded plan arrangement, the plan sponsor is the covered entity under HIPAA and the service providers are merely business associates being paid by the plan with plan funds, sometimes directly, or more often through their TPA, it is outrageous the limitations certain service providers place on the release of data to plan sponsors. This practice leads to all sorts of plan management and administrative problems.

The difficulties plan sponsors have accessing even deidentified information has been truly highlighted by the reticence so many plan vendors have exhibited when it comes to providing plans with the group-specific operation data they need to complete the non-quantitative treatment limitation analyses required by the CAA and the Mental Health Parity and Addiction Equity Act (MHPAEA). While the CAA and related guidance suggest that plan sponsors may require such data sharing in their service provider contracts to complete these analyses, it is important for the Committee to realize that the contracts plan sponsors enter into with large health plan vendors are almost always contracts of adhesion, and so the plan sponsor's ability to procure needed data is limited.

HIPAA and Cybersecurity

1. *The Committee seeks comment on whether gaps exist due to HIPAA's structure and its lack of jurisdiction over entities in the commercial market. The Committee also seeks comment on whether DOL should have a more robust role in overseeing the protection of PHI, including overseeing HIPAA protections pertaining to self-funded ERISA plans and plan sponsors.*

The HIPAA and HITECH privacy and data security requirements already provide a robust structure of protection for both fully-insured and self-funded plans. As technology and data use have evolved over time, so have privacy and security gaps related to health-related data. For example, a great deal of health information is collected and transacted by entities that may seem to be health-related but are beyond the bounds of HIPAA and HITECH's applicability to covered entities and business associates. Smartphone applications, wearable devices, and pharmacy discount programs that are distinct from the structure of the group health plan are all examples of entities that collect large

amounts of health information and are not typically covered by HIPAA and HITECH protections. Congress may want to consider measures to protect the security of this data, but HIPAA and HITECH's requirements do directly apply to self-funded plans, and consumers are protected accordingly.

2. *The Committee is requesting comments on policies to strengthen and build upon privacy protections for employer-sponsored plans and their business associates. The Committee seeks feedback on ways DOL can better provide plan sponsors, plan fiduciaries, group health plans, TPAs, and other business associates with best practices for maintaining cybersecurity.*

   As cybersecurity threats emerge and evolve, NABIP members believe it would be helpful for the DOL to serve as a trusted source of the most up-to-date guidance for plan sponsors. Most employers need guidance as to the best and most cost-effective ways plan sponsors and their service providers and potential associate fiduciaries can identify and prevent cybersecurity threats. True cybersecurity knowledge is a highly specialized and expensive commodity. Any way that the federal government can buttress the knowledge and resources of employer-sponsored group health plans and the healthcare system in this regard would be appreciated.

3. *The Committee seeks comments on the types of emerging cybersecurity threats that health plans face and any policy suggestions to help combat these threats.*

   The recent cybersecurity attack on Change Health, and the overwhelming downstream financial and operational impact on all providers and other entities relying on Change Health's healthcare clearinghouse capabilities, is a profound example for the Committee to consider. The need for federal economic support to combat the impact of this attack on providers is telling, as is how the attack occurred, its spread and effect on so many associate entities, and its impact on consumers. The market and individuals have been dramatically affected not just due to the data breach, but also because of the overall healthcare system disruption the breach after-effects continue to cause.

4. *The Committee seeks feedback on privacy regulations regarding business associates under HIPAA and whether privacy protections within these agreements can be strengthened through ERISA.*

   NABIP believes that the privacy and data security requirements for business associates are already very strong, especially since the HITECH Act extended the same level of liability and responsibility HIPAA bestowed on covered entities to their business associates. Unlike many other federal healthcare laws which are codified in three sections of the federal code including as part of ERISA, HIPAA and HITECH were enacted independently. Expanding ERISA to include the HIPAA and HITECH provisions would not necessarily increase the effectiveness of the protections themselves, but it could help

expand enforcement of these protections. It might also increase the ability of the DOL to provide privacy and data security resources to employer plan sponsors. As such, NABIP believes it warrants the Committee's consideration.

