APRIL 2022

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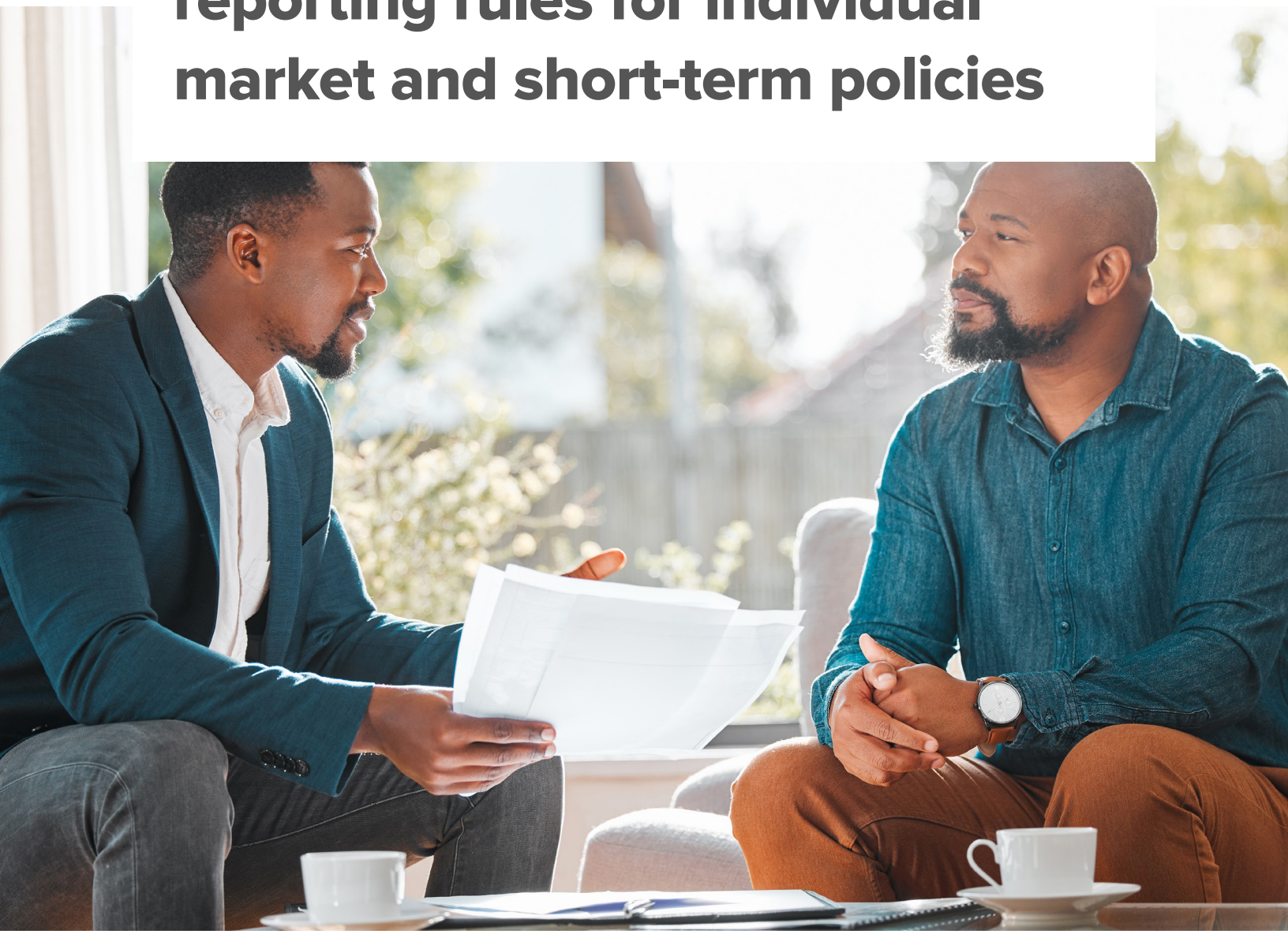
New federal broker and agent compensation disclosure and reporting rules for individual market and short-term policies



Alston & Bird LLP and Aflac

The Consolidated Appropriations Act, 2021 (CAA) requires health insurers to disclose to policyholders direct and indirect compensation related to individual market coverage (other than excepted benefits) and short-term limited duration insurance (STLDI). Related information is required to be provided annually to the Department of Health and Human Services (HHS).

