THE COUNCIL
of INSURANCE
AGENTS & BROKERS
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February 11, 2008

Via Email

Employee Benefits Security Administration
Attn: 408(b)(2) Amendment
Room N-5655
U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

Re: Comments of The Council on Insurance Agents and Brokers to the Department's proposed regulations on "Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure," 72 Fed. Reg. 70987 (Dec. 13, 2007)

Dear Sir/Madam:

The Council of Employee Benefits Executives, a standing committee of The Council of Insurance Agents & Brokers (collectively "The Council"), appreciates the opportunity to comment on the Department's recently proposed regulations on "Reasonable Contract or Arrangement Under Section 408(b)(2)—Fee Disclosure." The Council's comments follow below.

The Council represents the nation's leading insurance agencies and brokerage firms. Council members specialize in a wide range of insurance products and risk management services for business, industry, government, and the public. Operating both nationally and internationally, Council members conduct business in more than 3,000 locations, employ more than 120,000 people, and annually place more than 80 percent – well over $200 billion – of all U.S. insurance products and services protecting business, industry, government and the public at-large. Council members also place the majority of U.S. employee benefit insurance products and provide a range of insurance-related consulting and administrative services. Since 1913, The Council has worked to secure innovative solutions and create new market opportunities for its members at home and abroad.

The Council applauds the Department's efforts to provide guidance to fiduciaries in the hiring and monitoring of plan service providers. Our members support transparency in service provider relationships in a manner that will assist a plan fiduciary in making judgments on behalf of the plan. Having said that, we emphasize that our members are brokers of insurance products for welfare benefits, such as life, health, disability and long term care. We have studied the proposed regulation carefully and respectfully, we believe that it was written with a different set of service providers in mind. To our thinking, the regulation is focused on, and most appropriate to, 401k plans. Indeed, many of its requirements make sense for 401k plans. We are concerned, however, that it is not consistent with the way insurance products are sold to fund welfare plans. One distinction is that Council members often provide services to plan sponsors in their settlor capacities (e.g., assisting with plan design), rather than to the plans themselves or to plan beneficiaries. In such cases, it is not clear how the proposed

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regulation, which mandates that service providers provide certain disclosures in a written document, applies. We generally act as intermediaries to plans, providing quotes on a broad array of products. This "in-between" function does not readily lend itself to the proposed regulation.

When the regulation under section 408(b)(2) was originally promulgated, it was written so broadly that it could readily apply to any type of service provider to any type of plan. We fully understand the Department's interest in putting some specificity into the requirements but we urge the Department not to rush to cover all plans and all service providers under one regime. The adage that one can't fit a square peg into a round hole may hold true here. This is especially evident from the different penalty scheme for welfare plans, since they are specifically excepted from Code section 4975.We respectfully request that the Department reorient the proposed changes to apply to participant directed defined contribution arrangements, reserving sections for welfare plans and perhaps for other retirement arrangements.

We believe that a more measured approach will allow the Department to fine tune the requirements to the type of plan at issue. For example, insurance brokers and carriers are heavily regulated under state law. In addition, most carriers contractually require significant disclosure.[1] Their

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[1] As an example:

> The Broker or Consultant agrees to *explicitly and fully disclose in writing to policyholders* or *potential policyholders at the time of sale* of the policy and on each subsequent renewal date of the policy:
>
> a) The *amount of Platinum Compensation the Broker or Consultant anticipates receiving or has actually received* under this Addendum related to the specific policy; and
>
> b) That the Platinum Compensation is not part of the regular commissions related to the policy; and
>
> c) That the Platinum Compensation is not dependent on the Broker or Consultant selling a particular policy on behalf of _____ ; [and]
>
> d) The nature of any other material business relationship the Broker or Consultant has with _____, including without limitation any consulting agreements or managing agency functions or that the Broker or Consultant represents the Company as well as the policyholder.