5. *Are privacy gaps created by not defining a plan sponsor as a "covered entity" under HIPAA? If so, how might those gaps be addressed?*

Under HIPAA and HITECH, self-funded plan sponsors are considered to be covered entities, and their service providers and consultants, such as their health insurance agent, their TPA, their PBM, and others are their business associates. If an employer plan sponsor opts for fully-insured health insurance coverage for its workforce, then its insurance carrier is the covered entity, and the fully insured plan sponsor is the business associate of the carrier. So, in both cases, all of these entities are bound by the law's requirements to ensure the integrity and safety of PHI.

6. *In what ways can DOL coordinate with HHS, the Internal Revenue Service, and others to harmonize cybersecurity rules that may conflict or overlap?*

NABIP members believe that one of the most helpful ways the DOL could act is to assert directly that state-level cybersecurity and privacy laws that address PHI are preempted by ERISA.

7. *What should the legal responsibilities of plan sponsors and plan fiduciaries be with respect to protecting against cybersecurity threats and safeguarding PHI?*

Since plan sponsors, as the named plan fiduciary, are already subject to HITECH's provisions and legal liability as either covered entities or business associates depending on their plan's funding structure, legal responsibilities already exist. NABIP believes that this is the appropriate level of liability for employer plan sponsors.

8. *The Committee seeks comments on DOL's guidance issued in 2021 regarding cybersecurity. Should any of this guidance explicitly apply to health plans or be codified?*

The 2021 DOL cybersecurity guidance was primarily directed at retirement plans and protecting the security of related financial information. Health and welfare plans not only include financial data, but health information that must be protected as well, so the threats they get and the protections they need may be different than retirement plans. Furthermore, cybersecurity issues and threats are constantly evolving, so guidance issued three years ago may not be fully relevant now. NABIP believes what might be most helpful would be for the Committee to consider legislative action requiring the DOL to prepare and distribute updated general cybersecurity guidance, as well as specific best

practice guidance for health and welfare plans, as well as retirement plans, on an annual basis.

9. *State privacy laws are not uniform and create a patchwork of standards for ERISA plans. How do state privacy laws impact ERISA self-insured plans? What are ways Congress can align state and federal privacy regulations?*

   Congress should act to clearly specify that state-level privacy and cybersecurity measures that address PHI are preempted by ERISA.

10. *Are there portions of HIPAA or the Health Information Technology for Economic Clinical Health (HITECH) Act that should be written into ERISA and implemented by the DOL?*

    Amending ERISA to include HIPAA and HITECH provisions warrants the Committee's consideration, as it would likely give plan sponsors more resources and could increase the enforcement and effectiveness of these protections for group plan participants.

11. *Many employer-sponsored health plans contract with a TPA through an administrative-services-only (ASO) agreement. The Committee seeks feedback on ways plan sponsors and plan fiduciaries can ensure proper cybersecurity protections through ASO provisions.*

    Self-funded and level-funded group health plans are considered to be covered entities under the HIPAA and HITECH requirements, with both independent TPAs and carriers that serve these plans through administrative services only (ASO) agreements being considered the business associates of the plan. As business associates, TPAs and carriers offering ASO services are obligated to uphold the HITECH Act's data security protection to guard against cybersecurity threats and attacks. The business associate agreements that self-funded plans hold with their TPAs ensure this is the case. When business associates of covered entities need to share data with other business associates and service providers of an employer-sponsored group health plan, then they ensure that all actors are compliant and liable under the HITECH requirements through mutually signed data use agreements.

12. *Should DOL make explicit that acting prudently with regard to cybersecurity risks is a responsibility of fiduciaries of employer health benefit plans?*

    HIPAA and HITECH already hold plan sponsors who serve as covered entities liable for cybersecurity incidents and breaches. To ensure that these plan sponsors can mandate that their service providers are compliant with the HITECH rules, the plan sponsors must engage their service providers in business associate agreements.

