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Department of Labor Hearing on the Definition of Fiduciary Proposed Regulation

Testimony on behalf of

America's Health Insurance Plans and

Blue Cross Blue Shield Association

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My name is Jon Breyfogle. I am an attorney specializing in ERISA and health care law, and a Principal of the Groom Law Group, Chartered, here in Washington, DC. I am testifying here today on behalf of America's Health Insurance Plans (AHIP) and Blue Cross Blue Shield Association (BCBSA). Thank you for providing us the opportunity to testify at this hearing and we look forward to working with the Department to clarify and hopefully narrow the potential impact the fiduciary proposal may have on issuers of insurance policies to ERISA-covered group health and welfare plans. As you know, both AHIP and BCBSA have filed detailed comments on the Department's proposal and this testimony represents a high level summary of those comments.

AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. AHIP's member health insurance plans offer a broad range of health insurance products in the commercial marketplace, as well

other insurance coverage to employee welfare benefit plans, including disability, long-term care, supplemental, and life insurance coverage.

BCBSA is made up of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for nearly 106 million – one-in-three – Americans. BCBS Plans offer coverage in every market and every ZIP code in America.

In addition to commercial insurance, AHIP members and BCBS Plans also partner with the federal government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

Over the past 5 years, the health insurance industry has worked diligently to implement the Affordable Care Act (ACA). AHIP, BCBSA and their member health companies continue to devote significant resources to ACA implementation and ensuring that the interests of consumers are met in the today's rapidly evolving marketplace

It is clear that the Department's goal in proposing modifications to the existing definition of fiduciary is to protect those who receive retirement investment advice from potential conflicts of interest. The Department's regulatory proposal is at least in part motivated by a desire to update regulations to address the role that financial advisers may play in a retirement plan marketplace where individuals make investment decisions in participant directed plans, and where substantial assets are held in IRAs as a result of rollovers from retirement plans. Ensuring access to quality and unbiased investment information by ERISA plan fiduciaries and plan participants in this changed landscape is an important objective.

However, AHIP and BCBSA are concerned that the definition of fiduciary in the proposed rule, if finalized in its proposed form, will have unintended and significant consequences for issuers and providers of insurance coverage to ERISA covered health and welfare plans. Unless addressed in final rulemaking, the result could be to significantly limit the valuable information and services available to employers that purchase health insurance coverage for group health plans, as well as their employees. Insurers, as well as agents, brokers and consultants, should be encouraged to offer more, rather than less information to group purchasers related to available health insurance options. We hope that the potential impact on health care plans, and other insured welfare plans, was not intended in this rule making, at least in part because the Department's proposal, including its preamble and economic analysis, speaks only to retirement plans and IRAs and is generally silent on health and welfare plans.

We have a number of recommendations to address this uncertainty in your final rulemaking process:

I. Carve-out for insured health and welfare plans

Insured employee group health and welfare plans are significantly different from employee pension plans in structure and purpose, and in the allocation of risks between the employer and employee. The goal of a retirement plan is to provide participants and beneficiaries with accumulated assets for their retirement needs. In today's workplace, employees are much more likely to be responsible for their retirement savings either by participating in their employer's defined contribution plan or an IRA. Retirement benefits are generally a function of the employee's own contributions, as well as employer contributions, and the investment returns on those amounts. Generally, amounts accumulate over many years and it

is possible that relatively small differences in returns year over year can affect the individual's retirement benefit. Ultimately, for defined contribution plans and IRAs, participants bear the risk that retirement savings could fall short of their retirement needs, either because of insufficient contributions or investment results.

Insured health and welfare plan benefits are substantially different. Participants in insured group health and welfare plans do not bear risk in the same way as their counterparts in retirement plans or IRA holders. Instead, health benefits are fixed in advance of the plan year and reimbursed according to the terms of the insurance contract. For fully insured plans, the premiums are set in advance of the plan year and funded by a fixed periodic premium payment (often comprised of a mix of employer and employee contributions). The insurer bears the risk that premiums will be sufficient to pay claims for any particular plan. We note that the same is true for self-insured health and welfare plans – participant benefits are fixed and defined in advance. The difference is that the self-funded plan sponsor bears the risk of adverse claims experience rather than the insurance company.

Because of the very different role that insurance plays for health and welfare plans, under an ordinary understanding of the term "investment advice" it would seem that advice to plan sponsors and plan participants concerning health insurance contracts would not be subject to the Department's proposals. However, we are concerned that absent a clear carve-out for health and welfare plans, that assumption could prove incorrect, particularly as the definition is interpreted by the courts. Our concern is rooted in the broad definition proposed by the Department. In short, "fiduciary advice" would include any "recommendation" as to "the advisability of acquiring, holding, disposing or exchanging securities *or other property*", if it is provided under an arrangement, understanding or agreement that it is *individualized* or *specifically directed to*

the recipient. A recommendation is broadly defined as a communication that would reasonably be considered a *suggestion* of a course of action for the plan fiduciary or plan participant. Under this expansive definition, AHIP and BCBSA believe that any advice or recommendation related to an insurance contract that is used to fund a welfare benefit plan could trigger fiduciary status because insurance contracts constitute property.

