

**DEPARTMENT OF LABOR****Pension and Welfare Benefits  
Administration****29 CFR Part 2550****RIN 1210-AA58****Insurance Company General Accounts****AGENCY:** Pension and Welfare Benefits Administration, Labor.**ACTION:** Final rule.

**SUMMARY:** This document contains a final regulation which clarifies the application of the Employee Retirement Income Security Act of 1974 as amended (ERISA or the Act) to insurance company general accounts. Pursuant to section 1460 of the Small Business Job Protection Act of 1996, section 401 of ERISA was amended. Section 401 now provides that the Department of Labor (the Department) must issue regulations to: provide guidance for the purpose of determining, where an insurer issues one or more policies to or for the benefit of an employee benefit plan (and such policies are supported by assets of the insurer's general account), which assets held by the insurer (other than plan assets held in its separate accounts) constitute assets of the plan for purposes of Part 4 of Title I of ERISA and section 4975 of the Internal Revenue Code of 1986 (the Code), and provide guidance with respect to the application of Title I to the general account assets of insurers. This regulation affects participants and beneficiaries of employee benefit plans, plan fiduciaries and insurance company general accounts.

**DATES:** Effective Date: This rule is effective January 5, 2000.

*Applicability Dates: Except as provided below, section 2550.401c-1 is applicable on July 5, 2001. Section 2550.401c-1(c) [except for paragraph (c)(4)] and (d) are applicable on July 5, 2000. The first annual disclosure required under § 2550.401c-1(c)(4) shall be provided to each plan not later than 18 months following January 5, 2000. Section 2550.401c-1(f) is applicable on January 5, 2000.*

**FOR FURTHER INFORMATION CONTACT:**

Lyssa E. Hall or Wendy M. McColough, Office of Exemption Determinations, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N-5649, 200 Constitution Avenue, N.W., Washington, DC 20210, (202) 219-8194, or Timothy Hauser, Plan Benefits Security Division, Office of the Solicitor, (202) 219-8637. These are not toll-free numbers.

**SUPPLEMENTARY INFORMATION:** On December 22, 1997, the Department published a notice of proposed rulemaking in the **Federal Register** (62 FR 66908) which clarified the application of ERISA to insurance company general accounts. The Department invited interested persons to submit written comments or requests that a public hearing be held on the proposed regulation. The Department received more than 37 written comments in response to the proposed regulation. A public hearing, at which 13 speakers testified, was held on June 1, 1998 in Washington, D.C.

The following discussion summarizes the proposed regulation and the major issues raised by the commentators.<sup>1</sup> It also explains the Department's reasons for the modifications reflected in the final regulation that is published with this notice.

**Discussion of the Regulation and Comments**

Pursuant to section 1460 of the Small Business Job Protection Act of 1996 (SBJPA), Public Law 104-188, the proposed regulation amended 29 CFR Part 2550 by adding a new section, 2550.401c-1. This new section was divided into ten major parts. Paragraph (a) of the proposed regulation described the scope of the regulation and the general rule. Proposed paragraphs (b) through (f) contained conditions which must be met in order for the general rule to apply. Specifically, paragraph (b) addressed the requirement that an independent fiduciary expressly authorize the acquisition or purchase of a Transition Policy. Paragraph (c) described the disclosures that an insurer must make both prior to the issuance of a Transition Policy to a plan and on an annual basis. Paragraph (d) provided for additional disclosures regarding separate account contracts. Paragraph (e) contained the procedures that must apply to the termination or discontinuance of a Transition Policy by a policyholder. Paragraph (f) contained notice provisions regarding contract terminations and withdrawals in connection with insurer-initiated amendments. Proposed paragraph (g) set forth a prudence standard for the management of general account assets by insurers. The definitions of certain terms used in the proposed regulation were contained in paragraph (h). Proposed paragraph (i) described the effect of compliance with the regulation

and proposed paragraph (j) contained the effective dates of the regulation. For a more complete statement of the background and description of the proposed regulation, refer to the notice published on December 22, 1997 at 62 FR 66908.

*1. Scope and General Rule*

Proposed § 2550.401c-1(a) and (b) essentially followed the language of section 401(c) of ERISA. Paragraph (a) described, in cases where an insurer issues one or more policies to or for the benefit of an employee benefit plan (and such policies are supported by assets of an insurance company's general account), which assets held by the insurer (other than plan assets held in its separate accounts) constitute plan assets for purposes of Subtitle A, and Parts 1 and 4 of Subtitle B, of Title I of the Act and section 4975 of the Internal Revenue Code, and provided guidance with respect to the application of Title I and section 4975 of the Code to the general account assets of insurers.

Paragraph (a)(2) stated the general rule that when a plan acquires a policy issued by an insurer on or before December 31, 1998 (Transition Policy), which is supported by assets of the insurer's general account, the plan's assets include the policy, but do not include any of the underlying assets of the insurer's general account if the insurer satisfies the requirements of paragraphs (b) through (f) of the regulation.

One commentator stated that paragraph (a)(2) lacked clarity and did not properly cross-reference the definition of the term "Transition Policy." In response to this comment, the Department has clarified paragraph (a)(2) to provide that " \* \* \* when a plan acquires a Transition Policy (as defined in paragraph (h)(6)), the plan's assets include the policy, but do not include any of the underlying assets of the insurer's general account if the insurer satisfies the requirements of paragraphs (c) through (f) of this section."

Several commentators requested that the final regulation contain a total exclusion from the definition of "plan assets" for all assets held in or transferred from the estate of an insurance company in delinquency proceedings in which an impaired or insolvent insurer is placed under court supervision pursuant to State insurance laws governing rehabilitation or liquidation. One commentator explained that delinquency proceedings are initiated when the insurance regulator in the State where the insurer is domiciled files a petition in State

<sup>1</sup> References to "comments" and "commentators" include both written comment letters as well as prepared statements and oral testimony at the public hearing.

court requesting a takeover of the insurer's operations from existing management. Such a petition is predicated on the regulator's conclusion that continued operation of the insurer by management would be hazardous to policyholders, creditors or the public. The precipitating event is usually the insolvent condition of the insurer. Upon the granting of the petition, a new legal entity called the estate is created. The court gives control over the estate to a receiver who is charged under State law with the fiduciary duty to fairly represent the interests of all policyholders, creditors and shareholders of the insolvent insurer. To stabilize the situation, the court is almost always compelled to order a moratorium or other restrictions on cash withdrawals, subject to individual hardship exceptions. All activity in the proceedings is carried out under the close supervision of the court.

In consideration of the concerns expressed by commentators, the Department has adopted a new paragraph (a)(3) which specifically provides that a plan's assets will not include any of the underlying assets of the insurer's general account if the insurer fails to satisfy the requirements of paragraphs (c) through (f) of the regulation solely because of the takeover of the insurer's operations as a result of the granting of a petition filed in delinquency proceedings by the insurance regulatory authority in the State court where the insurer is domiciled.

## 2. Authorization by an Independent Fiduciary

Proposed paragraph (b)(1) stated the general requirement that an independent fiduciary "who has the authority to manage and control the assets of the plan must expressly authorize the acquisition or purchase of the Transition Policy." A fiduciary is not independent if the fiduciary is an affiliate of the insurer issuing the policy. Paragraph (b)(2) of the proposed regulation contained an exception to the requirement of independent plan fiduciary authorization if the insurer is the employer maintaining the plan, or a party in interest which is wholly-owned by the employer maintaining the plan, and the requirements of section 408(b)(5) of ERISA are met.<sup>2</sup>

<sup>2</sup> This exception for in-house plans of the insurer under section 401(c)(3) of ERISA is similar to the statutory exemption contained in section 408(b)(5) of ERISA which provides relief from the prohibitions of section 406 for purchases of life insurance, health insurance or annuities from an insurer if the plan pays no more than adequate

The Department notes that, because section 401(c)(1)(D) of the Act and the definition of Transition Policy preclude the issuance of any additional Transition Policies after the publication of the final regulation, the requirement for independent fiduciary authorization of the acquisition or purchase of the Transition Policy no longer has any application. Accordingly, the Department generally has determined not to respond to the comments which raised issues regarding this requirement. However, the Department has determined to respond to the comments concerning the definition of "affiliate" contained in paragraph (h)(1) of the proposed regulation because of its potential relevance to other conditions under the final regulation.

One commentator suggested that the definition of "affiliate" contained in paragraph (h)(1) of the proposed regulation should be expanded to include: (1) 10% or more shareholders or equity holders of insurers and of persons controlling, controlled by, or under common control with insurers; (2) businesses in which a person described in proposed subparagraph (h)(1)(ii) is a 10% or more shareholder or equity holder; and (3) relatives of persons who are officers, directors, partners or employees of the insurer. Other commentators requested that the definition of affiliate be narrowed. A commentator noted that the proposed definition of affiliate would include all insurance agents and brokers of the insurer, even non-exclusive agents, as well as all employees of the insurer and of all entities in which an employee of the insurer is an officer, director, partner or employee. The commentator noted that the proposed definition would force the insurer to assume a difficult monitoring function with respect to its employees, agents and brokers. As a result, this commentator argued that the definition of affiliate in the proposed regulation need not be broader than the affiliate definition contained in Prohibited Transaction Class Exemption 84-14 (the QPAM Exemption).<sup>3</sup> Additionally, according to this commentator, it was unclear under the definition of affiliate whether a "partner of" an insurer is intended to mean a partner in the insurer or a partner with the insurer.

After consideration of the comments, the Department has determined that it would be appropriate to narrow the

consideration and if the insurer is the employer maintaining the plan.

<sup>3</sup> Class Exemption for Plan Asset Transaction Determined by Independent Qualified Professional Asset Managers (QPAMs), 49 FR 9494 (March 13, 1984) as corrected at 50 FR. 41430 (Oct. 10, 1985).

category of persons included under the affiliate definition and to clarify certain of the terms used in the definition. Accordingly, the Department has modified subparagraph (h)(1)(ii) to provide that an affiliate of an insurer includes any officer of, director of, 5 percent or more partner in, or highly compensated employee (earning 5 percent or more of the yearly wages of the insurer) of, such insurer or any person described in subparagraph (h)(1)(i) including in the case of an insurer, an insurance agent or broker (whether or not such person is a common law employee) if such agent or broker is an employee described above or if the gross income received by such agent or broker from such insurer or any person described in subparagraph (h)(1)(i) exceeds 5 percent of such agent's gross income from all sources for the year. In addition, under subparagraph (h)(1)(iii), the Department has determined to delete those corporations, partnerships, or unincorporated enterprises of which a person described in subparagraph (h)(1)(ii) is an employee or less than 5 percent partner.

## 3. Duty of Disclosure

Section 401(c)(3)(B) of the Act provides that the regulations prescribed by the Secretary "shall require in connection with any policy issued by an insurer to or for the benefit of an employee benefit plan to the extent the policy is not a guaranteed benefit policy \* \* \* (B) that the insurer describe (in such form and manner as shall be prescribed in such regulations), in annual reports and in policies issued to the policyholder after the date on which such regulations are issued in final form \* \* \*, (i) a description of the method by which any income and expenses of the insurer's general account are allocated to the policy during the term of the policy and upon termination of the policy, and (ii) for each report, the actual return to the plan under the policy and such other financial information as the Secretary may deem appropriate for the period covered by each such annual report."

Proposed paragraph (c)(1) of the regulation similarly imposed a duty on the insurer to disclose specific information to plan fiduciaries prior to the issuance of a Transition Policy and at least annually for as long as the policy is outstanding. Paragraph (c)(2) required that the disclosures be clear and concise and written in a manner calculated to be understood by a plan fiduciary.

Although the Department did not mandate a specific format for the

disclosures, the information should be presented in a manner which facilitates the fiduciary's understanding of the operation of the policy. The Department expected that, following disclosure of the required information and any other information requested by the fiduciary pursuant to proposed paragraph (c)(4)(xii), the plan fiduciary, with independent professional assistance, if necessary, would be able to ascertain how various values or amounts relevant to the plan's policy such as the actual return to be credited to any accumulation fund under the policy, would be determined.