Direct and Indirect Compensation

1. *The Committee seeks feedback on the implementation of the CAA and requirements that brokers and consultants disclose compensation to plan fiduciaries.*

   The disclosure of fees and the indirect compensation provisions of the CAA clearly apply to licensed health insurance agents and brokers. Additionally, the law states that they apply to consultants of the group health plan. However, there seems to be some confusion in the marketplace as to what constitutes a consultant role and therefore disclosure is not consistent. Accordingly, we suggest that the Committee consider more clearly delineating the applicability of this requirement to health plan consultants and the definition of a consultant subject to the disclosure law. If the Committee decides to move forward with the concept of associate fiduciaries, we suggest that the related amendments to ERISA clearly apply this disclosure standard to sub-fiduciaries.

   Additionally, the current requirement disclosure requirements apply to direct and indirect compensation in excess of $1000. However, that standard does not fully align with the way that compensation is paid to many consultants, agents, and brokers. NABIP proposes that this requirement be adapted to reflect per member per month (PEPM) pricing by perhaps setting a minimum floor, and then requiring all PEPM pricing agreements that exceed that floor to be disclosed to plan sponsors.

   Finally, we encourage the Committee to examine the effectiveness of essentially requiring the employer to enforce this requirement through the prohibited transaction methodology outlined in the CAA. In our membership's experience plan sponsors largely do not understand the requirements and their responsibilities, so many service providers who are non-compliant go undetected. Furthermore, plan sponsors have no way to verify the accuracy of their disclosures, so incomplete disclosures may be rampant. This requirement should not be complicated or a nuisance for either agents, brokers, and consultants or plan sponsors. Instead, the Committee's goal should try to make it as simple as possible while ensuring that compensation of value in all forms is transparent to all involved.

ERISA Advisory Council

1. *The Committee broadly seeks feedback on whether Congress should consider expanding the role of the ERISA Advisory Council to provide recommendations to Congress on issues affecting employer-sponsored health benefits, similar to the Medicare Payment Advisory Committee.*

NABIP believes that expanding the role of the ERISA Advisory Council to make recommendations to Congress similar to MEDPAC would be a good idea. If Congress were to receive updates on ERISA's workability in the marketplace and related recommendations, resulting legislative fixes would likely be timelier and more relevant. If changes are made to the ERISA Advisory Council through legislation, NABIP also suggests a review of the Council's membership criteria and structure, to ensure appropriate representation from attorneys, industry advocates, consumers, and others representing the health and welfare benefits space.

Medical Loss Ratio

1. *The Committee broadly seeks feedback on the use of medical loss ratio (MLR) requirements and whether limiting MLR requirements may increase insurers' incentives to reduce healthcare spending for plans.*

   In our experience, the medical loss ratio (MLR) requirements have had no impact on insurers relative to reducing premium costs for plans and plan participants. The more the carrier needs to make up money, the more they will pay for providers and claims, so the plan participant pays on both ends. In addition, our members have determined the way insurers are able to calculate the MLR for prescription drugs enables them to shield cost-savings from plan sponsors and participants. The current methodology only captures the average wholesale price and the plan's direct cost for the medication, ignoring the savings that come from rebates, spread pricing, and other factors.

   NABIP recommends the committee examine the way MLRs are calculated currently, what are allowable claims and quality improvement expenses, and what are considered to be administrative expenses to assess if these categorizations and how they are applied fully meet the needs of today's marketplace. Specifically, compensation collected by insurers and then paid to agents and brokers is currently classified as an administrative expense, despite the fact that employers choose their broker, who provide value, quality, and service to the client entirely independent of the carrier and have no bearing on the carrier's actual administrative expenses. Broker compensation is a pass-through expense for carriers that legally must be collected by carriers and distributed to agents and brokers in this manner due to state premium tax laws. Efforts to change that by the National Association of Insurance Commissioners and also by federal agencies has been stymied by the existing MLR legislative language limitations.

