**BlueCross BlueShield Association**

An Association of Independent Blue Cross and Blue Shield Plans

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September 19, 2006

Mr. Robert Doyle
Director
Office of Regulations and Interpretations
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Room N-5669
Washington, D.C. 20210



**By Electronic Mail (e-ori@dol.gov)**

**Re: BCBSA Comments on the Proposed Form 5500 Regulations and Forms**

Dear Mr. Doyle:

This letter provides the comments of the Blue Cross and Blue Shield Association ("BCBSA" or "Association") on the Department of Labor's ("the Department") proposed changes to the regulations governing the Form 5500 Annual Report for ERISA-covered pension and welfare plans. BCBSA represents the 38 independent, locally operated Blue Cross and Blue Shield companies that collectively provide health care coverage for more than 96 million people, nearly one in three Americans.

As a key stakeholder affected by the reporting and disclosure requirements, BCBSA member companies are committed to assisting the Department in developing reasonable and administrable standards for the reporting of fees and commissions as required in Schedules A and C of the Form 5500. For two years a BCBSA workgroup of member Plans has been reviewing the Form 5500-related reporting obligations of insurance companies and plan service providers. On a number of occasions, the Association met with and provided comments to the Department regarding both the Schedule A and the Schedule C reporting requirements for the Form 5500. Unfortunately, the proposed changes to the regulations and Forms do not address any of the continuing issues under Schedule A and impose significant new and problematic reporting obligations on plan service providers under Schedule C.

In the Association's view, the Department's proposed approach to the reporting of fees and commissions on Schedules A and C is unduly burdensome on insurers and service providers and lacks a clearly articulated and consistently followed purpose. It is essential that the Form 5500 reporting obligations be described in clear rules (*i.e.*, bright line tests) known to the entire industry. It is even more important that the scope of the very significant reporting obligation placed on insurers, service providers and plan administrators be consistent with an articulated rationale and purpose for such reporting.

## I. Schedule A Reporting: BCBSA Requested Changes

This letter does not repeat in detail the points made in our prior correspondence to the Department regarding Schedule A reporting standards, except to note that the Association

remains convinced that modification of the Schedule A reporting rules is required in the following respects:

- Insurers and plans should report on Schedule A only those payments made by insurers for or because of the sale or renewal of insurance contracts, as this would be most consistent with Congress' direction that insurer's report their "acquisition costs."

- The Department should reinstitute the "general agent override" exception for payments made to general agents and calculated based on policy value.

## II. Schedule C Reporting: BCBSA Requested Changes

The modifications to Schedule C proposed by the Department are troubling in several respects. First, the required reporting goes beyond that necessary to accomplish the Department's disclosure goals. Second, the reporting required of service providers relating to indirect compensation will be duplicative, misleading and confusing to plan administrators. Lastly, the cost to providers and plan administrators of producing this information greatly exceeds the benefits to be obtained for plans.

As explained in detail below, BCBSA recommends the following changes to the Schedule C proposal, which will accomplish the Department's objectives, while minimizing the confusion and burdens imposed on both plan administrators and service providers.

- Confirm that only those entities with direct service relationships with an ERISA plan should be identified as plan service providers on Schedule C (Section A below).

- Refine the scope of the reporting obligation for indirect compensation received by a service provider (Section B below).

- Permit a reasonable allocation of all payments not specifically related to any particular plan (Section C below).

- Eliminate the requirement to report float retained by service providers (Section D below).

- Eliminate the requirement that administrators identify to the Department those service providers that do not provide information relating to Schedule C (Section E below).

### A. Confirm that a "service provider" is a person with a service relationship directly with the plan and that the only sub-contractors reportable on the Schedule C are certain providers in a "bundled fee arrangement."

The Association believes that the Schedule C and Instructions require the plan administrator to report compensation paid to persons who directly provide services to the plan (whether or not the person is paid directly by the plan). This is consistent with ERISA § 103(c) (3) which requires reporting on those "who received directly or indirectly compensation from the plan . . . for service rendered to the plan."

The Department's requirements that compensation be reported for certain providers (including the broad category of "contract administrators") in a "bundled fee arrangement" suggests that the Schedule C reporting obligation might extend beyond those persons with direct service relationships with plans to require reporting on sub-contractors of service providers. The Association asks that the Department make clear that certain providers in a bundled

arrangement are the only providers without direct services relationships with plans whose compensation needs to be reported on the Schedule C. Compensation received by "sub-contractors" need not be reported.