Many of the commentators expressed a number of general objections to the disclosure provisions. These commentators stated that the level of disclosure required by the proposed regulation exceeded Congressional intent and the requirements of section 401(c) of ERISA. They also asserted that the disclosure provisions were too broad and vague to provide an insurer who is attempting to comply with the regulation any level of comfort. Moreover, the commentators maintained that other financial service providers are not required to provide the same level of disclosure to their investors. The commentators further asserted that compliance by insurers with the regulation would result in increased costs for plans without adding anything of value. In this regard, many of the commentators expressed the belief that the disclosure provisions, as proposed, impose unnecessary financial and administrative burdens on plans and insurance companies. The commentators suggested that the information required to be disclosed goes well beyond that which is necessary for a plan fiduciary to determine whether or not to invest in or retain a Transition Policy. One commentator stated that disclosure should be limited to matters immediately connected to the contract and the contract's "bottom line". Finally, several commentators asserted that the proposed disclosure provisions require an insurer to disclose proprietary information but did not specifically identify which items would require the disclosure of such information as the Department requested in the preamble to the proposed regulation.

Other commentators expressed the opposite view and generally supported the proposed disclosure provisions, stating that the provisions would allow plan fiduciaries to get the basic information necessary to analyze a general account contract for investment purposes. More specifically, one

commentator offered the following concerns with respect to the level of disclosure currently provided in connection with insurance company general account contracts:

The insurance companies issuing the general account contracts have not provided sufficient information for fiduciaries to monitor contractual compliance. The insurance companies have not provided sufficient information to allow fiduciaries to validate that all contractholders are receiving equitable treatment within the general account. The insurance companies have not provided sufficient information for fiduciaries to calculate the rate of return on general account contracts comparable to the rate of return information they obtain for other plan investments.

Similarly, several commentators indicated that currently, plan fiduciaries often have a difficult time obtaining any meaningful information to assist them in making informed decisions concerning whether to purchase or retain a Transition Policy. In this regard, commentators also noted that the disclosures set forth in the proposed regulation are even more important for small plans, which do not normally have the economic leverage to negotiate any voluntary disclosure of information by the insurer. Another commentator expressed his belief that the proposed disclosure provisions are consistent with the intent of the Congressional Conferees.

Two commentators supported the disclosures mandated by the proposed regulation but asserted that those provisions did not go far enough. These commentators suggested that a clear and comprehensive standard form for disclosures should be issued to assist plan fiduciaries as well as small insurance companies seeking to comply with the regulation. One commentator suggested that the Department create sample written disclosures or issue a guide to writing disclosures in plain English. The commentator also stated that the regulation does not provide any penalties for an insurer's failure to comply with a policyholder's request for information. In this regard, the Department notes that paragraph (i) of the final regulation contains an explanation of the consequences of an insurer's failure to comply with the provisions of the regulation.

The Department has considered the comments regarding the scope and level of detail required by the proposed disclosure provisions in light of the Congressional mandate set forth in section 401(c)(3) of ERISA. The Department continues to believe that it was given broad discretion to require that insurers provide meaningful

disclosure of information regarding Transition Policies in order to enable plan fiduciaries to evaluate the suitability of such policies. The Department notes that, with respect to the annual report, section 401(c)(3)(B) of ERISA expressly directs the Department to require the disclosure of " \* \* \* such other financial information as the Secretary may deem appropriate for the period covered by such annual report." The Department believes that a plan fiduciary, at a minimum, must be provided with sufficient information about the methods used by the insurer to allocate amounts to a Transition Policy, and the actual amounts debited against, or credited to, the Transition Policy on an ongoing and on a termination basis in order to evaluate whether to invest in or to retain the Policy. In this regard, the Department notes that an insurance company general account, which necessarily operates under a complex allocation structure for fees, expenses and income, is unlike other investment vehicles. Thus, the Department believes that the information that an investor must be furnished in order to compare an investment in a general account contract to other available investment options must necessarily be more comprehensive. However, the Department recognizes that providing a plan fiduciary with the financial information needed to evaluate the suitability of a particular policy may place additional administrative costs and burdens on both insurers and plans. After careful consideration of all of the comments, the Department has concluded that modifications to the disclosure provisions are necessary in order to balance the costs of additional disclosures against the fiduciary's need for sufficient information to make informed investment decisions. Accordingly, the Department has determined, as discussed further below, to modify paragraph (c) of the disclosure provisions in the final regulation to more precisely define the scope of the information which must be furnished to the policyholder. In recognition of the variety of insurance arrangements available to plans, the Department has not been persuaded that it is necessary or feasible for plan fiduciaries to receive the information required to be disclosed to them pursuant to the regulation in a standard format. Therefore, the Department has not adopted the commentator's suggestion regarding developing a standard format or a guide for writing such disclosures. In addition, the Department has made minor modifications to the final

regulation to reflect the fact that the initial disclosures cannot be provided by an insurer prior to issuing a Transition Policy because no new Transition Policies can be issued after December 31, 1998.

Proposed paragraph (c)(3) set forth the content requirement for the information which must be provided to the plan either as part of the Transition Policy, or as a separate written document which accompanies the Transition Policy. For Transition Policies issued before the date which is 90 days after the date of publication of the final regulation, the proposed regulation required the insurer to provide the information identified in paragraph (c)(3)(i) through (iv) no later than 90 days after publication of the final regulation. For Transition Policies issued 90 days after the date of publication of the final regulation, the proposed regulation required the insurer to provide the information to a plan before the plan makes a binding commitment to acquire the policy.

Under paragraph (c)(3), an insurer must provide a description of the method by which any income and expenses of the insurer's general account are allocated to the policy during the term of the policy and upon its termination. The initial disclosure under this paragraph must include, among other things, a statement of the method used to determine ongoing fees and expenses that may be assessed against the policy or deducted from any accumulation fund under the policy. The term "accumulation fund" is defined in paragraph (h)(5) as the aggregate net considerations (*i.e.*, gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to the contract, less partial withdrawals and benefit payments and less charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

Under the proposed regulation, the insurer must also include, in its description of the method used to allocate income and expenses to the Transition Policy: an explanation of the method used to determine the return to be credited to any accumulation fund under the policy; a description of the policyholder's rights to transfer or withdraw all or a portion of any fund under the policy, or to apply such amounts to the purchase of benefits; and a statement of the precise method used to calculate the charges, fees or market value adjustments that may be imposed in connection with the policyholder's

right to withdraw or transfer amounts under any accumulation fund. Upon request, the insurer must provide the information necessary to independently calculate the exact dollar amounts of the charges, fees or market value adjustments.

A number of commentators objected to the provisions contained in subparagraphs (c)(2), (c)(3)(i)(D) and (c)(4) of the proposed regulation which, in their view, would require insurers to disclose or make available upon request by a plan fiduciary, information relating to the pricing of their products, internal cost calculations and/or methodologies sufficient to enable the fiduciary to independently calculate the insurer's adjustments. The commentators stated their belief that such information is proprietary. In this regard, the commentators argued that disclosure of very detailed pricing information would place insurance companies at a severe competitive disadvantage vis-a-vis other financial institutions that market products or services to employee benefit plans. Moreover, they stated that, while disclosure of fees and returns is common and appropriate, disclosure of the underpinnings of such fees and returns is neither common nor necessary. The commentators further asserted that plan fiduciaries do not need such information to make prudent investment decisions.

Two commentators requested that the Department eliminate the last two sentences of paragraph (c)(2) of the proposed regulation and all of paragraph (c)(3)(i)(D) other than the following: "A statement of the method used to calculate any charges, fees, credits or market value adjustments described in paragraph (i)(C) of this section." According to the commentators, these modifications would eliminate the requirement that an insurer provide all of the data necessary to enable a plan fiduciary to replicate the insurer's internal adjustments.

One commentator suggested that, because the method used to determine a market value adjustment involves several layers of internal general account calculations, the Department should provide more clarity with respect to how far back an insurer should "unpeel" the market value adjustment calculation to satisfy the disclosure requirements in subparagraph (c)(3)(i)(D). The commentator further urged the Department to eliminate the requirements in paragraphs (c)(2) and (c)(3)(i)(D) that the insurer disclose any data necessary to permit the fiduciary, with or without professional assistance, to independently calculate the exact

dollar amount of the charges, fees or adjustments. The commentator offered the following language in lieu of the deleted text in subparagraph (c)(3)(i)(D):

Upon request of the plan fiduciary, the insurer must provide as of a stated date: (1) The formula actually used to calculate the market value adjustment, if any, to be applied to the unallocated amount in the accumulation fund upon distribution to the policyholder; and (2) the actual calculation of the applicable market value adjustment, including a reasonably detailed description of the specific variables used in the calculation.

One commentator suggested that the final regulation establish a 30 day time limit for responding to a fiduciary's request for information from an insurer pursuant to subsection (c)(3)(i)(D). Other commentators expressed general support for the disclosure provisions but maintained that the Department should require that additional items of information be disclosed to policyholders. Specifically, one commentator requested that the initial disclosure provisions be expanded to require that insurers disclose the following additional information upon the request of a policyholder: Copies of reports relating to the financial condition of the insurer pursuant to subparagraphs (c)(3)(i)(A) and (B); amounts which have been offset, subtracted or deducted from the gross earnings of the general account before income is credited to a Transition Policy pursuant to subparagraph (c)(3)(i)(B); gross and net return and income prior to returns being credited to the Transition Policy; and, pursuant to subparagraph (3)(c)(i)(C), any alternative withdrawal options which might scale-back charges, fees or adjustments in exchange for a longer withdrawal term. Finally, the commentator suggested that a condition should be imposed which would require insurers to disclose the treatment of capital gains and losses, any establishment of reserves or contingency funds, or smoothing or stabilization funds, as well as areas in which management of the insurer has discretion in creating or modifying the above.

Another commentator stated that, in order to maintain transparency of all material features and aspects of general account contracts, the following requirements should be added to the regulation: disclosure of the assets supporting specific general account contracts; disclosure of data that permits comparison of a plan's contract to other contracts within the same class; and comparison of the class of contracts to all classes of contracts participating in the general account. The specific data

would include: gross and net returns, and the methodology and data to verify such returns; investment income generated by the general account; allocation of contract assets within the general account; and allocation procedures, risk and reserve charges, and other expenses attributable to all classes of contracts, as well as quarterly disclosure of gross and net rates of return.

As previously noted, the Department believes that it is important for plan fiduciaries to be provided with the information necessary to adequately assess the financial strength of an insurer, the suitability of a particular policy for the plan, as well as the appropriateness of continuing a plan's investment in a such policy. Nonetheless, the Department agrees with the commentators' views that a plan fiduciary need not replicate all of an insurer's internal cost calculations in order to make these assessments. However, the Department continues to believe that information necessary to calculate the exact dollar amount of the charges, fees or adjustments upon contract terminations must be disclosed to plan fiduciaries. In order for the termination provisions in the regulation to be meaningful, plan fiduciaries must have access to the information necessary to calculate and monitor the charges which would be assessed against a Transition Policy in the event of termination. Therefore, the Department has determined not to make all of the deletions to subparagraphs (c)(2) and (c)(3) requested by the commentators. However, the Department has determined that it would be appropriate to modify paragraph (c) to narrow the scope of the disclosures which must be provided in order to enable a plan fiduciary to determine the charges or adjustments applicable to the plan's policy. Pursuant to these modifications, the last two sentences of subparagraph (c)(2) have been deleted and subparagraphs (c)(3)(i)(A)–(C) have been modified to delete the requirement regarding disclosure of the data necessary for application of the methods or methodologies for determining the various values or amounts relevant to the plan's policy. The Department has retained the requirement in subparagraph (c)(3)(i)(D) that the insurer provide, upon request of a policyholder, data relating to any charges, fees, credits or market value adjustments relevant to the policyholder's ability to withdraw or transfer all or a portion of any fund under the policy. However, this requirement has been restated to clarify the level of "unpeeling" which must be

provided by the insurer and to require that such information must be provided to the policyholder within 30 days of the request for disclosure. Accordingly, upon the request of a plan fiduciary, the insurer must provide the formula actually used to calculate the market value adjustment, if any, applicable to the unallocated amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, the actual calculation as of a specified date of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of the variables was determined.

In response to the commentators who suggested that the Department expand the disclosure requirements in the regulation, the Department agrees with their assertions that there are a number of additional items of financial information regarding an insurance company general account, which may be relevant to a plan's fiduciary's consideration of the appropriateness or the prudence of a Transition Policy. In this regard, the Department notes that the disclosure requirements in the regulation reflect what the Department believes is the minimum level of information that an insurer must provide to a fiduciary of a plan which has invested in a Transition Policy. If the fiduciary believes that there are additional items of information which must be reviewed to evaluate a Transition Policy, the Department encourages the fiduciary to request, or to negotiate for, where appropriate, such information from the insurer.