HHS proposed rules that provide details on new disclosure and reporting requirements for health insurers in the individual and STLDI markets.

- Disclosure is intended to provide information to prospective and current policyholders regarding potential conflicts of interest of the broker or agent. The reporting is intended to better enable HHS to monitor the marketing practices of covered insurers.
- The CAA also requires brokers and consultants to ERISA-covered group health plans to disclose compensation information to plan fiduciaries.

The requirements with respect to group health plans are different than the requirements for individual market coverage and STLDI and are addressed in a **separate article**.

Key elements of the disclosure and reporting requirements based on the proposed rules are summarized in the following tables.

At a glance

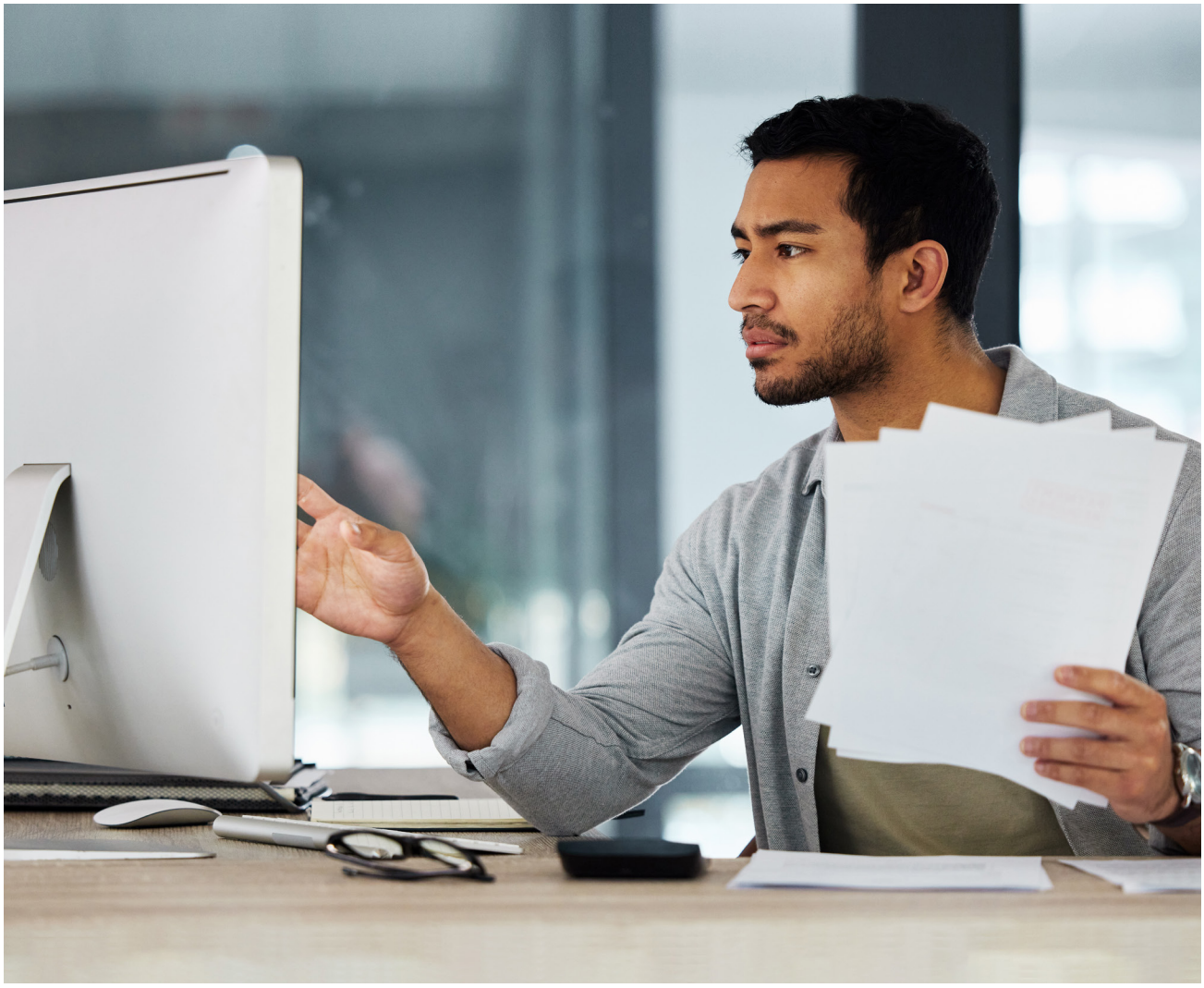
Who must disclose and report?	■ Health insurers with respect to :
	  ■ Individual market health plans other than excepted benefit plans (e.g., stand-alone vision and dental plans, specified disease plans, and fixed indemnity excepted benefits).
	  ■ STLDI.
	■ An insurer's disclosure obligation can be satisfied if the agent or broker makes required disclosures to policyholders on the insurer's behalf.