Including sub-contractors of plan providers on Schedule C would result in "double" counting of compensation. This, in turn, could result in plan decisions based on inaccurate information. Moreover, sub-contractors to plan service providers are often not even aware of the identities of the service providers' plan customers, as they do not contract with and often have no contact with them. Most importantly, disclosure of sub-contractor compensation does nothing to assist the plan fiduciary in evaluating the reasonableness of the fees or the quality of services provided by the service provider the plan has engaged and with whom it has contracted. Because there is no "service" relationship between the sub-contractor and the plan, there is no potential for conflicts and no negotiation between the plan and subcontractor for which the information might be relevant.

While it may be appropriate to require reporting of the allocation of compensation among certain providers in bundled arrangements, we ask that the Department more narrowly define bundled fee arrangements so as not to encompass more traditional sub-contracting arrangements. In our view, a "bundled fee arrangement" should be defined as an arrangement under which the plan formally contracts with and pays a single entity a "bundled fee" for multiple services, but the role of each of the underlying providers in providing those services is clearly identified in the services agreement and the ERISA plan has some rights with respect to changes involving the provider (e.g., advance notice or an opportunity to reject a substitution of providers). In this type of bundled arrangement, the reporting of compensation for certain underlying providers may be appropriate because they are effectively evaluated and chosen by the plan fiduciary. Where the plan fiduciary does not evaluate and choose the underlying providers, the plan has no relationship with that provider. In that case, the entity is a sub-contractor and there is no reason to require reporting of that sub-contractor's compensation.

We note that under the forgoing standard, BCBSA believes that the National Accounts programs offered by Blue Cross and Blue Shield Plans would not constitute a bundled fee arrangement. Participation in National Accounts Programs is an obligation of the member Plans pursuant to the License Agreement between each of the member Plans, and the Association, which facilitates the offering of Blue Cross and Blue Shield services on a national basis. Under National Accounts programs, a single Blue Cross and/or Blue Shield Plan is able to offer a multi-state ERISA plan access to medical providers in all states pursuant to provider agreements that other Blue Cross and/or Blue Shield Plans have entered into in those states.

Under the National Accounts program, the direct contracting Blue Cross and/or Blue Shield Plan is responsible to the ERISA plan for handling the claims administration for the ERISA plan, and the identity of each underlying Blue Cross and/or Blue Shield Plans is typically not identified in the administrative services agreement. Nor does the ERISA plan fiduciary have any negotiated rights relating to the use of underlying Blue Cross and/or Blue Shield Plans that provide services to the Blue Cross and/or Blue Shield Plan that has entered into the services agreement with the ERISA plan. Requiring individualized reporting of compensation paid to each Blue Cross and/or Blue Shield Plan in connection with the National Accounts program would be difficult, and would provide ERISA plan customers with no meaningful information by which to evaluate the services provided.

Lastly, the Association requests that the Department specifically confirm in the Instructions that an insurance company is not a service provider whose "compensation" is reportable on

Schedule C if the insurance company's only relationship with the plan is as issuer of an insurance contract, notwithstanding the fact that the insurer may provide services as part of its administration of the insurance contract. *See* DOL Adv. Op. 76-36.

In summary, the Association suggests that the Instructions to Schedule C be revised as follows:

> BCBSA Proposed Instruction: For purposes of Schedule C, a "service provider" includes any person that directly provides services to a plan (as well as those providers involved in a "bundled product" as defined below), and does not include (1) a person who has no direct service relationship with the plan, (2) a person whose only relationship with the plan is as a salesperson of products or services, or (3) an insurance company providing services solely in connection with an insurance contract.
> A "bundled arrangement" is an arrangement under which the ERISA plan formally contracts with and pays a single entity a "bundled fee" for multiple plan-related services and the underlying providers are identified as such in the agreements governing the arrangement and the plan fiduciary has some rights with respect to the underlying providers.