2. *The Committee seeks feedback on whether MLR requirements have driven vertical integration in the healthcare sector, and if so why.*

There are many factors that have led to vertical integration within the healthcare marketplace. Health insurer's MLR requirements are not the only reason for increased vertical integration. However, these requirements do not contribute positively to the situation either. Pressure insurers face from MLR requirements may increase their likelihood to invest in the provider and pharmaceutical spaces, but that trend would likely exist even without the MLR.

COBRA and Portability

1. *The Committee broadly seeks feedback on improving the affordability and usability for plans and enrollees of continuing health coverage under COBRA.*

While NABIP members certainly understand the Committee's concerns about the cost of COBRA coverage. However, the price COBRA recipients pay to extend their coverage under a group health plan simply reflects the true price of employer-sponsored health insurance in this country. A plan's COBRA rate is in no way intended to be punitive. It is just a reflection of the total cost employers pay for coverage, instead of simply the employee's contribution. The two percent administrative fee employers are allowed to add onto to the total cost of the COBRA premium is generally nowhere near the true administrative costs involved with offering and maintaining a group health plan, nor is it even a true reflection of the extra costs that COBRA administration adds to a plan.

NABIP believes that any action the Committee could take to lower the costs of medical care and coverage generally would also benefit COBRA recipients tremendously. Many of the actions and recommendations we have described above would help towards those objectives. However, if the Committee were to consider taking action related to COBRA directly, NABIP does have a suggestion that could help reduce the costs both self-funded and fully-insured plans incur related to high-cost COBRA beneficiaries. If Congress were to take action to either prevent or significantly restrict, third-party payments of COBRA premiums, it would both reduce the cost of coverage for other plan participants and also address a tax issue for these COBRA recipients.

Current law allows for third parties to pay for COBRA beneficiary premiums. This provision was intended to allow for COBRA premium payments to be part of severance payments. However, over time other entities have found it to be financially beneficial to pay for individuals' COBRA premiums, to the point that the National Kidney Fund is now the greatest payer of COBRA premiums since the reimbursement dialysis providers receive under group plans is so much more than they do under Medicare. Hospital systems also often elect to pay COBRA premiums if they determine that a high-cost uninsured patient has COBRA eligibility. This issue was particularly a problem during the COVID-19 national emergency period, as individuals had up to a year to retro-elect

COBRA. However, the concern existed long before then and it persists now that the COBRA election period has returned to its original 60 days. By paying for high-cost claimants to remain on their group policy, the health plan must absorb the full price of their care. Otherwise, these individuals might have obtained coverage through Medicare, Medicaid, an individual policy, or through a new employer's group health plan. Furthermore, since an unrelated third party is paying for an individual's premiums, there is uncertainty as to whether federal gift tax rules apply.

NABIP suggests the committee consider three different options for addressing this concern. One would be unilaterally banning the practice. The second would be clarifying via statute that COBRA premiums paid by a third party are considered to be taxable income to the individual. The third is to limit third-party payments to those made through an IRC §125 Cafeteria Plan, which would then limit the practice to simply previous or current employers, and clarify the tax status of such payments for the individual recipient.

2. *The Committee broadly seeks feedback on ways to improve the portability of health benefits under ERISA.*
When ERISA and COBRA were initially enacted, the health insurance individual coverage marketplace was vastly different than it is today. However, given the passage and implementation of the Affordable Care Act and related individual market reforms, as well as the existence of exchange-based individual market premium tax credits, portability is no longer the concern it once was. Accordingly, NABIP believes that addressing the other concerns we have articulated in this letter would be a more appropriate focus for the committee.

