

**TESTIMONY OF**

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**ON BEHALF OF**

**THE AMERICAN COUNCIL OF LIFE INSURERS,**

**FOR THE**

**DEPARTMENT OF LABOR**

**HEARING ON REASONABLE CONTRACTS OR ARRANGEMENTS**

**FOR WELFARE BENEFIT PLANS UNDER ERISA SECTION**

**408(b)(2)--WELFARE PLAN FEE DISCLOSURE**

**DECEMBER 7, 2010**

## ***Introduction and Overview***

Assistant Secretary Borzi and members of the panel, good morning. It is a pleasure to be with you today. My name is Todd Katz. I am the Executive Vice President for Insurance Products at MetLife, one of the nation's largest providers of workplace benefit programs. I am testifying today on behalf of the American Council of Life Insurers (ACLI) as to whether the Section 408(b)(2) disclosure rules should apply to products sold to employee welfare benefit plans.

ACLI is a Washington D.C.-based trade association backed by an industry with more than 200 years of experience protecting American families, workers, and businesses. ACLI represents more than 300 life insurer and fraternal benefit society member companies operating in the United States. Employers rely on ACLI member companies to provide life insurance, disability, accidental death and dismemberment, long-term care, critical illness, and other coverages that are offered to employees through ERISA welfare benefit plans.

My testimony today will focus on these non-medical welfare benefit products sold by ACLI members, including MetLife. I will explain the characteristics of these products, how they are structured, and the disclosures employers and employees generally receive under existing law and practice. My testimony covers a wide array of products issued by numerous companies. It is intended as a general overview of these matters, since specific details may vary among ACLI member companies.

ACLI supports appropriate disclosure to ERISA welfare benefit plan sponsors about the products they purchase for their employee benefit plans. In particular we believe that disclosure of product pricing, terms, and conditions are necessary to permit plan administrators to make informed decisions about the products to be included within a benefit plan. Disclosures provided to plan sponsors, however, are not cost-free. They should be required only when they add

value by improving the ability of the plan sponsor to make decisions about the plan without inundating the sponsor with unnecessary, duplicative, or potentially confusing information.

Current disclosures required by the regulatory framework for non-medical products sold to ERISA welfare plans are more than adequate to provide plan sponsors the information needed to make these decisions. While concerns about indirect compensation of service providers, investment advice, bundled services, and conflicts of interest with plan fiduciaries drove the decision to enhance the disclosures provided to retirement plans, these considerations are seldom present in the structurally simple arrangements used for non-medical welfare benefits. In short, there is neither a need nor a substantive basis nor a cost-benefit justification for additional disclosure requirements under ERISA for these insured welfare products.<sup>1</sup>

### ***Description of non-medical benefit products***

Millions of Americans are covered by non-medical benefit products sold to ERISA welfare benefit plans. The vast majority of these products are simple “protection” products, with no investment or other features. The plan pays a premium or fee to the insurance carrier, and in return the carrier promises to pay a benefit upon the occurrence of a specified event. For example, a plan that purchases group term life or disability insurance for its employees will pay the specified premium to the insurer. If a covered employee dies or becomes disabled, the insurer pays a death or disability claim in accordance with the terms of the plan. Generally, these simple “protection” products contain no investment features and no bundling of services. These products readily lend themselves to comparison of their costs and features by plan sponsors and their advisers as they make product

selections for their plans. And most importantly, in these structurally simple products, indirect compensation typically is not received by the insurer.

### ***Current Disclosures by Insurers Relating to Welfare Benefit Plans***

Extensive regulatory disclosures for non-medical benefit products are already required under federal and state law.

#### Existing ERISA Disclosure Requirements

ERISA regulation already addresses these issues in two forms. First, insurers disclose information to plan sponsors, on an annual basis, about premiums, broker commissions, claim payments, claim reserves, and related information, so the plan sponsors can complete Schedules A and C to Form 5500.<sup>2</sup> Second, to the extent prohibited transaction relief is needed for the sale of the insurance product or any commission payment to an insurance broker or agent, DOL has promulgated Prohibited Transaction Exemption 84-24, which requires important disclosures to the plan about the product, the commissions, and the relationship between the sales agent and the insurer, all in advance.<sup>3</sup>

#### State Law Disclosure Requirements

In addition, as you know, the insurance industry is heavily regulated outside of ERISA. State insurance laws and regulations impose meaningful, mandated disclosures to state insurance regulators and plan sponsors, and other important safeguards, relating to non-medical benefit products. These protections are provided under a rigorous state insurance regulatory scheme and have been adopted on a broad basis by the states. Some important features of the state regulatory regime are as follows.