The following examples highlight the application of this proposed clarification:

> EXAMPLE: Identify as a service provider the ERISA plan's third party administrator, but do not include the claims processor engaged by the third party administrator to assist in the performance of the TPA's contractual duties to its plan customers, where that claims processor has not specifically been identified in the plan's contract.
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> EXAMPLE: Where the plan has purchased claims administration and pharmacy benefit administration services in connection with a single agreement, identify the claims administrator and pharmacy benefits administrator (both could be a "contract administrator") only if the contract with the plan identifies the role of each firm and the plan fiduciary has some rights under the contract with respect to changes in providers in the future.
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> EXAMPLE: Insurer sells a health insurance contract to a plan and processes and pays claims under that contract. The insurer is not a service provider required to be identified on Schedule C. The insurer will provide information to the administrator for use in completing the Schedule A.

### B. Adopt a more targeted approach for the reporting of "indirect compensation"

The Proposal requires the reporting of "indirect compensation" received by certain types of plan service providers ("Special Service Providers"). Indirect compensation is defined generally as amounts "received from a source other than the plan or the plan sponsor by a person who is a service provider *in connection with that person's position with the plan or services rendered to the plan.*" (Emphasis added.)

This standard is broader than necessary to accomplish the Department's goal of permitting the fiduciary to assess the reasonableness of the provider's compensation and the impact of conflicts of interest on the quality of its services. BCBSA's concerns are as follows:

- The proposed standard appears to require reporting of a third party payment received by a plan service provider even though the provider provides no advice or

recommendations that could affect its compensation and would appear to require reporting even though the payment is received as compensation for services provided not to the plan but to the payor.

- The reporting proposed by the Department will mislead and confuse plan administrators. Given the double and even triple counting inherent in the proposal, plan administrators may believe that the plan's total costs are much higher than they actually are. And, it will be difficult for the fiduciary to discern the truly relevant information from among the mountain of information its service providers are required to provide.

- The costs of the proposed reporting will be very high. Although the Department has estimated that the Schedule C changes will result in minimal additional time and costs to plan administrators, the costs will be very significant for service providers and such costs will be passed on to the ERISA plan customer.

To address the overly broad reporting of indirect compensation, BCBSA proposes that the Department modify the proposal in three ways:

1. **Limit the circumstances in which a service provider must report indirect compensation to where the service provider gives advice or recommendations (whether or not fiduciary) that could affect their compensation**

The proposed Schedule C requires the reporting of "indirect compensation" received by certain types of service providers ("Special Providers").[1] In the Department's proposal, all but six (6) of the twenty-seven (27) types of service providers would be classified as Special Providers whose "indirect compensation" must be reported.[2] This reporting requirement is far too broad.

The Department has indicated that one of its objectives in requiring reporting of indirect compensation is to assist plan fiduciaries in evaluating the provider's conflicts. Yet most plan providers (including those specifically identified by the Department) do not, as part of their plan services, provide to plan fiduciaries advice or recommendations that need to be evaluated for conflicts. Instead, they provide specifically agreed upon support services. Where the provider makes no discretionary decisions for the plan and provides no advice (fiduciary or non-fiduciary), the provider's receipt of third party payments (*e.g.*, as compensation paid to the provider for services it performs for the payor, such as marketing services) is neither relevant to assessing the "reasonableness" of plan-paid compensation nor germane to assessing provider conflicts. Accordingly, the Association proposes a revision to the reporting standard for "indirect compensation."

BCBSA's Proposal: The Association proposes that the enhanced reporting (*i.e.*, the requirement to report third party payments) be required only with respect to those plan service providers whose services include the provision of advice or recommendations to the plan fiduciaries regarding plan transactions.

The Association's proposal is illustrated by the following examples -

[1] Although the Department at times refers to this as "indirect compensation," its description of reportable compensation is much broader and encompasses not only compensation for plan services paid to the provider indirectly through third parties (indirect compensation) but also compensation paid by a third party for services provided to it and not to the plan.

[2] Of the entire list of service providers, only accountants, actuaries, real estate brokers, computing/data processors, lawyers and printers are currently excluded from the list of Special Service Providers.

EXAMPLE: Report a referral fee paid by a TPA to a consultant engaged by the plan to, among other things, advice the plan fiduciary regarding which TPA to hire.

EXAMPLE: Do not report the payment of pharmacy rebates to a third party administrator where the administrator provides no advice or recommendations to plan regarding the drugs to be included on the plan's formulary.