Proposed paragraph (c)(4) described the information which must be provided at least annually to each plan to which a Transition Policy has been issued. The proposal required the insurer to provide the following information at least annually to each plan regarding the applicable reporting period: the balance in the accumulation fund on the first and last day of the period; any deposits made to the accumulation fund; all income attributed to the policy or added to the accumulation fund; the actual rate of return credited to the accumulation fund; any other additions to the accumulation fund; a statement of all fees, charges or expenses assessed against the policy or deducted from the accumulation fund; and the dates on which the additions or subtractions were credited to, or deleted from, the accumulation fund.

In addition, the proposed regulation required insurers to annually disclose all transactions with affiliates which

exceed 1 percent of group annuity reserves of the general account for the reporting year. The annual disclosure also had to include a description of any guarantees under the policy and the amount that would be payable in a lump sum pursuant to the request of a policyholder for payment of amounts in the accumulation fund under the policy after deduction of any charges and any deductions or additions resulting from market value adjustments.

As part of the annual disclosure, the proposed regulation requires that an insurer inform policyholders that it will make available upon request certain publicly-available financial information relating to the financial condition of the insurer. Such information would include rating agency reports on the insurer's financial strength, the risk adjusted capital ratio, an actuarial opinion certifying to the adequacy of the insurer's reserves, and the insurer's most recent SEC Form 10K and Form 10Q (if a stock company).

Several commentators objected to the annual disclosure provisions in subparagraph (c)(4)(xii) of the proposed regulation which required an insurer to make available on request of a plan, copies of certain publicly available financial data or reports relating to the financial condition of the insurer, including the insurer's risk adjusted capital ratio, and the actuarial opinion with supporting documents certifying the adequacy of the insurer's reserves. The commentators asserted that the risk-based capital report and actuarial opinions should not be disclosed because the information contained therein could be misleading to plan fiduciaries. With respect to the risk-based capital reports, the commentators explained that these documents are designed as a regulatory tool and are not intended as a means to rank insurers. They noted that the NAIC Risk-Based Capital for Insurers Model Act specifically prohibits publication of such reports and recognizes that such information is confidential.<sup>4</sup> The commentators further noted that the supporting memoranda to the actuarial opinions are not publicly available and that the memoranda contain proprietary information such as interest margins and expense and pricing assumptions. With respect to the

<sup>4</sup> The Department notes that subparagraph (c)(4)(xii)(C) of the proposed regulation required annual disclosure of the risk based capital ratio and a brief description of its derivation and significance, rather than disclosure of the risk based capital report as suggested by the commentators. It is the Department's further understanding that the risk based capital ratio is currently publicly available to policyholders.

actuarial opinion, one commentator stated that pension plan administrators do not have the expertise and may not be sufficiently knowledgeable about insurance to understand the limitations of this opinion. This commentator also expressed concern regarding the Department's characterization of the actuarial opinion as a certification of the insurer's reserves, noting that "no one can offer absolute assurance of the continued solvency of an insurance company." Lastly, the commentator was concerned that the provision of the actuarial opinion could subject the appointed actuary to unanticipated liability and costs as a plan fiduciary.<sup>5</sup> Another commentator suggested that to the extent that information regarding the financial condition of the insurer is publicly available, the insurer should be required to inform policyholders where such information may be found on the Internet.

The Department notes that there is nothing in the regulation that would preclude an insurer from providing a statement, accompanying the reports or data made available to a plan upon request, which contains a clear and concise explanation of the disclosures, including an objective recitation as to why such information may be misleading to policyholders. Accordingly, the Department has determined not to delete these disclosure requirements. However, in response to the concerns raised by the commentators, the Department has revised subparagraph (c)(4)(xi)(D) under the final regulation to delete the requirement that the supporting documentation be provided in connection with disclosure of the actuarial opinion.

One commentator noted that the information regarding expense, income and benefit guarantees under the policy, which is required to be disclosed annually pursuant to subparagraph (c)(4)(x) of the proposed regulation, is contained in the contract. The

commentator opined that, since contractholders already have this information, requiring insurers to reproduce it on an annual basis is unnecessary. As a result, the commentator urged the Department to delete this disclosure from the final regulation. The Department finds merit in this comment and has modified subparagraph (c)(4)(x) to require annual disclosure of the expense, income and benefit guarantees under the policy only if such information is not provided in the policyholder's contract, or is different from the information on guarantees previously disclosed in the contract.

Two commentators expressed concern regarding the requirement in subparagraph (c)(4)(iv) that the actual rate of return credited to the accumulation fund under the policy be disclosed on an annual basis in connection with Transition Policies that are issued to individuals. According to the commentators, it will be difficult to determine the actual plan level rate of return in cases where interest is calculated at the participant level. Consequently, the commentators sought clarification that, in the case of individual policies issued by an insurer to plan participants, the requirement of subparagraph (c)(4)(iv) will be deemed satisfied by annual disclosure of the rate of return under the policy to the individual policyholder. The Department is of the view that subsection (c)(4)(iv) will be satisfied where an insurer which issues individual policies to plan participants makes an annual disclosure of the rate of return to the individual policyholders.

With respect to the required annual disclosure of termination values in subparagraph (c)(4)(xi) of the proposed regulation, two commentators asserted that determining termination values is a manual time-consuming customized procedure which cannot be automated without significant difficulty and associated cost. One commentator noted that its pension division policyholders receive an annual statement which gives them, among other things, their account value, without charges being applied, and a "surrender" value, which is their account value less all applicable charges except the market value adjustment. The commentator maintains that it is impossible, if not almost impossible, to have a firm withdrawal amount reported to all pension division policyholders on an annual basis. The commentator recommended that subparagraph (c)(4)(xi) be modified to permit insurers to comply with this requirement by approximating the amount that would

be payable in a lump sum at the end of such period.

On the basis of these comments, the Department has determined to modify subparagraph (c)(4)(xi) of the final regulation to make clear that the insurer generally may comply with its annual disclosure obligations by disclosing to the plan the approximate amount that would be payable to the plan in a lump sum at the end of such period. In this regard, the Department expects that any approximation of the lump sum payment would be determined in good faith as a result of a rational decision-making process undertaken by the insurer. As modified, subparagraph (c)(4)(xi) additionally provides, however, that the policyholder may request that the insurer provide the more exact calculation of termination values specified in subparagraph (c)(3)(i)(D) as of a specified date that is no earlier than the last contract anniversary preceding the date of the request.

One commentator stated that the disclosure of affiliate transactions is not relevant or useful to plan policyholders in evaluating the merits of a contract or the performance of an insurer.

Moreover, the commentator argued that affiliate transactions are monitored and regulated by State insurance authorities which require, among other things, that any such transaction be effected on arm's-length terms. Accordingly, the commentator requested that the Department delete subparagraph (c)(4)(ix) and replace that requirement with a statement in subparagraph (c)(3) to the effect that an insurer may engage in transactions with corporations or partnerships (including joint ventures), controlling, controlled by, or under common control with, the insurer along with a general description of the basis on which such transaction will be effected. Another commentator stated that the disclosure of related party transactions is necessary to evaluate the potential impact of such transactions on the general account contract and the potential impact the transaction may have in affecting a contract's returns. The commentator would add the following to subparagraph (c)(4)(ix):

Whether the 1% threshold for reporting related party transactions has been met should be based on whether the aggregate of related party transactions exceeds this threshold, since there may be many cases when this threshold far exceeds any individual transaction amounts. If the threshold is met, all related party transactions should then be reported.

In addition, the commentator suggests that the focus of the disclosure requirement in subparagraph (c)(4)(ix)

<sup>5</sup> In this regard, the Department notes that ERISA establishes a functional approach to determine whether an activity is fiduciary in nature. Under section 3(21) of ERISA, a fiduciary includes anyone who exercises discretion in the administration of an employee benefit plan; has authority or control over the plan's assets; or renders investment advice for a fee with respect to any plan assets. The Department has indicated that it examines the types of functions performed, or transactions undertaken, on behalf of the plan to determine whether such activities are fiduciary in nature and therefore subject to ERISA's fiduciary responsibility provisions. See 29 CFR 2509.75-8, D-2. To the extent that an actuary performs none of the functions discussed under section 3(21) or the applicable regulations, the actuary's activities would not be subject to ERISA's fiduciary responsibility provisions.

should only be with respect to the reserves attributable to the assets that have been compartmentalized (segmented) within the general account to support the specific contract. In response to the comments, the Department continues to believe that disclosure of large affiliate transactions is relevant to a plan fiduciary's determination regarding the appropriateness of continuing a plan's investment in a Transition Policy. Accordingly, the Department has determined to retain this requirement in the final regulation.

Several of the commentators believe that there is a need to further enhance the information required to be disclosed annually. One commentator suggested that the annual disclosure provisions be amended to require the following: pursuant to subparagraph (c)(4)(iii)—the disclosure of all gross investment results, including interest income and realized capital charges generated by the assets in the group annuity segment, and all of the offsets, deductions, charges, fees, reductions due to smoothing techniques, etc. that are taken off before a rate of return is credited to the policyholder or the accumulation fund. In addition, the commentators stated that plan fiduciaries need access to relevant general account portfolio statistics in order to assess risk and evaluate investment income in relation to risk. The commentators further stated that pension fiduciaries need to evaluate factors such as the vulnerability of the portfolio to manipulation such as churning. They concluded that the general information that should be made available with respect to a general account portfolio should include types of exposure for given asset classes, performance characteristics such as delinquencies and write-downs; the proportion of loans that are public, those that are direct placements and those in default. In addition, the commentators also urged disclosure of other types of information relative to risk assessment such as pending material litigation, adverse regulatory rulings and material corporate reorganizations.

The Department believes that the annual disclosure provisions reflect a balance between the plans' need for information about general account contracts against the costs associated with providing such information. Accordingly, after consideration of the comments, the Department has determined that it would not be appropriate to mandate the disclosure of additional information. However, this determination does not preclude a plan

fiduciary from requesting, or negotiating for, where appropriate, any additional information from an insurer which the fiduciary believes is necessary to properly evaluate a Transition Policy.

Two commentators stated that there should be quarterly reporting in the following situations: significant write-downs, delinquencies, adverse events with respect to reinsurance, and the possibility of demutualization. Although the Department has determined not to require more frequent reporting, the Department notes that an insurer's unwillingness to provide more frequent disclosures with respect to material events that may impact on the insurer is a factor that should be considered by the fiduciary in its evaluation of the continued appropriateness of the Transition Policy.

#### *4. Alternative Separate Account Arrangements*

Proposed paragraph (d)(1) contained an additional disclosure requirement regarding the availability of separate account contracts. Under this paragraph, the insurer must explain the extent to which alternative contract arrangements supported by assets of separate accounts of the insurer are available to plans; whether there is a right under the policy to transfer funds to a separate account; and the terms governing any such right. An insurer also must disclose the extent to which general account contracts and separate account contracts pose differing risks to the plan. Proposed paragraph (d)(2) contained a standardized statement describing the relative risks of separate accounts and general account contracts which, if provided to policyholders, will be deemed to comply with paragraph (d)(1)(iii) of the regulation.

A commentator questioned whether the Department intended to require that the disclosure to policyholders concerning alternative separate account arrangements be provided both with the initial and annual disclosures, or only with the initial disclosure. The Department has clarified paragraph (d)(1) to require that the insurer provide the plan fiduciary with information about alternative separate account arrangements at the same time as the initial disclosure under subparagraph (c)(3).

Another commentator suggested that the Department insert the following phrase within the parenthetical contained in the second sentence in subparagraph c. of the separate account disclosure statement "and except any surplus in a separate account." The commentator noted that, to the extent

that insurance companies place some of their funds in these separate accounts to provide for contingencies, this separate account "surplus" should not be subject to the fiduciary responsibility rules.<sup>6</sup> Although the Department agrees with the commentator that the separate account surplus would not constitute plan assets with respect to other plan investors in the separate account, the Department is unable to conclude that such surplus would not constitute plan assets under all circumstances. Section 401(b)(2)(B) provides, in part, that the term "guaranteed benefit policy" includes any surplus in a separate account, but excludes any other portion of the separate account. In light of the holding in the Harris Trust decision, the Department is unable to conclude that the surplus in an insurance company separate account would never constitute plan assets with respect to plan policyholders who have purchased general account contracts. Therefore, the Department has determined not to make the requested modification.