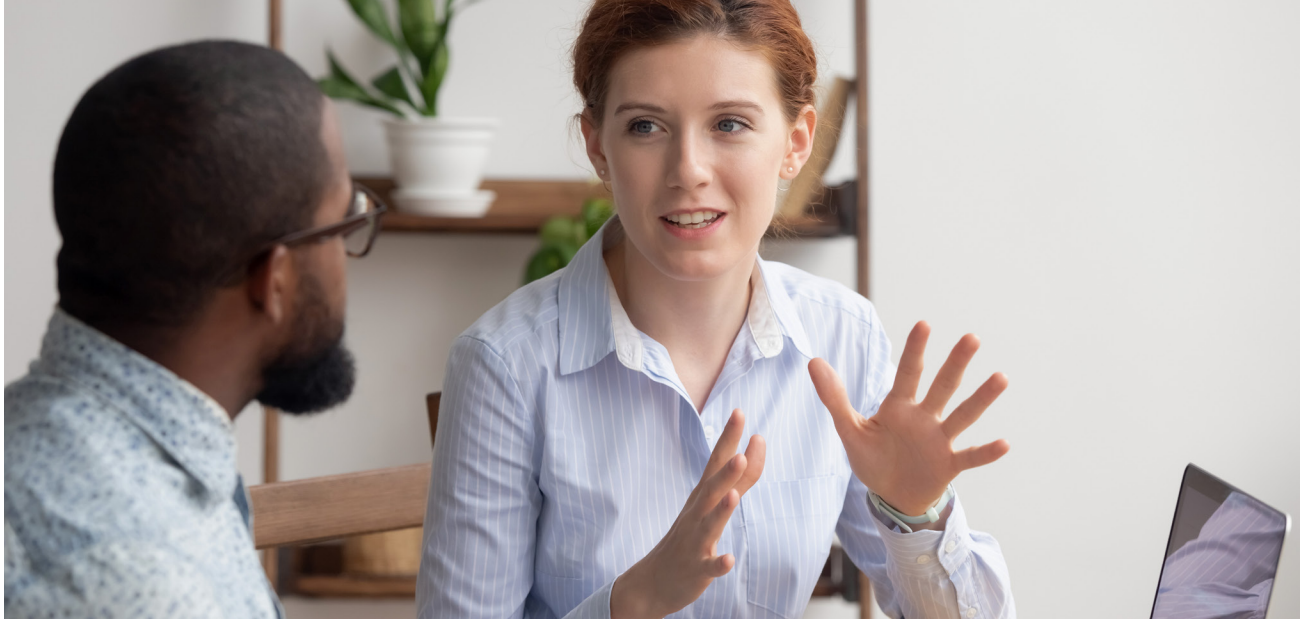
Who is required to receive the information?	■ Disclosure is made to current and potential policyholders, defined as the individual who purchases individual health insurance or STLDI and who is responsible for the payment of premiums. ■ Reporting is made to HHS.
When are the requirements effective?	■ **The disclosure requirement** is effective for contracts executed between health insurers and agents or brokers on or after Dec. 27, 2021. The execution of contract addenda or revisions to the material terms of a pre-existing contracts on or after Dec. 27, 2021 is considered the execution of a new contract. ■ The **reporting requirement** is generally effective at the same time as the disclosure requirement. In addition, HHS may exercise discretion on a case-by-case basis for contracts executed and policies effective between Dec. 27, 2021 and Jan. 1, 2022, and adopt a policy of relaxed reinforcement in such cases. HHS does not expect this would apply in many situations.
How are the requirements enforced?	■ States have primary enforcement authority with respect to disclosure to policyholders. ■ HHS intends to enforce the requirement for reporting to HHS.