Filing and Approval of Policy Forms and Premium Rates By State Insurance Regulators. Non-medical benefit policy forms are generally required to be *filed and approved* by the state insurance department *in each state* where the product

will be offered.<sup>4</sup> Such policy forms must contain certain required clauses, may not contain certain prohibited provisions, and must meet prescribed minimum standards before they can be offered for sale and issued. Typically, a detailed *actuarial memorandum* describing and demonstrating the propriety of the policy's rates and charges must be filed with the state regulator for approval in support of such filing.<sup>5</sup>

*Premium rates* also must generally be filed with and approved by state insurance regulators for certain forms of non-medical benefit insurance.<sup>6</sup> The state regulator reviews such rate filings to determine whether the rate to be charged is sufficient, but not disproportionate to the benefits provided.

Advertising Requirements. In addition to state regulatory review of policy forms and rates, most states have adopted advertising regulations that set forth mandated disclosure standards and other requirements relating to the marketing and sale of non-medical benefit insurance policies. The term “advertisement” is a very broad term and includes any “material designed to create public interest” in insurance or to “induce” the purchase of a policy.

The National Association of Insurance Commissioners has issued model advertising regulations governing both life insurance and accident and sickness insurance. Such models have been adopted in whole or with revisions in a majority of states – accident and sickness by approximately 42 states, and life insurance by approximately 37 states.<sup>7</sup> The advertising regulations require:

- that advertisements disclose the important policy features (such as benefits, exclusions, limitations, renewability, termination, premium charges);
- that advertisements be truthful, complete and not misleading;
- that advertisements contain fair and accurate comparisons of other products; and

- that insurers adopt certain procedures and safeguards.

The regulations require that the insurer maintain an advertising file that can be examined by state insurance regulators. Some states require that advertising material be filed with its insurance department, and sometimes approval is required.

To enforce advertising and other disclosure requirements, 55 states and other U.S. jurisdictions have adopted, in whole or with revisions, the National Association of Insurance Commissioners “Unfair Trade Practices Act” which prohibit an insurer, agent or broker from making misrepresentations or false statements about the benefits, terms and conditions of a policy or its premium rates.<sup>8</sup>

Filing and Disclosure of Agent/Broker Compensation. Some states require that compensation payable to third parties under group non-medical benefit policies be filed with the state insurance regulator.<sup>9</sup> In New York, effective January 1, 2011, insurance agents and brokers are required to disclose, to the purchaser, compensation payable to the agent or broker.<sup>10</sup>

Requirement That Certain Compensation Agreements Be In Writing. If the insurance agent or broker is compensated directly by a plan or other purchaser pursuant to agreement between them, some state insurance laws require that such agreement be (i) in writing and (ii) signed by the party to be charged.<sup>11</sup> This assures that such compensation is disclosed to and approved by the purchaser.

#### Additional Insurer Disclosures

While the foregoing are the legal requirements that apply to most insured welfare products, they are not the only disclosures that plan sponsors receive. It is common for insurers to supply cost and benefit summaries to plan sponsors detailing the price, benefits, and material terms and conditions of the non-medical benefit products being offered to the plan. These disclosures enable plan sponsors to understand what is being purchased and to compare non-medical benefit

offerings among different insurers. If the insurance product has an investment feature – such as a group variable life insurance policy – SEC registration requirements, including delivery of a prospectus, will apply.

As a consequence of both law and practice, plan sponsors receive comprehensive information allowing them to evaluate and select insured welfare products, including information about: (1) the scope of insurance coverage that will be provided; (2) claims administration and underwriting; (3) the premium or other fees that will be paid for the insurance coverage; and (4) commission payments, if any. These disclosures are often provided to the plan sponsor at multiple times, including in the response to the sponsor's Request for Proposal (RFP), in marketing materials, in the insurance policy or evidence of coverage outlining the scope of benefits, and in annual policy, Form 5500 and other reporting to the plan sponsor. And premium rates often are subject to state regulatory review and approval.

***Section 408(b)(2) disclosure rules would not enhance the ability of plan sponsors to exercise their fiduciary duties***

As I noted earlier, the non-medical benefit products sold to ERISA plans usually involve a straightforward payment of premium in exchange for the insurer's promise to pay covered claims. The basic coverages purchased -- term life, disability insurance, and the like -- readily lend themselves to comparisons by plan sponsors, and existing disclosures for such non-medical benefit products ensure that sponsors obtain the information needed to select a product.

The simplicity of the sale and operation of these welfare products significantly distinguishes them from many retirement plan arrangements. Non-medical benefit products do not pose the risk that plan sponsors will not know how much they are paying for those services or benefits or who is being paid. The

insurer providing the product or service typically receives no indirect compensation, and services provided to the plans are not typically bundled across providers. In addition, no investments are made or managed on behalf of the plan, so the insurer is acting neither as an “investment adviser” nor an “investment manager.” Since there are no assets to manage, there can be no concern regarding conflicted investment decisions.