Still another example:

> Producer agrees to *disclose in writing to each existing or prospective Group Customer prior to the renewal or sale to such existing or prospective Group Customer any compensation Producer may be eligible to receive from the Company in connection with the placement or servicing of the Group Customer's business*, including, if possible, *a reasonable estimate of the amount of such compensation or the basis upon which it will be determined*, as well as the nature of any material business relationship that producer has with the Company. Producer will provide to Group Customers any additional disclosure and obtain any acknowledgement required under applicable state or federal law, including ERISA. *Upon request by Company, Producer will provide*

selling activity, and their required disclosures, are the subject of substantial existing regulation. In addition, unlike other service providers, the Form 5500 Schedule A disclosure is already comprehensive and robust.[2] We believe that the Department's mission will not be thwarted or even slowed in the

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Company with a copy of such disclosure, any acknowledgement by Group Customer as well as any confirmation of disclosure to Group Customers as may be required by Company as a condition of payment of any compensation....Producer shall also respond promptly to any request by a Group Customer for information regarding compensation paid to Producer or for which Producer may be eligible. If Producer fails to make the disclosure required by this Agreement, any disclosure required by law or obtain any acknowledgment required by law, in addition to any other available remedies, *Producer shall not be entitled to compensation that was not disclosed and/or if required, acknowledged by Group Customer.*

[2] Departmental guidance provides as follows:

> As indicated above, commissions and fees required to be reported on Schedule A include all commissions and fees directly or indirectly attributable to a contract or policy between a plan and an insurance company, insurance service, or similar organization. This includes commissions and fees paid by an insurance company where the broker's, agent's, or other person's eligibility for the payment or the amount of the payment is based, in whole or in part, on the value (e.g., policy amounts, premiums) of contracts or policies (or classes thereof) placed with or retained by an ERISA plan, including, for example, persistency and profitability bonuses. In that regard, it would not be a permissible reading of the Schedule A instructions to conclude that payments to a broker or agent are required to be reported only when they would be considered a "sales commission" on an individual policy or contract. *See* Advisory Opinion 86-17A. Further, non-monetary forms of compensation, such as prizes, trips, cruises, gifts or gift certificates, club memberships, vehicle leases, and stock awards, must be reported if the entitlement to or the amount of the compensation was based, in whole or in part, on policies or contracts placed with or retained by ERISA plans. Separate fee and commission information is required for the Schedule A, even if premiums for the contract or policy are paid from the general assets of the employer or the policy is held in the name of the employer sponsoring the plan. The fact that a broker or agent signs on behalf of an insurance company would not be a basis for failing to report fees and commissions attributable to the contract or policy on a Schedule A. Nor would the fact that fees and commissions are paid from a separate bonus fund, and not directly from the insurance company's general assets, provide a basis for not reporting the fees and commissions. Similarly, classifying fees or commissions attributable to a contract or policy as "profit-sharing" payments, delayed compensation, or as "reimbursements" for various marketing or other expenses would not justify a failure to disclose such amounts. Finder's fees and other similar payments made by a third party to brokers, agents, and others in connection with an insurance policy would be

welfare area if these proposed regulations reserve the section on welfare plan service providers, in large part because the Department has already addressed these issues in the Schedule A and in recent advisory opinions.[3] Because of the vaguaries of insurance broker compensation, we think the Department correctly focuses on full disclosure after the compensation has been determined.

If the Department concludes that its current organization of the regulation continues to make sense, we urge the Department to consider the following comments.

A. Existing Prohibited Transaction Exemptions

Section 408(b)(2) is one of several exemptions that provide relief for services. In the 34 years of ERISA's history, the Congress and the Department have promulgated a number of other exemptions that cover the provision of services, including, e.g., 408(b)(6), Section 408(b)(14), PTCE 75-1, PTCE 84-14, PTCE 84-24, PTCE 86-128, PTCE 90-1, PTCE 91-38, PTCE 95-60, and PTCE 96-23. Of particular importance to the insurance industry is PTCE 84-24, which permits insurance brokers and agents to place insurance products with plans when they are fiduciaries or affiliated with fiduciaries to the plans. Each of these exemptions has its own unique, carefully crafted conditions intended to protect the plans involved and appropriate for the industry covered by the exemption. In certain cases, the Congress and the Department decided not to condition relief on significant and burdensome disclosures, or to require only limited disclosures, because other conditions (e.g., relating to the sophistication of the fiduciaries directing the transactions or internal policies and procedures) were determined to be sufficient to protect plans. These class exemptions are, in our view, part of the Department's long held philosophy that one size does not fit all. We urge the Department not to abandon this approach, but instead to allow the industry/product tailored exemptions to survive unaltered. In particular, we think PTE 84-24, with the disclosure it requires, coupled with the Form 5500 disclosure for the same industry, creates a tandem structure of disclosure that has worked well for the last 30 years.