One commentator suggested that the Department delete subparagraph d. from the separate account disclosure statement based upon the view that State regulation of insurance company accounts is irrelevant to protections under the Act, and may lull plan fiduciaries into believing that they have protections for their investment decisions when they do not. In response to this comment, the Department clarified subparagraph (d)(2)d. of the separate account disclosure statement to provide that State insurance regulation of general accounts may not offer the same level of protection to plan policyholders as ERISA regulation.

#### *5. Termination Procedures*

Paragraph (e)(1) of the proposed regulation provided that a policyholder must be able to terminate or discontinue a policy upon 90 days notice to an insurer. Under the proposal, the policyholder must have the option to select one of two payout alternatives, both of which must be made available by the insurer.

Under the first alternative, an insurer must permit the policyholder to receive, without penalty, a lump sum payment representing all unallocated amounts in the accumulation fund after deduction of unrecovered expenses and adjustment of the book value of the policy to its market value equivalency. The Department noted that, for purposes

<sup>6</sup>The Department notes that language identical to the commentator's appears in the Report of the ERISA Conference Committee at pages 296 and 297. H.R. Conf. Rep. No. 1280, 93rd Cong., 2d Sess. 296 (1974).



of paragraph (e), the term penalty did not include a market value adjustment (as defined in proposed paragraph (h)(7)) or the recovery of costs actually incurred, including unliquidated acquisition expenses, to the extent not previously recovered by the insurer.

Under the second alternative contained in proposed paragraph (e)(2), an insurer must permit the policyholder to receive a book value payment of all unallocated amounts in the accumulation fund under the policy in approximately equal annual installments, over a period of no longer than five years, with interest.

### General Comments

Several commentators objected to the lump sum and five year book value payment requirements in the proposed regulation. The commentators' objections were based on their assertions that most insurers do not provide the termination rights set forth in the proposed regulation in their existing contracts. Many of the commentators stated that the Department should not impose retroactive amendment of in-force contracts.<sup>7</sup> The commentators assert that the following problems would result from inclusion of the proposed termination provisions in existing contracts: requiring insurers to amend their contracts to include the new termination provisions would subject insurers to increased risk of disintermediation and anti-selection that was not evaluated either when the contract was priced or when the types and durations of general account investments made to support the policies were determined; insurers would have to reduce the duration of the general account investment portfolios which support Transition Policies in order to mitigate the

increased risks of disintermediation and anti-selection; the consequences of this change in duration would be reduced earnings for the general account, lower yields being realized by Transition Policies, and a limitation on the insurer's ability to participate in the private placement market.

Other commentators stated that the three standard termination options (lump sum payout, five year book out and ten year book out) in New York's Regulation 139 (11 NYCRR 40) afford ample protection to plans and their participants, without locking plans into disadvantageous relationships. One of the commentators noted that Regulation No. 139 permits additional flexibility in negotiating contract terms by permitting the "Superintendent" to waive or modify applicable requirements through the approval process. The commentator further stated that the lack of flexibility in the proposed regulation would impair the insurance industry's ability to satisfy plan sponsors' long-term investment goals and it would also force the costly realignment (or transfer) of general account assets and pass the realignment (or transfer) expenses and the losses on the sale of assets to general account policyholders. One commentator asserted that: (1) No State other than New York has set minimum termination standards applicable to group annuity contracts; (2) the proposed regulation is considerably more restrictive than New York's regulations, and (3) the New York regulation applies only to contracts issued after the regulation was adopted.

One commentator stated that if the proposed termination rules are retained, the Department should revise the proposed regulation to allow an insurer the discretion to use an installment payout option that financially approximates the lump sum market value adjusted payout, in whatever combination of interest rate reduction and payout period that State insurance laws may permit. According to one commentator, permitting policyholders to terminate at any time, and to choose from the more favorable of a book value installment option or market value option, would create opportunities for some policyholders to "game" the system by timing terminations to take advantage of differing interest rate environments.

The Department stated in the preamble to the proposed regulation that the proposed termination provisions were designed to protect the interests and rights of plans by ensuring that they were not locked into relationships which had become economically disadvantageous. The

Department noted in footnote 5 of the proposed regulation that the termination provisions in the proposal were similar to the Department's rule governing contracts between plans and service providers under 29 CFR section 2550.408b-2(c). Several commentators objected to this reference and enumerated the differences between group annuity contracts and service provider contracts. In this regard, the Department wishes to note that the reference to the two types of contracts was intended to indicate that the underlying rationale for the rule and the proposed termination provisions was similar, not that insurance contracts and service contracts are alike in all respects. Thus, the footnote was intended to express the Department's belief that plans should not be locked into economically disadvantageous relationships under either type of contract.

A number of other commentators believe that the termination procedures in the proposed regulation should not be diminished in any respect in the final regulation. One commentator supported the Department's premise that the termination procedures are necessary to ensure that plans are not locked into economically disadvantageous relationships. The commentator stated that the inability to withdraw from a contract would be a result that would defeat the progress that would have been made by requiring insurers to provide additional disclosure. The commentator further stated that without such protections, plans may be subject to such large and arbitrary penalties at termination that the fiduciaries would be obligated to continue disadvantageous and poorly-performing contracts to the detriment of plan participants and beneficiaries. The commentator believed that the termination provisions would not materially change how most insurers invest contract assets because over time, market conditions and forces, as well as competitive factors, rather than termination procedures, would determine how assets are invested.

Another commentator stated that the terms set forth in the proposed rule are all absolutely essential for the protection of plan and participant interests. The commentator further stated that, if insurers are left with the discretion to impose either an installment or lump sum option, in the commentator's experience the insurer would act out of self-interest, not the interest of plan participants, in selecting the option.

One commentator stated that the regulation's disclosure provisions will

<sup>7</sup> The Department recognizes that this regulation may give rights to plan policyholders which their contracts did not independently contain. The regulation, however, also benefits insurers by enabling them to limit exposure to the full panoply of fiduciary obligations and liabilities normally associated with the management of plan assets. If an insurer complies with the regulation, it avoids substantial potential liabilities to plan policyholders. In exchange, however, the regulation requires the insurer to give the plan the disclosures necessary to evaluate the contract's performance and the right to withdraw the plan's funds when that performance proves inadequate. The Department's insistence on these disclosure and termination rights is consistent with the requirement in section 401(c)(2)(B) that the regulation "protect the interests and rights of the plan and of its participants and beneficiaries \* \* \*". The Department cannot, consistent with the statute, give an insurer a safe-harbor from ERISA's fiduciary responsibility provisions without also granting additional rights to plan policyholders.



be rendered nugatory without specified termination procedures. The commentator supported the regulation's attempts to balance the economic interests of employee benefit plans with the day-to-day operations of insurance company general accounts and stated that it is imperative to ensure that the regulation specifies an appropriate time frame and method for an insurer's payment to a plan upon the plan's termination of a contract. The commentator believed that without these procedures, insurers may hold plan assets longer than necessary, thus preventing participants and beneficiaries from gaining higher rates of return on their retirement monies.

Pursuant to the SBIPA, Congress required the Department to promulgate regulations to implement the new amendment to section 401 of ERISA that would ensure the protection of the interests and rights of the plans and of its participants and beneficiaries. While the Department intended that the disclosure provisions in paragraphs (c) and (d) of this regulation would ensure that plan fiduciaries have sufficient information upon which to make appropriate decisions regarding a plan's investment in a Transition Policy, the Department continues to believe that those provisions would be rendered meaningless if plans were not offered the right to terminate their Transition Policies under terms which are both objective and fair for all parties. Therefore, the Department has determined to retain the termination provisions in paragraph (e) of the regulation with certain modifications, as discussed further below.

#### *Lump Sum Payment*

Several commentators objected to proposed paragraph (e)(1) and the definition of the term "market value adjustment" as a method which permits both upward and downward adjustments to the book value of the accumulation fund. According to one commentator, a two-way market value adjustment requirement may provide an artificial incentive for contractholders to terminate their contracts. The commentators further asserted that if a disproportionate number of contractholders elect to terminate and withdraw their funds in a lump sum at any one time, the resulting disintermediation may impair the insurer's solvency.

The commentator further argued that paying the contractholder the book value of the accumulation fund upon contract termination, when market value exceeds book value, is fair

because the contractholder receives all guaranteed amounts, without reduction.

One commentator asserted that a large number of group annuity contracts provide only for negative adjustments and that the particular market value adjustment terms contained in any group annuity contract were put in place at the inception of the policy. The commentator was concerned that the proposed regulation would retroactively graft positive market value adjustment terms upon policies in a way that would be inconsistent with reasonable insurer expectations. This commentator also observed that no State law requires insurers to offer positive market value adjustments.

Other commentators stated that many insurers do not provide for positive market value adjustments because experience-rated group annuity contracts are intended to be long-term funding instruments supported by long-term investments. These commentators asserted that encouraging withdrawals from these contracts for arbitrage purposes by providing for positive market value adjustments disrupts the insurer's ability to make and implement investment decisions on the basis of accurate predictions of cash flow and interferes with asset-liability matching to the detriment of non-withdrawing contractholders.

Based on the Department's understanding that the purpose of a market value adjustment is to protect the policyholders who remain invested in the insurer's general account, the Department defined the term "market value adjustment" under the proposed regulation to reflect the economic effect (positive and negative) on a Transition Policy of an early termination or withdrawal in the current market. Thus, depending upon the economic environment at the time of termination, the terminating policyholder would either bear the costs or receive the benefit of the adjustment. The Department is not persuaded by the commentators' objections to the condition in subsection (e)(1) of the proposed regulation which requires an upward as well as a downward adjustment of the book value of the Transition Policy. Since an insurer cannot predict the direction of the economic markets or the timing of a notice to terminate, the Department is not convinced that insurers price their contracts based on an assumption that a predictable proportion of contracts will terminate when a positive market value adjustment would otherwise apply. Although the commentators argue that policyholders will terminate their Transition Policies in order to take

advantage of an economic market in which they would receive a positive adjustment, the Department notes that those same policyholders would have to take into account the fact that the same market that produced the favorable adjustment would produce lower returns on reinvestment of the Transition Policy's proceeds. As a result, a positive market value adjustment would not create an artificial incentive for policyholders to terminate Transition Policies. The denial of appropriate positive market value adjustments would, however, artificially penalize plans for the termination of Transition Policies by requiring them to accept less than fair market value for the funds associated with their policies. Such a result would be inconsistent with the regulation's goal of ensuring that plan policyholders are not locked into economically disadvantageous relationships. Because the Department has not been persuaded that application of an upward market value adjustment on termination of a Transition Policy would produce inequitable results or cause significantly larger numbers of policyholders to terminate those Transition Policies, as claimed by the commentators, subsection (e)(1) has not been modified as requested.

One commentator asserted that the lump sum alternative in subparagraph (e)(1) creates serious problems for certain insurers that avoid registration of their annuity products with the Securities Exchange Commission under section 3(a)(8) of the Securities Act of 1933. Section (3)(a)(8) excludes an annuity contract or optional annuity contract from the application of federal securities laws. Rule 151 under the Securities Act of 1933 provides a "safe harbor" for certain forms of annuity contracts issued by insurance companies. An annuity contract which meets all of the conditions in the Rule comes within the "safe harbor" and is deemed to be an annuity contract within the meaning of section (3)(a)(8).<sup>8</sup> As a result, the commentator requested that the Department eliminate the termination provisions in the final regulation.