Agents, brokers, and consultants will of course be impacted most directly by this proposed rule. These parties provide a variety of information and advice to plan sponsors, many of them small employers shopping for coverage, including information about the relative financial strength of insurers, differences between various insurance coverages, explanations of key features under competing policies, and pricing. These parties also offer invaluable expertise to an employer that helps the employer match an appropriate policy to its employee population, in many cases based on the unique needs of the employer's group. If these activities give rise to fiduciary status under the Department's regulation, then the payment of ordinary commissions could cause a prohibited transaction, unless an exception or prohibited transaction exemption is available. Alternatively, agents, brokers, and consultants could restrict the information and advice they provide in order to avoid fiduciary status. As a result, subjecting these ordinary consulting and sales activities to fiduciary standards would either introduce needless complexities and expense to the process of marketing and distributing insurance products to employer plans, or it would cause employers to lose access to valuable educational and other benefit and costs information about available insurance contracts.

Please note that there are special burdens and risks for the many BCBS Plans and other health insurers that employ their own sales force of licensed insurance agents who are only

permitted to sell the insurance offerings of their own BCBS Plans or insurer. It is unclear how these agents would satisfy a fiduciary obligation to the plan sponsor in these circumstances. And the BCBS Plan or insurer itself could face fiduciary liability for the actions of its agents.

Now is a critical time for consumers of health insurance in particular given the dynamic changes in the marketplace. It is critical that information flow freely to consumers – both plan sponsors and plan participants – to ensure informed consumer choices. We are concerned that absent a broad carve-out, issuers of group health and welfare plan contracts could be directly affected even where they are not directly selling a particular policy. The provision of sales and marketing materials, as well as sales support activities, might constitute a "recommendation" under the Department's proposal. We are also concerned that information provided to plan sponsors or plan participants, whether via web-based tools, computer programs or otherwise, that may identify a particular insurance plan as appropriate for a plan participant could also trigger fiduciary status.

Due to the fundamental differences between pension and group health and welfare plans, we ask the Department carve out from the definition of investment advice any recommendations relating to welfare benefit plans as defined by section 3(1) of ERISA. This will ensure that there is no confusion regarding group health and welfare plans, regardless of whether they are insured or self-insured. In the absence of a broad carve-out for health and welfare plans, then we ask that the Department carve-out recommendations for the purchase, sale or holding of an insurance contract used to fund a welfare benefit plan. This exception should apply regardless of plan size and without other conditions.

II. HSAs and MSAs

AHIP and BCBSA are also concerned about the Department's proposal to include health care savings accounts (HSAs) and Archer Medical Savings Accounts (MSAs) in this rule-making. The proposed rule applies to investment advice provided to IRAs and IRA owners. The term "IRA" for purposes of the rule is defined to include HSAs and MSAs.

In our view, HSAs and MSAs are fundamentally different from IRAs and other retirement vehicles. HSAs and MSAs are tax-advantaged accounts that are used to fund cost sharing and other qualified expenses not covered by a medical plan. Unlike IRA or defined contribution plan savings vehicles, they are not designed to fund virtually any kind of expense that may arise many years "down the road" in retirement, but are limited to use for "medical expenses" as defined by section 213(d) of the Code. Based on data recently published by the Employee Benefits Research Institute (EBRI), the average HSA account balance as of the end of 2014 was less than $2000. Contrast this amount with the average year-end IRA balance in 2013 of nearly $100,000.

Although investment options are available for some HSAs, they are an optional feature and rarely used. According to the EBRI data, only about 6% of all HSAs had an associated investment account. Typically, most small balance HSAs and MSAs are held in bank deposit accounts that utilize a debit card or checks for the payment of medical expenses. Although these accounts do receive modest interest, the accounts are not intended as investments but are designed to preserve principal so that the assets will be undiminished and available to pay eligible medical expenses as they are incurred. These facts show that HSAs and MSAs are

designed and used as a source of ready funds for eligible current medical expenses and generally do not accumulate substantial savings from year to year.

Significantly, the Department recognized that HSAs should be generally exempt from ERISA when it issued Field Assistance Bulletins 2004-01 and 2006-02. Since this helpful guidance was issued by the Department, in our experience, all plan sponsors seek to comply with the conditions of these Field Bulletins to ensure that their HSA will not be subject to ERISA. Given that the vast majority of HSAs are not covered by ERISA, it does not make sense to subject HSAs to the detailed requirements and compliance protocols associated with the proposed rule. Additionally, given the similarities between MSAs and HSAs, Archer Medical Savings Accounts should be exempt as well.

Because HSAs and MSAs simply have very little in common with retirement plans or IRAs, we ask the Department to simply remove HSAs and MSAs from the definition of "IRA" under the final rule. We believe this treatment would be consistent with DOL's determination to essentially carve HSAs out of ERISA coverage through the 2004/2006 Field Assistance Bulletins. Alternatively, if a complete carve-out is not possible for these accounts, we ask the Department for an approach that accomplishes three goals – (1) any HSA or MSA holding less than $5,000 should be exempt from the final rule; (2) the Department should extend the platform carve-out to cover HSAs; and (3) the Department should expand the education carve-out to explicitly cover information provided to HSA/MSA holders regarding the benefits, features, and uses of the account.

Thank you for the opportunity to provide comments today. We hope this statement, coupled with the formal comment letters on the proposed rule submitted by AHIP and BCBSA, will lead the Department to finalize the proposed rule in such a way as to carve out group health and welfare plans and activities related to their interactions with group purchasers and consumers.