We respectfully suggest that these conditions remain sufficient to protect plans and ask the Department to confirm that the final regulation under Section 408(b)(2) will in no way supersede or amend the conditions of these prior exemptions, PTCE 84-24 in particular.

If the Department is inclined to amend or supersede any other exemption through a regulation under Section 408(b)(2), we respectfully request that the Department consider each such exemption separately. The Congress and the Department took great care in crafting the protective conditions applicable to each exemption and they should not be discarded or expanded unless they have demonstrably failed to protect the plans.

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required to be disclosed by the insurer where the insurer reimburses the third party for the payment either separately or as a component of fees paid by the insurer to the third party.

[3] See, in this connection, DOL Adv. Opin 86-17A, DOL Adv. Opin. 2005-02.

B. Existing Regulation

The primary purpose of the regulation appears to be to protect plans from imprudent fiduciary decision making in the hiring and monitoring of service providers. We believe that ERISA already provides such protection. Section 404(a)(1)(B) requires a plan fiduciary to act prudently—i.e., consider all relevant facts—in hiring a service provider. If the fiduciary fails to do so and the plan is harmed, the fiduciary is liable to the plan for any damages under Section 409(a). Further, Section 406(a) currently prohibits service arrangements, except those that are reasonable – in terms of length, price, or need -- and any service provider violating this prohibition is liable to disgorge its fees under Section 503(a)(3). Where a fiduciary fails in his or her duty under Section 404(a)(1)(B), but the transaction is otherwise exempt under the current Section 408(b)(2) (i.e., the services and compensation are reasonable in fact), there is no harm to the plan. Where there is no harm to the plan, we respectfully suggest that it would be inappropriate to nevertheless render the service prohibited per se and penalize the service provider by forcing it disgorge its fees, providing a windfall to the plan.

For the foregoing reasons, we respectfully suggest that the Department consider issuing additional fee and disclosure guidance under Section 404(a)(1)(B), rather than changing the requirements of Section 408(b)(2) for all service providers.

Additionally, by mandating specific disclosures, the regulation creates a baseline of prudence for the engagement of service providers, depriving fiduciaries of their traditional discretion to expend limited resources only on information that is relevant and appropriate. This position is contrary to Section 404(a)(1)(B), which establishes prudence as a relative concept, driven by the facts and circumstances at hand. Therefore, to the extent the Department imposes any disclosure requirements, we respectfully suggest that the Department include an express savings clause that excuses a failure to disclose particular information if a prudent fiduciary would not have considered the information relevant under the circumstances.

Finally, the regulation requires that the disclosure be provided to the "responsible plan fiduciary". In the welfare benefits area, an agent or broker is generally talking to a human resources staff member or someone in the finance department of a company. The proposed regulation puts all of the burden of identifying the "responsible plan fiduciary"on the service provider, without requiring the entity contracting for the plan to identify itself as the responsible plan fiduciary. As our letter will point out, we think there are enormous pitfalls for the service provider in this proposed rule; we urge the Department to eliminate this one by requiring a fiduciary to identify itself as the responsible plan fiduciary for purposes of section 408(b)(2).

C. Duty of Loyalty for Non-Fiduciary Service Providers

Section 408(b)(2) of ERISA currently exempts the provision of services to plans if the services are appropriate, the compensation is reasonable, and the arrangement with the plan, written or not, is terminable upon reasonably short notice without penalty. The exemption does not condition relief on whether a plan fiduciary has satisfied his duty under Section 404(a)(1)(B) to prudently demand and

consider all information potentially relevant to a decision to hire a particular service provider or whether the service provider has voluntarily disclosed all such information, whether or not requested by the fiduciary. This structure makes sense: (i) Section 404(a) of ERISA imposes duties of prudence and loyalty on fiduciaries, not service providers;[4] (ii) Section 409(a) provides ample relief to a plan actually harmed by a fiduciary's imprudence; and (iii) Section 502(a)(3) provides ample relief to a plan where a service arrangement is unreasonably long, its cost is excessive, or it is unnecessary.