Disclosure to current and prospective policyholders

What must be disclosed?	**Direct and indirect compensation** paid by an insurer to an agent or broker, including: ■ Commission schedules (or other documentation) that clearly specify commissions paid to an agent or broker for the applicable plan and distinguish between commissions for new enrollments and commissions for renewals, if the insurer differentiates compensation for these two types of enrollment. ■ An explanation of the qualifying thresholds for the payment of indirect compensation. ■ Other documents that contain the necessary information, to the extent they are not reflected on commission schedules.
Definitions	■ **Agent or broker:** a person or entity licensed by a state as an agent, broker or insurance producer. ■ **Direct compensation:** amounts paid by an insurer to an agent or broker that are directly related to the sale, placement or renewal of covered insurance, including sales and base commissions. ■ **Indirect compensation:** any payments that are indirectly related to a covered insurance policy (other than sales and base commissions). Indirect compensation includes, for example, service fees, consulting fees, finders' fees, profitability and persistency bonuses, awards, prizes, volume-based incentives and non-monetary forms of compensation.
Timing of disclosures	■ **For initial enrollments**: Disclosure must be made before a potential policyholder finalizes their plan selection and on any documentation confirming the initial enrollment. ■ **For renewals:** Disclosure must accompany the plan renewal notice. ■ **If there is no applicable federal or state requirement relating to documentation confirming new coverage or renewal notices:** The disclosure is to be provided with the invoice for the first premium payment for the initial coverage term and for each renewal period.

Enforcement and consequences of nondisclosure	■ As is the case with other federal mandates on health insurers, states retain primary enforcement authority over the disclosure requirements. HHS will directly enforce the requirements if a state notifies HHS that it does not have the authority to enforce a federal requirement or HHS otherwise determines that a state is not substantially enforcing a federal requirement. ■ When a state is responsible for enforcement, consequences for noncompliance will vary based on state law. When HHS is enforcing, a number of consequences may apply under federal law, including a $100 fee per person, per violation, per day for noncompliance. ■ States may have additional reporting requirements for broker and agent reporting. State law is generally not preempted unless the state law prevents application of a federal requirement.





Reporting to HHS

What must be reported?	
	In general, the information that must be reported to HHS is more detailed than the information that must be disclosed to policyholders. The annual report to HHS must contain actual compensation amounts, rather than payment structures. In addition, the annual report must contain information regarding compensation arrangements through intermediary organizations, such as general line organizations and marketing organizations. HHS intends to require insurers to submit the following information for each payment recipient and intermediary organization in a specific month of the reporting year, a single row of data in comma-separated values (CSV) format containing the following fields/columns: 1 Payor Federal Tax ID Number (FTIN). 2 Recipient Identifier Type (National Producer Number (NPN) for writing agents or FTIN for payments made to intermediaries). 3 Recipient Identifier Value (the actual number). 4 The date on which the payment was made to the payment recipient. 5 Direct Compensation, expressed as a dollar amount (the commission). 6 Indirect Compensation, expressed as a dollar amount, if any (if indirect compensation payment amount was made in that month, for example, a bonus was paid out; bonuses for annual performance are accounted for in December of the reporting year rather than disaggregated into 12 parts for each month). 7 The basis for indirect compensation—a text field allowing entry of what the grounds for the indirect compensation were (bonus, incentive, etc.). 6 Other information specified by the HHS, which may include, for example, distinguishing between individual health insurance coverage and short-term, limited-duration insurance, listing the appointment arrangement duration, and providing the number of plans the agent sold.

How will the information be reported?	The precise form and manner for reporting direct and indirect compensation to HHS will be specified in future guidance and the information will be submitted to HHS through an online system. In general, however, HHS plans to collect information similar to information the Department of Labor (DOL) collects under ERISA relating to insurance on Form 5500 Schedule A.
Timing of disclosures	The report must be provided annually based on the calendar year. The deadline for reporting for a calendar year is the last business day in July of the following calendar year. The first reporting period will be for calendar year 2022 and the first report will be due by July 31, 2023. For non-calendar year policies, e.g., some STLDI coverages, calendar year reporting means that reporting for a single policy year will need to be split across two reporting years.
Enforcement and consequences of nondisclosure	The reporting requirement will be directly enforced by HHS.

Conclusion

The disclosure and reporting requirements impose significant new obligations on insurers with respect to of individual market polices (other than excepted benefits) and STLDI. Insurers subject to these requirements should contact their advisors about how the new requirements will impact them and compliance concerns. Stand by for updates, including the final published regulations.

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