Another commentator stated that the proposed lump sum termination feature is contrary to Ohio's standard nonforfeiture law which provides that

<sup>8</sup>The safe harbor in Rule 151 is not available for a contract which permits a lump sum payment subject to a market value adjustment. However, the Rule provides that the presence of a market value adjustment should not create the negative inference that no such contract is eligible for the exclusion under section 3(a)(8). See Definition of Annuity Contract or Optional Annuity Contract, Securities Act Release No. 33-6645 (May 29, 1986).

the insurer shall reserve the right to defer the payment of such cash surrender benefit for a period of six months after demand. See O.R.C. section 3915.073(C)(2). This provision applies to individual deferred annuity contracts. The commentator believes that amendment of the Transition Policies to include the lump sum termination provision will invalidate the policy under this provision of Ohio law. Similarly, one commentator determined that several States do not allow market value adjustments in individual annuity contracts that are subject to State nonforfeiture laws. Other States do not allow market value adjustments in individual annuity contracts except with respect to "modified guaranteed annuities" (MGAs). The commentator believes that none of the Transition Policies that would be subject to the regulation are MGAs and that, therefore, ERISA plan individual annuity contracts that would be subject to the regulation are not permitted, under State law, to impose a market value adjustment upon termination. The commentator believes that this information and the above comment concerning insurers that rely on section 3(a)(8) and Rule 151 of the Securities Act of 1933, present a strong case for only allowing a book value payout over time as one of the permitted termination options to be determined at the insurer's discretion under the regulation and not as a required option.

The Department continues to believe that the disclosure provisions set forth in subparagraph (c) of this regulation will only be meaningful if an independent plan fiduciary with respect to a Transition Policy has the ability to act upon such information by terminating the Transition Policy and receiving a payout within a reasonably short time-frame. Moreover, the Department has not been convinced that changing the lump sum payment option in the manner requested by the commentators would be in the best interests of the affected plans. Therefore, the Department has determined that it would not be appropriate to eliminate or modify the lump sum payment option as suggested by the commentators.

A commentator requested that the Department modify that portion of proposed paragraph (e)(1) that deals with contingent sales charges so that the phrase "the term penalty does not include \* \* \* the recovery of costs actually incurred" is changed to "the term penalty does not include \* \* \* charges that are reasonably intended to recover costs." In addition, another commentator requested that the

definition of "without penalty" be revised so that it is similar to the definition already contained in the regulations under section 408(b)(2) of the Act which allows the recovery of "reasonably foreseeable expenses" upon early termination. The Department believes that the modifications suggested by the commentators would diminish the clarity of the proposed regulation. Subparagraph (e)(1) of the proposed regulation provides an insurer with an objective standard regarding the allowable costs which may be recovered in connection with termination of a Transition Policy under which the policyholder has chosen the lump sum payout option.

Therefore, the Department has declined to modify the final regulation as requested by the commentators.

One commentator requested that the language explaining what would not constitute a "penalty" for purposes of paragraph (e), be modified to refer to subparagraph (e)(1) rather than paragraph (e), to clarify that market value adjustments can be imposed only on lump sum payments. The commentator suggested that the cross reference language state, "\* \* \* For purposes of this subparagraph (e)(1) \* \* \*." The Department acknowledges that this was the intended meaning of the language of proposed paragraph (e)(1) and has modified the final regulation accordingly.

#### *Book Value Installment Option*

Several commentators asserted that, if contractholders are able to withdraw funds over a period of five years at book value at any point in time when the investment return on such funds was below current market rates, they will be able to obtain amounts in excess of the present value of their investment. According to the commentators, when interest rates are rising, contractholders would inevitably select against insurers and remaining contractholders by making book value withdrawals and reinvesting withdrawn funds at current market rates. The commentators believe that such massive withdrawals would require insurers to liquidate their assets at substantial losses, thus, seriously impairing some insurers' financial capability to meet their contractual obligations.

A number of commentators noted that the terms and conditions of a book value installment payout are intended to serve the same purposes as market value adjustments, i.e. the equitable allocation of the effect of a withdrawal between the withdrawing and remaining contractholders, and the protection of the general account from severe anti-

selection risks. The commentators represented that the terms of book value payouts are structured to produce an actuarially equivalent value to that produced by a lump sum market value adjusted payout. However, the commentators asserted that the proposed regulation's payout period of no more than 5 years, coupled with no more than a 1% interest rate reduction will deprive insurers of the opportunity to achieve the objective of approximate actuarial equivalence and undermine the insurer's ability to adequately protect itself and its non-withdrawing policyholders from anti-selection and disintermediation. The commentators explained, that for an installment-payout provision to produce equity between withdrawing and non-withdrawing contractholders, and to prevent anti-selection and disintermediation, the length of the payout period must bear some reasonable relationship to the maturities of the investment portfolio supporting the insurer's liability to the contractholder under such provision. The commentators concluded that a five-year payout with a maximum interest rate reduction of 1% is insufficient to adequately protect an insurer's general account based on the typically longer maturities of investments in insurers' general accounts that fund retirement benefits.

To resolve these concerns, several commentators requested that the Department modify the proposed regulation to permit insurers to offer policyholders at least one of several termination methods, at the option of the insurer. Under this alternative, insurers would have the discretion to either not offer a lump sum option, offer a lump sum option without a positive market value adjustment, or offer a book value payment over a period in excess of 5 years (e.g., 10 years) with interest at a credited rate reduced by more than 1 percent.

The Department believes that allowing the insurer to determine the termination methods that will be offered to policyholders could have a negative impact on terminating Transition Policies. Therefore, the Department has decided not to adopt the commentators' requested modifications in the final exemption. However, the Department finds merit in the arguments submitted by the commentators with respect to the length of the book value payout term and has been persuaded that the term of the book value payout option should more closely reflect the maturity of the investments in the general account. Accordingly, on the basis of the comments, the Department has modified

the book value alternative in subsection (e)(2) of the final regulation to permit a policyholder to receive book value payment over a period of no more than ten years with interest at the rate credited on the contract minus 1 percent.

Several commentators requested that the Department provide an exception from the termination procedures during extraordinary circumstances to avoid the risk of severe disintermediation. The Department concurs with this request and has modified paragraph (e) to provide that the insurer may defer, for a period not to exceed 180 days, amounts required to be paid to a policyholder under paragraph (e) for any period of time during which regular banking activities are suspended by State or federal authorities, a national securities exchange is closed for trading (except for normal holiday closings), or the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

#### 6. Insurer-Initiated Amendments

Proposed paragraph (f) described the notice requirements and payout provisions governing insurer-initiated amendments. Under the proposed paragraph, if an insurer makes an insurer-initiated amendment, the insurer must provide written notice to the plan at least 60 days prior to the effective date of the amendment. The notice must contain a complete description of the amendment and must inform the plan of its right to terminate or discontinue the policy and withdraw all unallocated funds in accordance with paragraph (e)(1) or (e)(2) by sending a written request to the name and address contained in the notice. Proposed paragraph (f), unlike the more general termination provisions set forth in paragraph (e), was to be applicable upon publication of the final regulation in the **Federal Register**.

An insurer-initiated amendment was defined in proposed paragraph (h)(8) as an amendment to a Transition Policy made by an insurer pursuant to a unilateral right to amend the policy terms that would have a material adverse effect on the policyholder; or certain unilateral enumerated changes that result in a reduction of existing or future benefits under the policy, a reduction in the value of the policy or an increase in the cost of financing the plan or plan benefits, if such change has more than a *de minimis* effect.

One commentator expressed the view that the definition should be modified to include any insurer-initiated

amendment that is unfavorable to the plan. Two commentators suggested that any insurer-initiated amendment to a general account contract should eliminate the contract's ability to qualify as a Transition Policy. In this regard, one of the commentators urged the Department to adopt a standard under which there would be a rebuttable presumption that any insurer-initiated amendment has a material adverse effect on the policyholder. The Department has determined not to revise this definition as requested in recognition of the fact that many Transition Policies represent long term relationships that may require minor changes over time.

Other commentators requested that the Department reconsider the *de minimis* standard set forth in subparagraph (h)(8)(ii) of the definition. These commentators stated that the definition was so broad that it would be impossible for any insurer to know whether it is in compliance with these requirements. The commentators suggested that the Department modify the definition to include only unilateral changes that are "material" since this is a term that has a well understood meaning. After consideration of the comments, the Department has concluded that it would be appropriate under the final regulation to modify the definition of the term "insurer-initiated amendment" to include only unilateral changes that have a material adverse effect on the policyholder. To further clarify this matter, paragraph (h)(8) of the final regulation includes a definition of the term "material."

Several commentators requested that the Department restate subparagraph (h)(8)(ii)(G), from "[a] change in the annuity purchase rates" to "[a] change in the guaranteed annuity purchase rates." A commentator stated that changes in the market purchase rates for annuities are based on current interest rates and, accordingly, should not be considered an insurer-initiated amendment. Conversely, the commentator represented that modifying the guaranteed purchase rate would be considered an insurer-initiated amendment since it is usually prohibited by the contract or by State law. Another commentator suggested that the Department modify subparagraph (h)(8)(ii)(G) to include "a change in the annuity purchase rates guaranteed under the terms of the contract or policy, unless the new rates are more favorable for the policyholder." On the basis of these comments, the Department has determined to make modifications to subparagraph (h)(8)(ii)(G).

Several commentators requested that the Department clarify that any amendment or change that is required to be made to a Transition Policy to comply with applicable federal or State law or regulation (including this regulation), or to convert the policy to a "guaranteed benefit policy," is not an insurer-initiated amendment. A number of commentators urged the Department to clarify that a demutualization<sup>9</sup> or similar reorganization will not result in an insurer-initiated amendment. The commentators represented that policyholders retain all of the benefits under the policies to which they would have been entitled if the reorganization had not occurred. The policies remain in force with no change in their terms, except that the membership interest in the mutual company is removed from the policy and evidenced separately (e.g., by shares of stock). In further support of their position, the commentators argue that the Internal Revenue Service has held that where the terms and conditions of the contracts remain the same, a reorganization will not cause contracts issued by the insurer on or before the date of the proposed reorganization to be treated as new contracts for purposes of determining the date of issuance of the contract.<sup>10</sup>

The Department is unable to conclude that all changes made to a Transition Policy in order to comply with any applicable federal or State law, or to convert the policy to a guaranteed benefit policy, are changes that would not have a material adverse effect on a policyholder. However, the Department has determined to modify subparagraph (h)(8)(iv) to clarify that amendments or changes which are made: (1) With the affirmative consent of the policyholder; (2) in order to comply with section 401(c) of the Act and this regulation; or (3) pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be relinquished in exchange for separate consideration (e.g. shares of stock or policy credits); are not insurer-initiated amendments for purposes of the final regulation. The Department also has made parallel changes to subparagraph (h)(6)(ii) of the final regulation to clarify that such changes will not cause a policy to fail to be a Transition Policy.

<sup>9</sup>This involves a conversion from a mutual insurance company to a publicly owned stock company.

<sup>10</sup>See Rev. Proc. 92-57, 1992-2 C.B. 410.

One commentator suggested that subparagraph (h)(8)(iii) be revised to omit the word "affirmative" which precedes the word "consent" in the proposed regulation. According to the commentator, it should be acceptable to the Department for the insurer to send notice of a prospective change to the policyholder with an appropriate lead time during which the policyholder has time to object to the change. The policyholder's affirmative consent to an amendment or change was a necessary element of the Department's determination to exclude such amendments or changes from the definition of insurer-initiated amendment. Because the Department continues to believe that the policyholder's affirmative consent is a necessary protection against insurer-initiated amendments which may be adverse to the policyholder, it has determined not to adopt the commentator's suggested modification.

#### 7. Prudence

Proposed paragraph (g) set forth the prudence standard applicable to insurance company general accounts. Unlike the prudence standard provided in section 404(a)(1)(B) of ERISA, prudence for purposes of section 401(c)(3)(D) of ERISA is determined by reference to all of the obligations supported by the general account, not just the obligations owed to plan policyholders.<sup>11</sup>

Two commentators concurred with the standard of prudence established in the regulation. One of the commentators was pleased because paragraph (g) makes it clear that the prudence standard applies regardless of whether general account assets are also considered to be plan assets under ERISA. The commentator believed that the prudence standard contained in paragraph (g) addresses the conflict between State insurance laws which require that general account assets be managed so as to maintain equity among all contractholders, policyholders, creditors and shareholders and the ERISA fiduciary rules which require that plan assets be managed solely in the interests of, and for the exclusive purpose of, providing benefits to plan participants and their beneficiaries. The other commentator suggested that

application of this standard could lead to more limited investment opportunities for general account assets and lower returns than currently achievable under State investment laws. In turn, this could lead to increased plan contributions for defined benefit plans in order to maintain current benefit levels. In this regard, the Department notes that the prudence standard set forth in the proposal merely implements subsection 401(c) of ERISA which contains the prudence standard that is the subject of the commentator's concern.