The proposed regulation appears to reinterpret Section 408(b)(2) as: (i) imposing a duty of loyalty on each service provider, which includes a continuing obligation to disclose a broad range of information that may or may not be relevant to a prudent fiduciary's decision to engage that particular service provider; and (ii) precluding exemptive relief for any failure to meet that duty of loyalty, without regard to the seriousness of the failure or whether the plan suffers any harm.

Imposing a duty of loyalty on service providers that do not meet the definition of fiduciary under ERISA is inconsistent with ERISA's basic structure. Section 404(a)(1)(A) imposes a duty of loyalty, but only on ERISA fiduciaries. Section 406(b) precludes self-dealing and conflicts of interest, but only by ERISA fiduciaries. ERISA does not impose similar duties on non-fiduciary service providers. "In a comprehensive regulatory scheme like ERISA, such omissions are significant ones." *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837 (1988) (refusing to extend ERISA preemption provision to welfare plans where it expressly encompassed only pension plans) (*citing Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985)). Indeed, the Supreme Court has consistently refused to expand the scope of ERISA's protections beyond its text. *See, e.g., Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262-63 (1993) (refusing to "attempt to adjust the balance between those competing goals that the text adopted by Congress has struck [by judicially expanding remedies for plan participants].").

Council members are not fiduciaries under ERISA in connection with the services they provide. The definition of fiduciary in section 3(21)(A) requires that a fiduciary either have discretionary authority or control over a plan's assets or management, or provide investment advice for a fee. Insurance brokers acting as intermediaries for welfare arrangements satisfy neither of those tests. Where they do not act as fiduciaries, they should have no ERISA duty of loyalty, even to the extent they may be deemed to be providing services to plans. Where they do act as fiduciaries in other contexts, their duty to disclose is already defined by PTCE 84-24.

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[4] Even service providers negotiating over fiduciary services have no duty of loyalty to the plan with respect to the engagement. *See* 29 C.F.R. § 2550.408b-2(e)(2) ("A fiduciary does not engage in an act described in section 406(b)(1) of the Act if the fiduciary does not use any of the authority, control or responsibility which makes such person a fiduciary to cause a plan to pay additional fees for a service furnished by such fiduciary or to pay a fee for a service furnished by a person in which such fiduciary has an interest which may affect the exercise of such fiduciary's best judgment as a fiduciary."); 29 C.F.R. § 2550.408b-2(f)(1) (applying foregoing principle).

Additionally, imposing a regulatory duty of loyalty on non-fiduciary agents and brokers, regardless of their function or arrangements with their clients, is unnecessary because the issue is already well-addressed at the state level. A federal regulatory duty of loyalty would be an unnecessary burden on agents and brokers, forcing them to comply with inconsistent federal and state requirements. The relationship between insurance agents/brokers and their clients is governed by a well-developed body of state agency law and, in some states, insurance statutory law. The extensive case law in this area makes clear that the scope of the obligations owed in this context is a factual matter based on the business relationships in each case. Specifically, the business relationship between an agent/broker and client is defined in the agreement between the parties and rooted in the specific services provided by the agent/broker. The relationship varies by client and, under widely accepted analyses of state laws, any duties the agent/broker owes to the client flow directly from that relationship.

The fact that an agent/broker is compensated by the insurance carrier in a transaction does not dictate the nature of the agent/broker-client relationship. It is but one element of that relationship. Carrier-paid compensation is the standard in the industry – and has historically been the standard in the industry. Thus, it is well-known and not dispositive.

For the foregoing additional reasons, we respectfully suggest that the Department focus on providing disclosure guidance under Section 404(a)(1)(B). It should not change the requirements of Section 408(b)(2).

D. Compensation & Fees

The proposal requires service providers to disclose all compensation to be received in connection with the provision of services to a client. As we said at the outset, Council members support transparency in service provider relationships, including in the area of compensation. As a practical matter, however, we are concerned about the language of the proposed rule because compliance for our members will be difficult and expensive and at best speculative, based on how carriers compensate brokers and agents.