Finally, in contrast to what may be found in retirement plan service arrangements, non-medical benefit products do not have termination penalties or fees, leaving plans free to walk away from any arrangements that become unsatisfactory to them.

The significance of these differences becomes clear on examination of the potential extension of section 408(b)(2) requirements, currently applicable to retirement plan service providers, to insured, non-medical welfare benefits. The new 408(b)(2) regulation starts with a description of the services to be provided; however, the Department has long recognized that the issuance of insurance standing alone is not a service, a point it confirmed in the preamble to the proposed 408(b)(2) retirement plan regulation. In fact, it seems doubtful that an insurance company providing welfare benefits is a covered service provider within the intent of the new rule. Even were it to apply, the regulation next asks if the service provider is a fiduciary, but unlike in the retirement plan context, the status of the insurance company under these simple products is the same across providers and well understood; the insurance company is a fiduciary with respect to claim determinations (which does not seem to be the focus of the 408(b)(2) regulation) but not in any other respect.

The next item to be disclosed is direct or indirect compensation, and the manner in which that compensation is received; for these insurance products, the premium for the insurance coverage is the direct compensation, there is no indirect

compensation, and the plan sponsor decides how the premium is remitted. Next, the cost of recordkeeping services associated with individual account plans, which allow participants to direct investment activity, must be separately disclosed to correct any misunderstanding that those recordkeeping services are being provided for free; however, such recordkeeping as may be associated with simple welfare products does not fall within this category. Finally, the new 408(b)(2) regulation requires a number of investment-related disclosures; for these insured welfare products, there usually is no investment feature at all.

All of this means that neither the reasons for nor the mechanics of additional disclosure in the retirement plan context apply to insured, non-medical welfare benefits. Insurance company providers of these simple, unbundled products should be excluded from any additional disclosure requirements. At a minimum, in view of the significantly different nature of welfare benefit products, any disclosure requirements should be separately promulgated, specifically tailored to those products, mindful of the existing regulatory scheme, and limited to requirements that provide actual value to plan sponsors and participants in relation to the cost of implementing the requirements.

Finally, while my primary point is that there is neither a need nor a substantive basis for additional welfare plan disclosure rules for the already well-regulated insured benefit market, I should also note the significant import of the treatment of these insurance products under ERISA. As I noted earlier, the Department's view is that insurers are not inherently service providers. For that and other reasons, section 408(b)(2)'s impact may ultimately be limited. And where it might apply, the distinctions and complications that would be required to limit a section 408(b)(2) disclosure regime for insured welfare plans to its proper scope strongly suggest that the benefits would not be commensurate with the cost and effort required.

I should note that there are limited exceptions to the use of structurally simple, guaranteed insurance products for these plans. For example, group universal or group variable life insurance contracts with an accumulation feature sometimes may be used. Some large group insurance policyholders may have certain additional monies in the form of reserves held under their policy. And occasionally there are recordkeeping arrangements separate from the insurance guarantee. These cases, however, do not support a new ERISA disclosure initiative, first, because they are the exception rather than the rule; second, because they often involve large plan sponsors with the business leverage to negotiate for the terms and compensation structure they require; and third, because in arrangements for smaller employers where indirect compensation is even a structural possibility (these would primarily be group variable life products), the products are SEC registered and must meet SEC disclosure standards for indirect compensation. While not identical to the section 408(b)(2) disclosure required for retirement plans, the SEC standards are entirely adequate regulation in the circumstances.

### ***Conclusion***

In sum, these fundamental distinctions between typical retirement plan arrangements and non-medical welfare benefit products make any new 408(b)(2) disclosure rules for non-medical products both unnecessary and inappropriate. Plan sponsors already receive detailed disclosure of rates, fees and product features that allow them to determine that the products are appropriate and that the amount paid is reasonable. It is relatively easy for ERISA welfare plan sponsors to understand what they are buying and whom they are paying. It is also relatively easy for plan sponsors to comparison shop among different insurers. The indirect compensation and conflict of interest concerns that drove the Department's prior

disclosure initiative with respect to retirement plan arrangements are absent for these straightforward insurance protection products.

Appropriate disclosure of information concerning insurance products is necessary and can be very beneficial. But adding section 408(b)(2)-type disclosures for non-medical benefit products to the disclosures already made would not add commensurate value for benefit plan sponsors, and would much more likely be unnecessary, redundant, confusing, or otherwise counterproductive. Given that new disclosure requirements would unavoidably impose increased expenses on plans and participants and potentially decrease the availability of benefits, the cost-benefit analysis does not add up.