#### 8. Definitions

##### Accumulation Fund

Proposed paragraph (h)(5) defined the term "accumulation fund" as the aggregate net considerations (*i.e.*, gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to such Transition Policy less partial withdrawals, benefit payments and less all charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

A commentator requested modification of the term "accumulation fund" to satisfy the commentator's concern that upon termination, a policyholder would not be able to withdraw from the policy amounts set aside to pay benefits under the policy. The commentator suggested that the definition be revised to read as follows:

The term "accumulation fund" means the aggregate net considerations (*i.e.*, gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to such Transition Policy less partial withdrawals, benefit payments, amounts accrued or received under the Transition Policy for the purpose of providing benefits which are guaranteed by the insurer and less all charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

The Department believes that the term "accumulation fund" as defined and used in context in the proposed regulation correctly reflects the meaning intended by the Department. Therefore, after consideration of the comment, the Department has determined not to adopt the requested modification.

##### Market Value Adjustment

Proposed paragraph (h)(7) defined the term "market value adjustment" as an adjustment to the book value of the

accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a "market value adjustment" within the meaning of this definition only if the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the policyholder in accordance with paragraph (c)(3)(i)(D), and the method permits both upward and downward adjustments to the book value of the accumulation fund.

One commentator stated that the market value adjustment definition needs to be clarified and modified in order to encompass all reasonable types of market value adjustment formulas currently in use by the industry, but did not suggest any specific types of market value adjustment formulas for the Department's consideration. A commentator suggested that, for purposes of clarification, the first sentence of the market value adjustment definition in paragraph (h)(7) should be revised to read as follows:

For purposes of this regulation, the term "market value adjustment" means an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under general account assets.

After consideration of the comments regarding market value adjustment, the Department believes that the definition, as set forth in the proposed regulation, is sufficiently flexible to address the commentator's concerns and that no further modification is necessary.

#### 9. Limitation on Liability

Proposed paragraph (i)(1) provided that no person shall be liable under Parts 1 and 4 of Title I of the Act or section 4975 of the Code for conduct which occurred prior to the effective dates of the regulation on the basis of a claim that the assets of an insurer (other than plan assets held in a separate account) constitute plan assets. Paragraph (i)(1) further provided that the above limitation on liability will not apply to: (1) An action brought by the Secretary of Labor pursuant to paragraph (2) or (5) of section 502(a) of the Act for a breach of fiduciary responsibility which would also constitute a violation of Federal or State criminal law; (2) the application of any Federal criminal law; or (3) any civil

<sup>11</sup> In this regard, the Department notes in the proposal that nothing contained in the proposal's prudence standard modified the application of the more stringent standard of prudence set forth in section 404(a)(1)(B) of ERISA as applicable to fiduciaries, including insurers, who manage plan assets maintained in separate accounts, as well as to assets of the general account which support policies issued after December 31, 1998.

action commenced before November 7, 1995.

Proposed paragraph (i)(2) stated that the regulation does not relieve any person from any State law regulating insurance which imposes additional obligations or duties upon insurers to the extent not inconsistent with this regulation. Thus, for example, nothing in this regulation would preclude a state from requiring an insurer to make additional disclosures to policyholders, including plans.

Proposed paragraph (i)(3) of the regulation made clear that nothing in the regulation precludes a claim against an insurer or others for a violation of ERISA which does not require a finding that the underlying assets of a general account constitute plan assets, regardless of whether the violation relates to a Transition Policy. For example, a Transition Policy would give rise to fiduciary status on the part of the insurer if the insurer had discretionary authority over the administration or management of the plan. See section 3(21) of the Act. Thus, nothing in ERISA or this regulation would preclude a finding that an insurer is liable under ERISA for breaches of its fiduciary responsibility in connection with plan management or administration. Similarly, neither ERISA nor the regulation precludes a finding that an insurer is a fiduciary by reason of its discretionary authority or control over plan assets. If the insurer breaches its fiduciary responsibility with respect to plan assets, it would be liable under ERISA regardless of whether the insurer has issued a Transition Policy to a plan or ultimately placed the plan's assets in its general account.

Paragraph (i)(4) of the proposed regulation provided that if an insurer fails to meet the requirements of paragraphs (b) through (f) of the regulation with respect to a specific plan policyholder, the result of such failure would be that the general account would be subject to ERISA's fiduciary responsibility provisions with respect to the specific plan for that period of time during which the requirement of the regulation was not met. Once back in compliance with the regulation, the insurer would no longer be subject to ERISA (other than this regulation) or have potential liability under ERISA's fiduciary responsibility provisions for subsequent periods of time when the requirements of the regulation are met. In addition, the regulation made clear that the underlying assets of the general account would not constitute plan assets for other Transition Policies to the extent

that the insurer was in compliance with the requirements of the regulation.

Several commentators were concerned that under proposed paragraph (i)(4), an insurer's single (or *de minimis*) inadvertent failure to satisfy the conditions in the regulation might require a portion of every asset in the insurer's general account to be a plan asset for the period of noncompliance, thus subjecting the insurer to increased liability for fiduciary violations. The commentators believed that this "all or nothing" rule could cause significant disruption to the insurer and hinder the insurer's investment activities. The commentators believed that this result was not compelled by section 401(c) of the Act.

The commentators suggested that the Department: (1) Clarify that any finding that assets of an insurer are plan assets as a result of an instance of noncompliance should be operative only with respect to the dispute between the policyholder and the insurer; (2) modify the proposed regulation to state that the transition relief provided will be available if the insurer adopts reasonable procedures to implement the requirements of the regulation and takes reasonable steps to implement those procedures; (3) provide that an insurer's unintentional failure to comply with the regulation, that is not a result of willful neglect, will not cause any general account assets to become plan assets if the insurer cures such failure within 60 (or 90) days after discovering or being notified of the failure to comply and makes the plan or plans whole for any monetary loss resulting from the non-compliance. Alternatively, commentators suggested that the Department permit the insurer to remedy any failure to comply with the regulation, due to reasonable cause and not to willful neglect, within 30 days of receipt of notice of such noncompliance and to extend this "cure" period if state insurance department approval is required. Additionally, a commentator urged the Department to provide that failure to comply with the regulation should only be effective with respect to the adjudication of the action in which the finding is made.

The Department concurs with the commentators' assertions that the consequences of an insurer's *de minimis* or inadvertent failure to comply with the regulation may be too severe. Accordingly, the Department has amended subparagraph (i)(4) of the regulation to provide that a plan's assets will not include an undivided interest in the underlying assets of the insurer's general account notwithstanding the

fact that the insurer has failed to comply with the requirements of paragraphs (c) through (f) of the regulation with respect to a plan if the insurer cures the non-compliance in accordance with the requirements of subparagraph (i)(5), which describes the steps that an insurer may take to avoid plan asset treatment with respect to the underlying assets of the insurer's general account.

Pursuant to subparagraph (i)(5), an insurer must have in place written procedures that are reasonably designed to assure compliance with the regulation, including procedures reasonably designed to detect and correct instances of non-compliance. In addition, within 60 days of either detecting an instance of non-compliance or receipt of written notice of non-compliance from a plan, whichever occurs earlier, the insurer must comply with the regulation. Under this cure provision, the insurer would be required to make the plan whole for any losses resulting from the non-compliance. By following the procedure described in subparagraph (i)(5), the insurer could continue to take advantage of the safe harbor provided by the regulation, notwithstanding its initial failure to comply with one or more of the regulation's requirements. The Department believes that giving insurers a limited opportunity to cure their non-compliance and to compensate affected policyholders for any losses resulting from the non-compliance, will both address the concerns expressed by the commentators and continue to protect the interests of the policyholders from expense and unnecessary delays.

#### 10. Effective Date

Proposed paragraph (j)(1) stated the general rule that the regulation is effective 18 months after its publication in the **Federal Register**. Paragraph (j)(2), (3) and (4) of the proposed regulation provided earlier effective dates for paragraph (b) relating to independent fiduciary approval, paragraphs (c) and (d) relating to disclosures, and paragraph (f) relating to insurer-initiated amendments.

Paragraph (j)(2) of the proposed regulation stated that if a Transition Policy was issued before the date which is 90 days after the date of publication of the final regulation, the disclosure provisions in paragraphs (c) and (d) would take effect 90 days after the publication of the final regulation. Paragraph (j)(3) of the proposed regulation provided that paragraphs (c) and (d) were effective 90 days after the date of publication of the regulation for a Transition Policy issued after such date.

Proposed paragraph (j)(4) provided that the effective date for paragraphs (b) and (f) of the proposed regulation is the date of publication of the final regulation in the **Federal Register**. In addition, this paragraph provided a special rule for insurer-initiated amendments which are made during the period between the dates of publication of the proposed and final regulations. The rule provided that, if a plan elected to receive a lump sum payment on termination or discontinuance of the policy as a result of an insurer-initiated amendment, the insurer must use the more favorable (to the plan) of the market value adjustments determined on either the effective date of the amendment or determined upon receipt of the written request from the plan in calculating the lump sum representing the unallocated funds in the accumulation fund.

A number of commentators believed that, in the case of Transition Policies issued after a date that is 120 days after the date of issuance of the final regulations, the initial disclosures may be provided at the time of issuance of the policy. In their view, no other exception to the general 18 month effective date contained in section 401(c)(1) of the Act is appropriate or would allow insurers sufficient time to prepare the necessary disclosure with respect to thousands of previously issued policies to ensure compliance. In addition, the commentators requested that the date required for distribution of annual disclosures (contained in paragraph (c)(4) of the proposed regulation) be extended from 90 days to 180 days following the period to which it relates to allow for sufficient time for the substantial amount of information to be disclosed. Another commentator stated that the earlier effective dates for insurer-initiated amendments do not provide the insurer with sufficient time to implement the changes necessary to be able to comply with the regulation or to be able to determine precisely what constitutes an insurer-initiated amendment.

In the case of a plan electing a lump sum payment, one commentator objected to the proposed paragraph (j)(4) provision that the insurer must use the market value adjustment determined on either the effective date of the amendment or determined upon receipt of the plan's written request, depending on which is more favorable to the plan. The commentator believed that this will create serious and damaging anti-selection potential as the contractholder will have the ability to determine, at its option, the more favorable of the two dates for the determination of the

market value adjustment. To avoid this result, the commentator suggested that the market value adjustment should be determined as of the date the funds are actually withdrawn.

The Department continues to believe that the earlier effective dates for the disclosure provisions are consistent with section 401(c)(3)(B) of the Act, as added by SBIPA, which states that the disclosures required by the regulation be provided after the date that the regulations are issued in final form. In addition, section 401(c)(5)(B)(i) of the Act, as added by SBIPA, provides an exception to the general 18-month effective date for regulations intended to prevent the avoidance of the regulations set forth herein. Thus, the Department proposed an earlier effective date for the provisions relating to the independent fiduciary approval, disclosure and insurer-initiated amendments because the Department believed that the earlier effective dates would protect the interests and rights of a plan and its participants and beneficiaries by minimizing the potential for insurers to change their conduct in ways which are disadvantageous to plan policyholders without compliance with the terms and conditions of the regulation. The Department, therefore, finds good cause for waiving the customary requirement to delay the effective date of a final rule for 30 days following publication.

The Department notes that, because no new Transition Policies can be issued after December 31, 1998, it is no longer necessary to differentiate between Transition Policies issued before and after the date of publication of the final regulation. Therefore, those provisions in proposed subparagraphs (j)(2) and (j)(3) which contain different effective dates based upon the date of issuance of the Transition Policy have been eliminated. In response to a number of comments which indicated that state insurance departments may require that insurers file for approval of amendments to policies, the Department has adopted a new subparagraph (j)(2) which states that the initial disclosure provision and separate account disclosure provision in paragraphs (c) and (d) are applicable six months after publication of the final regulation. The Department believes that a period of six months from the date of publication would allow insurers sufficient time to produce the disclosure materials and seek any necessary state approvals.

Several commentators requested that the Department clarify the applicable date for the initial annual report. The Department has modified subparagraph (j)(3) to provide that the initial annual report required under subparagraph

(c)(4) must be provided to each plan no later than 18 months after publication of the final regulation. Subsequent reports shall be provided at least annually and not later than 90 days following the period to which it relates. In consideration of the comments regarding the harshness of the special rule in subparagraph (j)(4) for insurer-initiated amendments which were made during the period between publication of the proposed and final regulations, the Department has determined to eliminate that provision. The Department has added a new paragraph (k) which contains the effective date for the regulation.