Insurance brokers and agents generally receive compensation in a variety of forms. They may receive a commission from the carrier (the primary source), a fee from the client, or both. They may receive contingent payments from carriers when business originated by the broker/agent passes certain thresholds (e.g., relating to premium income levels and client retention). They may receive discretionary travel or other gifts from carriers as additional reward for their placement activities. [5]

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[5] Under most state laws, these forms of compensation are fully disclosed. Sample disclosure reads as follows:

> Our principal remuneration for the placement and service of your insurance policy(ies) will be by commission (a proportion of the premium paid that is allowed to us by the insurance company(ies)) and/or a mutually agreed fee.
>
> You should be aware that we may receive additional income from the following sources:

Although the **forms** of compensation are generally known at the outset of the agent/broker–client relationship, the amount of compensation an agent/broker receives from the placement of benefits coverage is generally unknown until well after the placement itself.[6] There are a few reasons for this. First, benefits programs vary in terms of carriers, products and price. A single plan could offer multiple products from multiple insurers in several categories of coverage (medical, dental, life, long term care,

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- **Interest or Investment Income** earned on insurance premiums,

- **Expense Allowances or Reimbursements** from insurance companies and other vendors for (a) educational and professional development programs; (b) managing and administering certain binding authorities and other similar facilities, including claims which may arise, and (c) attendance at insurance company meetings and events; all of which we believe enable us to provide more efficient service and competitive terms to those clients for whom we consider the use of such facilities appropriate.

- **Contingent Commission** (sometimes referred to as "profit sharing") which can be based on profitability, premium volume and/or growth. If any part of your account is on a fee basis, we will not accept contingent commissions related to your account.

  If you have questions or desire additional information about remuneration and other income, please contact your Agent who will put you in touch with our Senior Insurance Compliance Officer for assistance. If any part of your insurance program is placed through any sister companies disclosure of that income will also be included.

[6] With each new client,unless it is a start up company, we inherit an existing benefit program funded through existing insurance contracts, almost always with several different carriers. At this stage, the plan fiduciary should already know the commission rates being paid to the incumbent broker; we, as the new broker, merely step into those same shoes and in almost every case are paid at the same rate. So there should be no need to provide at this stage a disclosure of information the fiduciary should already know. At most we should be asked to disclose whether supplemental (contingent) compensation is possible, and pledge to supplement the general disclosure with specific data points at such time as the supplemental compensation becomes fixed and determined. Contingent compensation cannot really even be estimated before it is paid because it is subject to so many factors, and difficult if not impossible to attribute a portion of contingent compensation to a particular client unless the carrier breaks out the contingent compensation in that manner.

etc.). The agent/broker commission will vary depending upon the premium of the particular policy. The amount of premium, in turn, will vary depending upon the take-up rates by plan participants (i.e., the extent to which participants choose a particular option on the insurance menu). Because we do not know in advance how these factors will play out, we believe it is more appropriate to provide general disclosure of the types of compensation that we may receive, and permit the Form 5500 to provide the detail.

Similarly, with respect to contingent compensation and gifts, the broker/agent does not know in advance whether he or she will earn such compensation or, if earned, what the amount will be. The precise factors underlying such compensation (e.g., carrier discretion, client retention, and premium income levels) are outside the broker/agent's control and/or knowledge. In any event, because contingent compensation and gifts/rewards are generally based on the overall relationship between a carrier and an agent/broker (or, more likely, the firm for which the agent/broker works), we do not see how the broker/agent will be able to identify precisely the extent to which such compensation arose from the purchase of coverage under any particular plan.

Thus, if, as the preamble suggests, we can use ranges, formulas and factors to describe potential compensation, rather than a specific dollar amount or an absolute formula, we believe that the regulations will be less difficult to comply with. Therefore, we respectfully request the Department's confirmation that, at the outset, only the fact of such compensation need be disclosed, not the amount.

Brokers and agents also employ a number of individuals and other companies to assist them in their business generally, without regard to the identity of any particular plan (e.g., for accounting, legal, public relations, and marketing services, as well as mailing, printing, phone services and the like). Given the Department's past statements on the issue, we assume that the Department does not consider such persons to be parties in interest to any plans to which a broker or agent provides services. *See, e.g.,* 40 Fed. Reg. 50842, 50843 (Oct. 31, 1975) ("It is the view of the Department that such clearing broker-dealers are not parties in interest with respect to plans solely by reason of providing [clearing] services, if such services are initiated by another broker-dealer unrelated to the clearing broker-dealer."). We respectfully request confirmation on this point.

Finally, we request confirmation that disclosure of "compensation and fees" need not include any otherwise permissible gifts or awards provided to the service provider by the plan fiduciary. The plan fiduciary will be well aware of any such gifts or awards; therefore, there would be no benefit to forcing service providers, under pain of losing exemptive relief for their services, to describe to plan fiduciaries their own gifts and awards.