To the extent, however, the Department believes further disclosure is needed, separate rules should be promulgated so that they can be narrowly tailored to the specific characteristics of, and the disclosure rules already applicable to, welfare benefit programs. The ACLI would welcome the opportunity to play an active role in the process of developing such rules.

On behalf of the ACLI, I commend the Department for its ongoing and thoughtful attention to these issues, and I would welcome any questions you may have.

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<sup>1</sup> Although beyond the scope of my testimony today, it bears noting that insurance companies and other third parties provide a number of other benefits and services to plans--pre-paid legal, vacation services, severance, absence management, independent administrative services, credit protection services, etc.--that are structurally simple and that also do not raise the concerns addressed by section 408(b)(2) disclosure requirements.

<sup>2</sup> Schedule A is required only for plans with 100 or more participants.

<sup>3</sup> See 42 Fed. Reg. 32395 (June 24, 1977), as most recently amended, 71 Fed. Reg. 5887 (February 3, 2006).

<sup>4</sup> See e.g., Connecticut (Conn. Gen. Stat. §38a-430); Delaware (18 Del. C. § 2712); Florida (Fla. Stat. § 627.410); Georgia (Ga. Code Ann. §33-24-9); Indiana (Ind. Code §27-1-12-13); Minnesota (Minn. Stat. §61A.02); New Jersey (N.J. Stat. Ann. §17B:17-21); New York (N.Y. Ins. Law §3201); North Carolina (N.C. Gen. Stat. § 58-51-95(a)); Rhode Island (R.I. Gen. Laws § 27-18-8); South Carolina (S.C. Code Ann. §38-61-20); Washington (Wash. Rev. Code §48.18.20).

<sup>5</sup> See e.g., New York (N.Y. Comp. Codes R & Regs. tit. 62, § 52.34); Virginia (Regulation 14 VAC 5-130-60).

<sup>6</sup> See e.g., Arkansas (Ark. Code Ann. §23-79-109); California (Cal. Ins. Code § 10236.11); District of Columbia (D.C. Code § 31-5205); Iowa (Iowa Code §514A.13); New York (N.Y. Ins. Law §4235(h)(1)); Tennessee (Tenn. Code Ann. §56-26-102); Virginia (14 Va. Admin. Code § 5-130-50); Wyoming (Wyo. Stat. Ann. § 26-23-326).

<sup>7</sup> See National Association of Insurance Commissioners Model Advertising of Life Insurance and Annuities Model Regulation (570-1) and Advertisements of Accident and Sickness Model Regulation (40-1). See e.g., Arizona (Ariz. Admin. Code § 20-6-202); Arkansas (Rule & Regulation 11); Florida (Fla. Admin. Code Ann. r. 690-150.101 to 690-150.122); Georgia (Ga. Comp. R. & Regs. § 120-2-12); Illinois (Ill. Admin. Code tit. 50, §§ 909.10 to 909.112); Kansas (Kan. Admin. Regs. § 4-9-118); Michigan (Mich. Admin. Code r. 500.1371 to 500.1387); Missouri (Mo. Code Regs. Ann. Tit. 20, § 400-5.410); New Hampshire (N.H. Code Admin. R. Ann. Ins. 2602.11); New Jersey (N.J. Admin. Code §§ 11:2-23.1 to 23.10); New York (N.Y. Comp. Codes R & Regs. tit. 11, §§ 215 et. seq., 219 et. seq.); North Dakota (N.D. Admin. Code §§ 45-04-10-01 to 45-04-10-08); Pennsylvania (31 Pa. Code § 51.2); Rhode Island (02-030-052 R.I. Code R.); Virginia (14 Va. Admin. Code § 5-90-10 et seq.); Washington (Wash. Admin. Code 284-23-010 to 550); West Virginia (W. Va. Code R. §§ 114-11-1 to 114-11-11).

<sup>8</sup> National Association of Insurance Commissioners Unfair Trade Practice Act (880-1) at §4(A)(1) and (6).

<sup>9</sup> See e.g. New York (N.Y. Ins. Law §§4216(e) and §4235(h)(1)); Arkansas (Ark. Code Ann. § 23-64-520).

<sup>10</sup> New York (N.Y. Comp. Codes R & Regs. tit. 11, § 30); see also Colorado (3 Col. Code Regs. § 702-1.1-2-17).

<sup>11</sup> Connecticut (Conn. Gen. Stat. Ann. § 38a-707a); Florida (Fla. St. § 626.593); Idaho (Idaho Code Ann. § 41-1030); Indiana (Ind. Code § 27-1-15.6-22); Kansas (Kan. Stat. Ann. § 40-4911); New York (N.Y. Ins. Law §2119); Oregon (Or. Admin. R. 836-071-0260 and 836-071-0263).