#### 11. Miscellaneous Comments

Several commentators represented that the Department exceeded the scope of its authority with respect to a number of the provisions contained in the proposed regulation. In this regard, the Department notes that section 401(c)(1)(A) of the Act authorizes the Secretary of Labor to issue regulations to provide guidance in determining which assets held by the insurer (other than plan assets held in its separate accounts) constitute plan assets and to provide guidance with respect to the application of Title I of ERISA to the general account assets of insurers. The Department believes that this broad grant of authority to provide guidance authorized the issuance of the regulations proposed by the Department. Accordingly, the Department believes that the commentators' arguments have no legal basis.

A commentator urged the Department to clarify in the preamble to the final regulation that certain "traditional" guaranteed investment contracts (GICs) are guaranteed benefit policies under the Act. In support of its position, the commentator explained that, under a traditional GIC, an insurance company promises to pay a guaranteed rate of interest for a fixed period (*i.e.*, until a stated maturity date) with the rate of interest being a fixed rate (*e.g.*, 6.0% ) guaranteed for the fixed period, or a rate which is periodically reset by reference to an independently maintained index (*e.g.*, LIBOR ). Under this type of GIC, the principal invested is guaranteed to be repaid at maturity, and the rate of return on the amount invested is not dependent on the performance of the assets in the insurer's general account or any other assets. In the Department's view, a GIC containing the above described terms would constitute a guaranteed benefit policy within the meaning of section 401(b)(2)(B) of the Act. In addition, the Department wishes

to take the opportunity to state that no presumption should be drawn, from its determination to provide limited interpretive guidance, regarding the status of other insurance policies under section 401(b)(2)(B) of the Act.

Some commentators expressed concern that an insurer's decision to comply with the conditions in the regulation with respect to certain general account contracts issued to plans would be perceived as a determination that such policies are not guaranteed benefit policies. In this regard, the Department notes that no inference should be drawn regarding the status of any general account contract issued to a plan merely because the insurer has elected to comply with the regulation.

#### **Economic Analysis Under Executive Order 12866**

Under Executive Order 12866 (58 FR 51735, Oct. 4, 1993), the Department must determine whether a regulatory action is "significant" and therefore subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in, among other things, a rule raising novel policy issues arising out of the President's priorities. Pursuant to the terms of the Executive Order, the Department has determined that this is a "significant regulatory action" as that term is used in Executive Order 12866 because the action would raise novel policy issues arising out of the President's priorities. Therefore, the Department has undertaken to assess the benefits and costs of this regulatory action. The Department's assessment, and the analysis underlying that assessment, are detailed below.

The main features of the regulation which cause an economic impact: (1) Provide for greater disclosure to employee benefit plans concerning certain general account contracts with insurance companies; (2) provide, in those cases where an insurance company chooses to comply with the regulation, that some employee benefit plans may receive enhanced termination options; (3) provide insurance companies guidance in determining the circumstances under which a contract with an employee benefit plan will cause the general account to hold plan assets; (4) relieve insurance companies from certain requirements imposed by ERISA if they were to hold plan assets; and (5) provide insurers an opportunity to correct compliance errors with respect to the regulation without facing the full consequences of noncompliance

in terms of being considered to hold plan assets.

The regulation establishes conditions that must be met in order for certain contractual arrangements to not result in the insurer's general account holding ERISA plan assets. Compliance with the regulation is voluntary, except for a general prudence standard. Its economic consequences, therefore, arise only when insurance companies elect to avail themselves of this opportunity, presumably only those insurance companies expecting the benefits of the regulation to exceed its costs.

The Department believes that the benefits of the regulation to insurance companies, although difficult to quantify, will exceed its costs to them, and expects that all insurance companies affected by the *Harris Trust* decision will choose to comply. Because the regulation also provides benefits to plans, participants and beneficiaries, as well as to financial markets generally, while imposing little costs on them, the Department expects that the benefits of the regulation will considerably exceed its costs.

The costs and benefits of the regulation concern "Transition Policies." Transition Policies are general account contracts issued on or before December 31, 1998 which are, at least in part, not guaranteed benefit policies. In particular, the value of the benefit provided is related to the investment performance of the insurer's general account.

The regulation does not apply to general account contracts written after December 31, 1998, and for that reason the Department believes that it causes neither benefits nor costs with respect to those contracts. However, in the absence of the safe harbor provided by this regulation, the costs to an insurance company of any of those contracts which would result in the general account holding ERISA plan assets are so great relative to the benefits that no insurance company will offer general account contracts with nonguaranteed elements.

The regulation will result in a range of benefits that will primarily accrue to parties directly involved in the affected contracts, the insurance companies that have sold the policies and the employee benefit plans that entered into these arrangements. Insurance companies will benefit from the clarity regarding the circumstances in which they will be holding plan assets. This will afford greater flexibility in their efforts to manage the risks associated with engaging in transactions with employee benefit plans and the capacity to more efficiently make investment decisions.

They will also obtain some benefit from the provisions that enable them to correct certain errors that would otherwise result in their holding plan assets.

Employee benefit plans, and by extension the participants who are the beneficial owners of the contracts, will obtain some advantages as a result of the increased disclosure of information that will improve their ability to develop and adjust investment strategies and through potentially more favorable circumstances under which contracts could be terminated. In addition, the regulation will provide some more general indirect benefits to the economy through greater transparency and efficiency in the operation of financial markets.

There will be some expenses incurred by insurance companies to achieve these benefits. The Department perceives these as generally falling into two categories: (1) Expenses associated with fulfilling procedural requirements which represent costs in an economic sense, and (2) expenses that represent payments by insurance companies associated with the liquidation of contracts at levels above what might have been made absent the regulation. The Department views the second category as transfers between affected parties with the expense of one exactly offset by the gain of another and therefore not to be costs in an economic sense.

It has also been suggested that the regulation would impose some indirect costs on insurance companies and employee benefit plans because insurers electing to restructure their contracts to comply with the terms of the regulation would alter the composition of their general account portfolios. Particular attention was focused on the question of insurers hedging their exposure to interest rate movements that might diminish the returns available to the policyholders of general account products. The Department does not interpret this potential outcome as a cost by virtue of the fact that compliance with the regulation is elective and employee benefit plans have access to a range of substitutes for general account products. This enables them to purchase investment products across the full range of risk and return available without regard to products offered by insurance companies.

The Department does not construe the outcome of competition in financial markets by itself to represent economic costs. These outcomes are instead interpreted to be benefits to the extent that regulatory actions enhance the transparency and therefore the



efficiency of markets. Changes in relative market share that may result from enhanced competition are reflective of the reallocation of resources in a manner more reflective of the preferences of market participants and, absent direct evidence to the contrary, to represent efficiency gains.

As is the case with most regulations of this nature, the benefits of this regulation are difficult if not impossible to specifically quantify. Most of the advantages accrue through indirect mechanisms or represent changes relative to a baseline of future behavior and outcomes that cannot be readily observed or predicted. Some elements of the costs are similarly difficult to estimate. Others, primarily the expenses associated with meeting certain procedural or disclosure requirements are more easily estimated. Recognizing these limitations, a more complete discussion of the various elements of costs and benefits relevant to the regulation and specific estimates of the magnitude where feasible is presented below.

#### **Benefits of the Regulation**

The regulation is expected to have significant direct benefits to employee benefit plans. It satisfies the requirement in section 401(c)(2)(B) of ERISA that the interests of employee benefit plans that hold insurance company general account contracts be protected, and thus their participants and beneficiaries, through the requirement of certain disclosure and termination rights. Through mandatory disclosure by insurance companies of information concerning the determination of costs and income from general account contracts, disclosure of the conditions under which termination may occur, and disclosure of information about the financial strength of the insurance company, the regulation will increase the amount of information available to employee benefit plans concerning insurance company general account contracts. The information insurance companies disclose will allow employee benefit plan fiduciaries and participants to fully understand how insurance companies determine the expenses and rate of return they assign to a contract.

Greater disclosure of information will enable employee benefit plans to improve the quality of investment decisions. The complex nature of the insurance products can make it difficult for employee benefit plans to determine the risks associated with contracts backed by insurance company general accounts. With the improved disclosure, employee benefit plans will better

understand the risks associated with general account contracts and the net rate of return they can expect to receive. The enhanced information will increase their ability to manage their portfolios and allocate assets in a manner consistent with the specific needs and circumstances of the plan. Plans making decisions to restructure their asset allocation or change other aspects of their investment strategy will benefit from a clearer explanation of their rights under specific policies. Enhancing the information about the specific attributes of complex financial products will have a positive effect on market efficiency as the purchasers incorporate this information into investment decisions and vendors respond to the resulting competitive pressures.

Expected rate of return, risk and correlation of risks are three elements critical to effective portfolio decisions. The provision of more complete information by insurance companies due to this regulation allows employee benefit plans to better approximate the ideal portfolios that they would choose if they had full information about the financial characteristics of all possible investments.

This benefit of the regulation in principle could be measured by determining the increase in total investment income received on the portfolio the employee benefit plan has, holding constant its level of portfolio risk. This measure of the benefits of the regulation is difficult to quantify because of changing conditions over time in financial markets, so that any change in portfolio rate of return may be due to other factors. A further complicating factor is that the provision of more detailed information may also cause employee benefit plans to change the amount of risk they wish to hold. It is difficult to assess the value to plans of having better information about the financial risks associated with these contracts.

The termination provisions are another major source of benefits from the regulation to employee benefit plans and their participants. The termination provisions in the regulation may require insurers to give additional rights to employee benefit plan policyholders that their general account contracts did not previously contain. For many general account contracts, the regulation will liberalize payout options for employee benefit plans beyond those that were previously available. For other general account contracts, it will create new payout options. The termination provisions provide at least three benefits. First, the termination provisions allow employee benefit plans

to terminate general account contracts that contain provisions or changes in provisions they view as unfavorable. Second, the termination provisions may discourage some insurance companies from making unilateral contract changes that are adverse to employee benefit plans. Third, the termination provisions provide greater liquidity that allows plans to adjust to changing financial market conditions. A discussion of these three benefits of the termination provision follows.

First, employee benefit plans will benefit from the regulation by being able to terminate a general account contract if an insurance company unilaterally modifies such a contract to the detriment of the employee benefit plan. The termination provisions considerably enhance the value to employee benefit plans of the disclosure provisions since they increase the range of actions that can be taken as a result of better information being disclosed. Thus, the regulation gives employee benefit plans greater protection against unilateral action taken by insurance companies.

A second benefit of the termination provisions to employee benefit plans is that those provisions will discourage insurance companies from making some contract changes that are detrimental to the interests of employee benefit plans that they would otherwise make.

A third benefit of the termination provisions is that they provide employee benefit plans increased liquidity in their general account contracts. If an employee benefit plan faces an unanticipated expense and is forced to terminate its general account contract to obtain cash, the plan may be able to do so under more favorable conditions. In some cases, the plans will receive greater proceeds from a contract liquidation. For lump sum payouts, this is because the regulation requires that positive market value adjustments be given where they would not otherwise have been prior to the effective date of the regulation. Also for structured payouts, a minimum crediting rate that is also higher than some contracts provide is required. The choice of two payout options provides increased flexibility to many employee benefit plans.

The increased liquidity provided by the termination provisions also allows employee benefit plans to profit from changing conditions. For example, a change in interest rates may cause an employee benefit plan to adjust investment strategies. The regulation may permit the plan to terminate its general account insurance contract and

move its funds to the more attractive alternative.

The value of the benefit to employee benefit plans derived from the enhanced ability to terminate contracts following unilateral contract amendments by insurance companies is difficult to quantify. Plans will not be forced to accept contract modifications that they view as undesirable. The value of this benefit depends on the frequency that such modifications would occur and the value placed on this protection by employee benefit plans. The value of the benefit to employee benefit plans of discouraging some contract modifications by insurance companies is also difficult to quantify because there is no reliable way to estimate the number of contract modifications with adverse implications for plans that would otherwise occur.

As well as providing benefits to employee benefit plans and their participants and beneficiaries, the regulation provides benefits to insurance companies. The most significant of these results from the ability of insurance companies to expand the universe of investments that otherwise would be prohibited. In the absence of the regulation, with insurance companies holding plan assets in their general accounts, some investments would not be possible because they would involve potential self-dealing and conflicts of interest.