E. Contractually Requiring Disclosures

Respectfully, we submit that relief under Section 408(b)(2) should not be denied merely because an arrangement fails to contractually require the specified disclosures, provided that the specified disclosures are, in fact, made. Where such disclosures are made, there will be no harm to the plan and no need to penalize its service providers.

Further, we respectfully submit that the regulation expressly limit the required disclosures to information within a service provider's actual knowledge. If a plan fiduciary needs information outside the provider's actual knowledge, the fiduciary may either secure the information at the plan's expense or ask the service provider to absorb the cost as a matter of contract. Requiring the service provider to absorb the cost as a matter of law would afford the plan no additional protection; it would simply, and, we believe, unfairly, shift an economic burden onto the service provider without its consent.

We would also like the Department to confirm that a broker or agent can rely on the carrier's disclosure and incorporate it by reference (without having to paraphrase it or recreate it) at an obviously increase cost and burden. Moreover, if that disclosure is incomplete or in error, and the broker or agent has no reasonable basis to know that fact, the final rule should provide that the service provider will not lose the benefit of the exemption.

F. Method of Disclosure

We respectfully request the Department's confirmation that any disclosures required under the regulation may be separately made, in whole or part (e.g., disclosures need not be included in, attached to, or cross-referenced in the service agreement or, if previously provided, provided anew). Also, we respectfully request the Department's confirmation that such disclosures may be provided either in hard or electronic form, including, without limitation, on a website accessible by the plan fiduciary.

The proposed regulation clearly indicates that the arrangement need not be signed by both parties, nor must there be a formal contract with the service provider. We strongly believe that this is the right approach. In certain circumstances, applicable state law may deem a particular written arrangement to be a binding contract without signatures. With respect to subsequent disclosures, we propose that the Department allow for verbal notice within the 30 day period, with written confirmation within a reasonable time thereafter. This will afford service providers greater flexibility and minimize the risk of a technical failure of the exemption without sacrificing the benefit of prompt notice to the plans.

We also urge the Department is provide for a grandfather rule for contracts already in existence. Until those contracts are materially modified, they should not be required to be revised, especially in the extraordinarily short time period provided by the proposed rule. See our comments regarding the effective date of the rule, below.

G. Fiduciary Status

We would appreciate the Department's reconsideration of the need to disclose fiduciary status. Fiduciary status is a legal issue, and whether a service provider is a fiduciary is not always clear. Where a plan hires a service provider as a fiduciary (e.g., to manage the assets of a pension plan), the contracts generally state that the service provider acknowledges that it is a fiduciary. But in most consulting arrangements, the consultants do not intend to act as a fiduciary, and would perhaps not agree to provide the services if the plan sponsor required that they were obligated to admit to fiduciary status, regardless of whether, under the law, their conduct constituted fiduciary conduct.

ERISA provides that a person is a fiduciary "to the extent that" he has the requisite authority or control or provides the requisite level of advice with the mutual understanding that it will be a primary basis on which the plan fiduciary acts. We assume that if the parties agreed that the service provider would not act as a fiduciary, but the service provider later took discretionary control, the Department would not deem the parties initial understanding as determinative of whether the service provider had become a fiduciary. Accordingly, requiring such a statement in the written arrangement will only complicate the documentation of the arrangement, with no future benefit to the plan. We have seen these types of disputes in the documentation take months to work out, delaying the engagement of the services that the plan fiduciary believed were appropriate and necessary. Indeed, it is a common litigation tactic to allege that ordinary plan service providers are fiduciaries in order to impose ERISA's fiduciary responsibility regime and access ERISA's remedial provisions. This provision, in our view, needs to be reconsidered. If the parties agree that a service provider is not a fiduciary, but subsequently, the service provider's conduct is that of a fiduciary, has the failure to correctly disclose his conduct made section 408(b)(2) unavailable for all the services, and if so, what is the consequence of that failure?