### 2. Payments Between Affiliates Should Not Be Reportable

The Association requests that the Department confirm that amounts paid or allocated to a plan service provider by its affiliate are not required to be reported as "indirect compensation" on the Schedule C. Reporting these payments would serve neither of the objectives articulated by the Department for enhanced Schedule C reporting. Any "interest" that a service provider has in its affiliate should be readily apparent to a plan fiduciary and the fiduciary should evaluate any advice or recommendation provided by that provider relating to its affiliate accordingly. In addition, a plan fiduciary will understand the total compensation payable to the affiliated entities as a group and the precise allocation of fees, expenses and profits among these entities is irrelevant to the "reasonableness" of the total compensation paid by the plan.

Moreover, the allocation of revenues, costs and profits among affiliates frequently has nothing to do with the services provided by the respective affiliates to customers, but instead is designed for budgeting, accounting, or employee compensation purposes. Requiring the reporting of intra-company allocations will create a confusion and unwarranted distinction between companies that provide services using employees in multiple divisions and companies that instead use several subsidiaries to provide the same services. This reporting would not help the Department or plan administrators understand the "true cost" of plan services, one of the Department's reporting objectives. It should be sufficient to identify the service provider together with its affiliates in Part I, with reporting of compensation on an aggregate basis.

### 3. Refine the "in connection with" standard for identifying reportable compensation

The Association recommends that the Department modify the standard for determining when a particular third party payment made to a service provider required to report indirect compensation. Under the Department's proposal, the plan administrator would report (and the service provider would have to identify and disclose) any payment received "in connection with [the service provider's] position with the plan or services rendered to the plan." This test is imprecise and will be difficult to apply, resulting in the reporting of much unhelpful information to plan administrators, at great cost to providers.

BCBSA proposes a more precise test similar to the one recently adopted for Schedule A reporting. Under this test, a payment would be reported on Schedule C if either the eligibility of the provider for the payment or the amount of the payment is based on a transaction involving assets of the plan. This test is consistent with the authority under ERISA section 406(b) (3), the conflict of interest rule which prohibits payments to plan fiduciaries "in connection with" transactions involving plan assets.[3] And, it would satisfy the Department's objectives by

[3] If a plan fiduciary is viewed as not having an impermissible conflict where a payment is not received in connection with a plan transaction, a non-fiduciary provider with no fiduciary duties to the plan should be treated at least as generously. *See e.g.*, DOL Adv. Op. 99-03A (plan's investment in units of trust on secondary market not prohibited even though fiduciary's affiliate receives service payments from the trust so long as amount received by affiliate unaffected by plan's purchase).

requiring of information necessary to assess the "reasonableness" of the provider's compensation as well as its potential conflicts of interest.

> BCBSA's Proposed Instructions: Reportable compensation includes a payment received by a service provider from a third party (other than an affiliate of the provider) if either the eligibility of the provider for the payment or the amount of the payment is based on a transaction involving assets of the plan.
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> EXAMPLE: Report where a consultant has a marketing agreement with a TPA under which it receives sales commissions from a TPA based on the sale of the TPA's services to the consultant's client.
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> EXAMPLE: Do not report the value of a luncheon sponsored by a TPA to inform an insurance agency specializing in employee benefit plans about the services provided by the TPA. The agency did not become "eligible" for lunch because of any client plan transactions.

### C. It should always be permissible to allocate reportable compensation received by a provider where the compensation is not clearly received solely in connection with a specific plan

The proposed Instructions state that a plan's Schedule C should include only the portion of the compensation attributable to the plan making the Form 5500 filing. However, the Instructions go on to state that if "reportable compensation is due to a person's position with or services rendered to more than one plan or DFE, the total amount of the consideration received generally should be reported on the Schedule C of each plan or DFE *unless the consideration can reasonably be allocated to services performed for the separate plans or DFEs.*" *See* Instructions, at 2. We are very concerned about the Department's application of this rule, as illustrated by the following two examples it provided:

> For example, if an investment advisor working for multiple pension plans and other non-plan clients receives a gift valued in excess of $1,000 from a securities broker in whole or in part because of the investment advisor's relationship with plans as potential brokerage clients, the full value of the gift would be reported on the Schedule C of all plans for which the investment advisor performed services. On the other hand, if a securities broker received incentive compensation from an investment provider based on amount or value of business with the broker's clients, the Schedule C of each plan could report a proportionate allocation of the incentive compensation attributable to the plan.