<u>Specialty Drug Coverage</u>

1. *What challenges do employers face in offering coverage of high-cost specialty drugs, and how can those challenges be addressed?*
Designing benefit plans that balance affordability for both the employer and the employee while ensuring access to necessary medications can be quite complex. The most significant challenge employers face in providing coverage of both high-cost specialty medications to employees specifically, and healthcare and prescription drug coverage generally is the cost of medications, medical care, and related therapies. This issue is of most pressing concern now because the scope and cost of specialty drugs and related therapies are rapidly changing and growing, especially when new gene and cell therapies are taken into consideration. These therapies can cost tens or hundreds of thousands of dollars per year per patient; at times, specialty medications can account for up to one-quarter of a health plan's spending. In addition, plan sponsors need to deal with the related medical care costs for those who utilize high-cost specialty drugs, which

routinely include high-cost and lengthy hospital stays, surgical procedures, and extensive and long-term costs related to the management of chronic health conditions.

Balancing the need to provide access to life-saving medications with the financial sustainability of the organization can raise ethical dilemmas for employers, particularly when faced with difficult decisions about coverage and cost-sharing. High copayments or coinsurance for specialty drugs may deter employees from seeking necessary treatment, while TPAs and insurers may impose restrictions such as prior authorization, step therapy, or quantity limits on specialty drugs to manage costs. This can lead to delays in access or denials of coverage, creating additional challenges for employees seeking treatment.

As new structures are and have been introduced, employees often struggle to understand their coverage for specialty drugs or how to navigate the healthcare system to access them. Employers spend a great deal of time providing educational resources and support services to help employees make informed decisions about their healthcare, but they also require robust data analytics capabilities to understand the utilization patterns of specialty drugs within their workforce. This information is crucial for designing effective benefit plans and negotiating with insurers and pharmaceutical companies.

Addressing the challenges of offering coverage for high-cost specialty drugs requires a comprehensive approach involving various strategies:

- Utilization Management: Employers can work with TPAs/insurers and pharmacy benefit managers to implement utilization management strategies such as prior authorization, step therapy, and quantity limits to ensure appropriate use of specialty drugs while controlling costs.
- Formulary Management: Employers can work with TPAs/insurers to develop formularies that include preferred specialty drugs with lower costs or negotiate discounts and rebates with pharmaceutical manufacturers to lower overall drug costs.
- Value-Based Agreements: Employers can explore value-based agreements with pharmaceutical manufacturers, where reimbursement is tied to patient outcomes or the effectiveness of the medication. This can incentivize the use of more cost-effective treatments.
- Employee Education and Support: Providing employees with educational resources, support services, and decision-making tools can help them navigate their benefits effectively and make informed choices about their healthcare, including the use of specialty drugs.

- Wellness Programs: Investing in wellness programs and disease management initiatives can help identify and manage chronic conditions early, potentially reducing the need for high-cost specialty drugs in the long term.
- Data Analytics: Employers can leverage data analytics to understand utilization patterns, identify opportunities for cost savings, and evaluate the effectiveness of benefit designs and interventions.
- Legal and Regulatory Compliance: Staying informed about changes in healthcare regulations and ensuring compliance with applicable laws can help employers avoid penalties and legal challenges related to their benefit offerings.
- Collaboration and Advocacy: Employers can collaborate with other stakeholders, including healthcare providers, insurers, pharmaceutical manufacturers, and policymakers, to advocate for policies that promote access to affordable specialty drugs while ensuring the sustainability of employer-sponsored health plans.
- Financial Assistance Programs: Employers can explore options such as copay assistance programs, patient assistance programs, and manufacturer-sponsored discounts to help employees afford high-cost specialty drugs.

2. *What role can reinsurance models play in helping employers pay for high-cost specialty drugs?*

In the self-funded and level-funded marketplace, most employers, especially smaller and mid-size employers, already rely on stop-loss coverage to offset or reinsure against significant costs. However, stop-loss policies are issued and priced based on claims experience and medical underwriting, and stop-loss coverage can be limited or exclusionary of certain high-cost claimants or treatments. Plan sponsors are seeing the cost of stoploss coverage skyrocket due to specialty drugs and related costs, and they are also seeing stoploss insurers elect to refuse to cover the costs of some medications or specific plan participants So, reinsurance does not necessarily provide much help in these spaces when it comes to the highest cost claims, specialty-drug related or otherwise.