Additionally, we would appreciate clarification of the Department's reference to Advisers Act fiduciaries in defining the scope of the regulation. ERISA contains its own definition of fiduciary, and for purposes of ERISA fiduciary regulation, we believe that definition should govern. Further, we are concerned that importing the Advisers Act definition of fiduciary in the context of pooled funds may inadvertently supersede (and confuse future application of) the plan assets rules in Section 3(42) of ERISA, Section 401(b) of ERISA, and 29 C.F.R. § 2510.3-101. We think the reference to the Advisers Act is ill-advised, but more importantly, it underscores the fact that the Department's focus is on retirement plans and not welfare plans, and any regulations regarding welfare plans should be developed and considered on their own.

H. Scope of Disclosure and Conflict Disclosure

The conflict of interest disclosures required by the regulation are extremely broad. It is doubtful that any service provider could accurately identify all potential financial, relationship, or other interests targeted by the regulation, notwithstanding the severe penalty for failing to do so. Thus, we respectfully submit that disclosure should at least be limited to those items a prudent fiduciary would require under the circumstances in accordance with Section 404(a)(1)(B) of ERISA. Further, we submit that the failure to provide such disclosure should result in a prohibited transaction, only if the plan is harmed (i.e., the arrangement is unreasonable, in terms of duration, cost, or need). We respectfully request that the Department confirm that an inadvertent omission would not constitute a prohibited transaction. If the plan is not harmed, there is no need to penalize the service provider and provide a windfall to the plan. We believe a new subparagraph should make clear that in the event of an inadvertent failure to disclose a nonsignificant service, prompt correction of that disclosure failure is adequate to ensure that the exemption will continue to apply.

The proposed rule provides that a contract or arrangement must require that the service provider disclose specific information regarding conflicts of interest for the service provider in its performance of

services for the plan. Service providers generally will have to disclose any financial or other interest in transactions in which the plan will participate; describe material financial, referral, or other relationship it has with various parties that creates or may create a conflict of interest for the service provider pursuant to the contract or arrangement and identify whether a service provider can affect its own compensation from whatever source without prior approval of an independent plan fiduciary. The proposed rule is very broad and may act as a trap for the unwary, especially in the context of large institutions. We are certain that the Department did not mean to suggest that each potential conflict be specified, regardless of whether that conflict has anything to do with the services being performed. We think a series of examples would be helpful. For example, an agent or broker would disclose that he provides quotes from many carriers, and not all carriers have the same compensation structure, and the service provider may do more business with one carrier or another which could inure to his overall benefit in terms of incentive compensation. We seek confirmation that such disclosure would be adequate and would not need to add potentially irrelevant disclosure regarding the financial institution as a whole. We urge the Department to provide examples in the final regulation, as it does frequently when publishing class exemptions and as it did when the original section 408(b)(2) regulations were published.

I. Comment Period

The Council respectfully requests an additional 60 days to supplement these comments. The initial 60 day comment period does not provide enough time for us to accurately estimate compliance costs, an important consideration in determining the scope and other characteristics of the final regulation. The economic analysis supporting the paperwork burden of the regulation fails to consider a number of cost items that we believe to be important, all of which will take additional time to consider, including outside counsel time, time for reviewing and commenting on the proposed regulation, time for monitoring and updating disclosures.

J. Effective Date

The Department proposes that its amendments be effective 90 days after publication of the final regulation in the Federal Register. Unfortunately, 90 days will not afford service providers enough time to address the new requirements imposed by the regulation, including, e.g., identifying the items to be disclosed, developing disclosures, disseminating disclosures, and developing and implementing monitoring systems. Given the significant amount of time we have already spent analyzing and commenting on the proposed regulation, and given the large number of questions and comments we have, we believe it will consume hundreds of hours for each service provider to determine compliance and rewrite disclosures, and at least five additional hours per plan for documenting those arrangements. If the final regulation requires amendments to existing arrangements, this compliance burden will increase significantly, as providers struggle to locate all existing documentation, contact clients, and negotiate and then implement changes. The compliance burden will increase further if the final regulation requires providers to have actual written contracts with plans (as opposed to simply making the required disclosures). This is particularly true in our industry, where it can be difficult to secure the time and attention of clients until policy renewal time.

For these reasons, we respectfully propose that the regulation not take effect for new arrangements until one year after the final version is published in the Federal Register and that existing arrangements be grandfathered (i.e., protected under the prior interpretation of Section 408(b)(2) until the particular insurance program is materially amended or modified).

Thank you for your consideration of the views of The Council.

Sincerely,

Ken A. Crerar

President