There is no basis for drawing a distinction between these two situations. In neither case is the consideration directly related to providing access to or delivering the business of a single plan. Oddly, under the Department's rule, a much lower number is reported to the plan in the case where the business was actually delivered than in the case where it was only a potential.

If a "relationship-building" payment is required to be reported at all, there is no basis upon which to require allocation of the entire payment to a single client plan if there is no evidence that the payment relates only to that plan. This type of reporting would be grossly misleading, suggesting to the plan administrator that the compensation received by the service provider in connection with its plan is exponentially greater than it actually is.

BCBSA Proposal: Revise the allocation rule to provide that any third party payment is "reasonably allocable" to multiple plans where the payment does not clearly relate to one or more specific plans. For example, a TPA may pay provide a week-end seminar for consultants that work with large plan clients in order to educate the consultant about the TPA's capabilities.

### D. Reporting of float earned on plan assets by services providers should be deleted or simplified.

The Schedule C proposal identifies "float" as one of the types of "reportable compensation" for purposes of Schedule C. The Association recommends that the Department make clear that float need not be reported on Schedule C.

For administrators of large numbers of plans, the tracking and calculation (even the estimation) of float would be very complicated. The Department became aware of this complexity and the enormous costs that would be associated with tracking and allocating float when it developed its guidance on float disclosure in Field Assistance Bulletin 2002-03. In that Bulletin, the Department considered whether and when a plan service provider could retain "float" or other earnings on plan assets without being deemed to exercise fiduciary discretion, and it focused on the information that the provider would have to provide to the plan fiduciary regarding the float so that it, and not the provider, would be deemed to approve it. The Department spent considerable time reviewing the nature and extent of the float-related disclosure necessary to obtain the plan fiduciary's consent to the provider's retention of the float as compensation. Significantly, the Department did not require that the service provider calculate and disclose the precise amount of the float it retained on an annual basis; instead, disclosure of the rate of the float and the circumstances giving rise to it were deemed sufficient.

In the proposal regarding Schedule C reporting, where the stakes are arguably much lower (*i.e.*, satisfying a reporting requirement versus avoiding fiduciary status and self-dealing), the Department appears to be requiring much more precise and costly tracking and reporting of float by plan on an annual basis. Four years ago, the Department made a policy decision regarding the extent to which float compensation should be disclosed, and providers have modified contracts and implemented new disclosure procedures to comply with the procedures described in FAB 2002-03. The procedures described in the FAB represent a reasonable balance between the significant costs of tracking and allocating float and the need to provide to fiduciaries sufficient information about provider compensation. The Department should not revisit that judgment as part of a Form 5500 revision.

The costs of building and operating systems to track and allocate float earnings will in many cases far exceed the actual float earnings attributable to each plan, encouraging providers to leave plan cash uninvested, forego the float and seek the required compensation through direct fees. This would surely not be in the interests of plans. If Schedule C reporting on float is to be required at all, we suggest that the plan administrator simply describe the circumstances under which float is earned, *e.g.*, interest on contribution/distribution accounts.

### E. Eliminate or revise the requirement for administrators to report service providers to the Department

Part II, Line 2 of the proposed Schedule C requires that administrators report each service provider who "failed or refused" to provide any of the information required to complete Schedule C. The Association recommends that this provision be eliminated. This provision will needlessly create tension between ERISA plan fiduciaries and service providers. Unlike

insurance companies and the Schedule A, ERISA imposes no statutory duty on service providers to supply administrators with Schedule C information. Such rights can be obtained by ERISA plans in their contracting with providers. Moreover, there will be many circumstances where reporting requirements under the Schedule C are ambiguous and there are good faith disagreements between ERISA plans and service providers. Such good faith disputes should not trigger a reporting obligation on administrators or disharmony between ERISA plans and service providers.

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We appreciate the opportunity to provide these comments and would welcome the opportunity to meet with you to discuss them. Questions on this issue may be directed to my office at 202.626.8651 or by e-mail at Jane.Galvin@bcbsa.com.

Thank you.

Sincerely,

Jane Galvin

Jane Galvin
Director, Regulatory Affairs