Some very large employers are feeling this problem very acutely now, since these entities may not have previously held stop-loss insurance, and instead have been managing their own risk for years. For these employers, the exploding cost of specialty drugs is crippling, and unlike any cost crisis seen in the market before. Having not held stoploss coverage previously, some of our country's largest employers and now finding it impossible to obtain reinsurance coverage that will cover their needs in this area. Individual coverage reinsurance pools exist via Section 1332 waivers in many states, but reinsurance pooling has yet to be successfully used in state fully insured group marketplaces on any wide scale.

3. *What barriers exist in ERISA or elsewhere that hinder employers' ability to leverage reinsurance for the purposes of mitigating the risks of covering high-cost specialty drugs?*

   As noted above, cost and the willingness of reinsurers to underwrite these known risks are barriers.

4. *What tools can employers use to expand risk pools to lower the collective costs of coverage of high-cost specialty drugs?*
   It is important to understand that even a very large employer risk pool is unlikely to have a significant enough population taking specific high-cost specialty drugs to truly have significant negotiating power with prescription drug manufacturers. In any given state, the largest risk pool of employees is the employers pooled together in the small group market sector of the state's leading small group carrier. These risk pools of hundreds of thousands, or in some cases millions, of lives, are not sufficient enough to make a significant dent in the cost of new and extremely expensive medications. One example is the devastating impact that the cost of covering the injectable medication semaglutides is currently having on state employee health benefit plans in multiple states. Making tools available to employers to expand their risk pools is unlikely to address this significant problem in any meaningful way.

5. *Can employers enter into multiple employer welfare arrangements or similar risk-sharing models to help decrease the cost of high-cost specialty drugs?*
   As noted above, merely expanding the number of covered lives in a risk pool is not an effective strategy to truly reduce the high cost of specialty drugs. That is a problem that needs to be addressed through other means. In addition, forming a multiple-employer welfare arrangement is a significant endeavor, with both state and federal laws and regulations involved. Not only is a MEWA an inappropriate health plan arrangement for many employers, but in many cases, state and federal laws and regulations would prevent certain types of employers from forming them.

6. *What role should the federal government play in assisting employers, drug manufacturers, and other entities to manage risks and to share the costs and savings of employer-sponsored coverage of high-cost specialty drugs?*

   NABIP believes the committee should consider a greater federal role in helping employers and plan participants have better access to specialty medications by providing some type of cost offset or federal reinsurance back-stop. The cost of specialty medications and their related impact on access to healthcare is at a crisis point and unlike anything the market has experienced before. It is changing the whole concept of risk management in the health and welfare plan space, and so we encourage Congress to

explore this issue further and work towards both immediate relief and long-term solutions.

7. *What barriers exist in ERISA or elsewhere that prevent employers from entering into value-based arrangements with drug manufacturers for coverage of high-cost specialty drugs?*
   Due to the power imbalance between even the largest employers and the manufacturers of high-cost specialty drugs (many of which are not even manufactured by U.S.-based companies) even group health plans sponsored by Fortune 100 companies are unlikely to have the leverage to enter arrangements that would truly move the price needle on the highest-cost specialty drugs.

8. *What innovative coverage models are currently in use that address the high cost of specialty drugs?*
   In the market today, our members see the use of international sourcing, co-payment assistance and drug manufacturer discount programs, discount card programs and promoting the use of alternative sourcing such as GoodRx, the exclusion of coverage of all specialty drugs, and the exclusion of certain high-cost specialty drugs. In addition, PBMs apply strict utilization management criteria when it comes to high-cost pharmaceuticals, including prior authorization and step therapy.

We truly appreciate the opportunity to provide information to the committee on potential improvements to ERISA, as well as your willingness to consider the viewpoints of all stakeholders. If you have any questions or need additional information, please do not hesitate to contact John Greene, senior vice president of government affairs, at jgreene@nabip.org or (202) 595-3677.

Sincerely,

John Greene
Senior Vice President of Government Affairs
National Association of Benefits and Insurance Professionals