The regulation may provide significant benefits to insurance companies because it clarifies and mitigates the constraints imposed by ERISA on the operation of insurance company general accounts. It does so by providing that insurance companies that comply with the specific requirements of the regulation will receive some assurance that their general accounts do not contain plan assets. Insurance companies thus could have reduced litigation costs and liabilities with respect to their general accounts. They will be shielded from the fiduciary responsibility and prohibited transactions rules under ERISA that would otherwise apply to them as a result of the *Harris Trust* decision.

Because of the retroactive effect of the Supreme Court decision, numerous transactions by insurance company general accounts may have violated ERISA's prohibited transaction and general fiduciary responsibility provisions. Without the safe harbor the regulation affords, some insurance companies would be liable under part 4 of Title I of ERISA as a result of the operation of their general accounts.

This regulation provides insurance companies the benefit of reduced

uncertainty concerning the application of ERISA. Some insurance companies may be uncertain as to whether the general account contracts they have with employee benefit plans are affected by the *Harris Trust* decision. This uncertainty arises primarily from what constitutes a guaranteed benefit policy.

The value to insurance companies of less uncertainty arises in part through lower fees they would pay to attorneys and other benefits specialists to try to resolve the uncertainty. Also, insurance companies may be overly conservative in attempting to avoid holding ERISA plan assets. The lowering of risk in this regard will allow insurance companies to pursue business they might otherwise avoid.

The cure provision in the regulation is an additional source of benefits. Insurance companies under certain circumstances can correct certain errors in compliance with the regulation without causing the company to hold employee benefit plan assets. This feature of the regulation greatly reduces the risk of an inadvertent failure of an insurer to comply with the regulation that would result in them holding plan assets.

This cure provision should reduce the likelihood of litigation between employee benefit plans and life insurance companies. The ability to correct errors without incurring the risk of future liability should reduce the incidence of noncompliance and substantially reduce costs for insurance companies to correct inadvertent errors.

The value of the benefits arising from the cure provision are positive but impossible to accurately measure. They will depend on the extent that insurance companies make inadvertent or good faith errors and then use the cure provision to correct them. The level depends on the cost to insurance companies of correcting the errors under the regulation in relation to what would have otherwise occurred. The cure provision also affords benefits to employee benefit plans because it reduces the likelihood of failure to comply with the regulation. This is similarly impossible to quantify.

The value of these benefits to insurance companies should be substantially shifted to employee benefit plans over time through a higher net rate of return received on life insurance company general account contracts so long as insurance companies remain competitive. This will increase the investment income of defined benefit plans holding those contracts. An increase in investment income will over the longer term lead to either a reduction in contributions required or

allowed by plan sponsors or to an increase in benefits. A reduction in contributions by plan sponsors would reduce their corporate income tax deductions and raise their corporate tax payments. Increased benefits will result in higher taxable income received by beneficiaries.

The regulation will have a relatively small but positive benefit to the Federal government, and thus taxpayers, by reducing the need for employee benefit investigation, enforcement and litigation activities of the government. By reducing the number of violations of ERISA through compliance with the safe harbor provisions of the regulation, and by providing through the cure provision the incentive for insurance companies to self-correct minor compliance problems, investigation, enforcement and litigation expenses of the government may be reduced.

As well as the direct benefits discussed above, the regulation has indirect benefits through improved functioning of financial markets. The indirect benefits are positive externalities that benefit all participants in financial markets through the greater efficiency of the functioning of those markets. The positive externalities are benefits received by parties other than insurance companies and employee benefit plans, participants and beneficiaries. With more efficiently functioning capital markets, capital is directed to its best use, which benefits not only the investor but also enterprises seeking investors. Thus, this is a benefit to the economy at large. The termination provisions of the regulation also provide positive externalities in that by providing greater financial market liquidity, there is freer movement of capital so it can be applied to its best use.

### Costs of the Regulation

As with the benefits, the costs of the regulation are both direct and indirect. Direct costs should fall nearly exclusively on insurance companies rather than on plans, participants and beneficiaries. Although, some commentators have argued that there may be indirect costs to the economy through effects on the functioning of capital markets, as discussed in more detail below, the Department believes those costs to be insignificant or nonexistent.

Three types of direct costs are relevant. Insurance companies will bear some costs that are effectively transfers to plans. While these may be viewed as costs in the accounting sense, they result in little or no net cost to the economy, as the cost to the insurance

company is exactly offset by the benefit received by the employee benefit plan.

Second, there are direct costs that arise because insurance companies undertake certain activities in order to fall within the requirements of the regulation. These will primarily take the form of increased payments to service providers or insurance company employees. These type of costs represent costs in both an accounting as well as an economic sense and are the primary burden imposed by the regulation.

A third type of cost are those potentially associated with a distortion of economic activity. These also represent a net cost to the economy. Typically these distortions are associated with taxation. Distortions can also potentially result from government regulations requiring activities or expenditures which exceed the associated benefits.

Insurance companies will incur administrative costs due to the disclosure and termination requirements. To comply with increased disclosure requirements, they will incur costs to prepare and distribute the annual statement to employee benefit plans explaining the methods by which income and expenses of the insurance company's general account are allocated to the policy. To minimize these costs, the regulation requires disclosure of materials that are prepared for other purposes. One time only administrative costs will be incurred by insurance companies to modify contracts so that they will comply with the regulation and to file revised contracts with state regulatory authorities.

The enhanced options for employee benefit plans to terminate their contracts will create administrative costs for insurance companies in that they will be discouraged from making some unilateral contract modifications they otherwise would make. The magnitude of this cost to insurance companies is difficult to quantify because the number and effect of contract modifications that will be discouraged from occurring is not readily determinable. This cost to insurance companies is largely a benefit to employee benefit plans and participants and beneficiaries.

Some commentators have argued that the regulation will impose costs on insurance companies in financial markets. Because the termination options will permit some contracts to be terminated earlier than otherwise, insurance companies may adjust the investments in their portfolios. The increased probability of early termination shortens the period over which the preponderance of payments

are made. To the extent that insurance companies attempt to match the timing of their receipts and payouts, they will shorten the timing of their receipts.

Insurance companies with a significant percentage of affected funds in their general account may make fewer long maturity investments and private placements. Long maturity investments are investments where the preponderance of the payments are received relatively far into the future. Private placements are investments that are not publicly traded on financial market exchanges. They may reduce those investments due to their needs for reduced maturity and greater liquidity of investments because of the increased probability of early termination of general account contracts. Both of these changes in maturity of investments and in private placements would reduce the expected rate of return on their portfolios. Lower maturity investments generally receive a lower rate of return than longer maturity investments. Private placements tend to have relatively low liquidity because they are not publicly traded. Liquidity is a desirable aspect of investments and therefore investors must pay a price for it in terms of lowered rate of return. The termination requirements may also cause insurance companies to incur costs in determining the market value of some assets that are not publicly traded, such as private placements. These costs will discourage investments in those types of assets because they will reduce the net rate of return (after costs) on those investments.

Because of the sophistication of capital markets, with a large number of competent purchasers and sellers, any initial effect on capital markets due to insurance companies changing their portfolios and their investment strategies probably would be offset by a re-allocation of investments among investors. If insurance companies reduce their investments in a certain class of assets, the price of those assets will fall due to the reduced demand for the investment, which will raise the rate of return on that investment. The lowered price and increased rate of return will motivate other investors to invest in those assets, which will in turn drive the price up towards its original level. One time only transaction costs will be incurred by insurance companies and other investors as they adjust their portfolios. These costs are primarily fees paid to other financial institutions to transact sales and purchases.

The cure provision creates administrative costs for insurance companies that choose to use it because

they are required to establish administrative procedures to detect and correct failures to comply with the regulation. Costs will be incurred in terms of staff time required for creating and maintaining these procedures. These costs are largely quantifiable in terms of specific actions that are required, with the cost of those actions being estimable.

While the increased administrative costs are borne initially by insurance companies choosing to comply with the regulation, they may be shifted at least partially through a reduced rate of return net of expenses to employee benefit plans and then to participants, and to other investors who have contracts supported by the general accounts of those companies. A reduction in the net rate of return received on the general account portfolio may be passed on to employee benefit plans having contracts with participating features. Whether that occurs may be a business decision made by insurance companies depending on the competitive pressures they face or may be determined by their contracts. It may also reduce the rate of return insurance companies offer on new contracts. The extent to which they do that depends in part on the competitive pressures faced by insurance companies. It should be noted again in this context that new contracts will not be covered by the regulation.

These effects on the rate of return received by insurance companies on their general account portfolios generally will be small. For most insurance companies the percentage of general account assets affected is small and thus the effect on the insurance company's portfolio rate of return, which is proportional to the share of those assets in the general account portfolio, is also small. The effects on employee benefit plan rates of return is further diminished to the extent that plans hold other investments. The effect on participants may be even further reduced to the extent that employee benefit plan sponsors bear the effects that are shifted to employee benefit plans.

Employee benefit plans can offset lower risk and expected return from their insurance contracts by increasing the risk and expected return of their other investments. They may also reduce their investments held with insurance companies and shift funds to other financial intermediaries. If these changes are made, there may be no effect on the expected portfolio rate of return for employee benefit plans.

## Cost Estimates

The following are the Department's estimates of the potential costs associated with the regulation. The Department's analysis is responsive to the public comments received on the economic impact of the proposed regulation that focused on the potential costs attributable to the regulation. This discussion also reflects additional analysis by the Department in response to changes to the substantive provisions of the regulation and the availability of more recent data.

### Direct Costs

The direct costs associated with the regulation are attributable to the disclosure and termination requirements. The discussion that follows provides details of the direct costs associated with the regulation.

#### 1. Impact on the Insurance Industry—Amount of Assets Affected

In connection with its publication of the proposed regulation, the Department solicited comments from the interested public regarding the economic impact of the proposed regulation. Specifically, the Department requested current data on the number and characteristics of potentially affected insurance contracts that would provide the basis for a more extensive analysis of the costs and benefits of the proposed regulation.

The Department received a few comments which disagreed with its estimate of the value of the accounts potentially affected by the regulation of \$40 billion in 1994 (slightly less than 3 percent of general account assets). These comments provided limited data on the number of potentially affected insurance contracts. For example, one commentator estimates that based on their reading of the 1997 Life Insurance Fact Book (1996 data), the total value of contracts potentially affected by the regulation is \$261.8 billion (15.4 percent of general account assets). It appears that this estimate includes the allocated portions of general account group insurance contracts, whereas the Department excludes the allocated portions of group annuity contracts from its estimates. Allocated group annuity contracts are excluded because the benefits from the contracts are guaranteed and the employee benefit plans do not participate in the risk associated with those contracts. Representatives of the insurance industry estimated for 1996 that the amount of unallocated assets that would be affected by this regulation was approximately \$100 billion (6.7 percent of general account assets).

In response to these comments, the Department asked the insurance industry to provide specific information on the amount of affected assets. The industry declined to provide the information, contending the proprietary nature of the data. As an alternative data source the Department used information reported on the Form 5500 reports and attached Schedule A's filed for the 1995 plan year. The Schedule A attachment is required to be filed for all pension plans holding insurance contracts with unallocated funds. Both the amount of unallocated funds and the name of the insurance carrier issuing the policy are reported on the Schedule A. While the manner of reporting unallocated funds held in insurance policies does not enable a precise determination of whether the policies are Transition Policies or other types of policies, the Department believes that reasonable estimates can be derived from the data. Using Form 5500 data, the Department revised its earlier estimates of the amount of assets potentially affected by the regulation and the distribution of those assets within the life insurance industry. The Department now estimates between \$80 and \$98 billion (between 5.8 and 7.1 percent of general account assets) would have been potentially affected by the regulation in 1995. The Department believes that this estimate comports with that provided by the representatives of the insurance industry.

For the 1995 plan year, a total of 123,567 Schedule A reports were filed by pension plans reporting assets held in contracts with unallocated funds that appear to be used to pay benefits or purchase annuities. It is the Department's belief that these policies are most commonly immediate participation guarantee (IPG) contracts, in which the value is directly related to the investment performance of the insurer's general account. These contracts will therefore meet the definition of a Transition Policy. The total amount of assets reported in Schedule A for these types of contracts was \$98 billion.

The following discussion explains how the figures of between \$80 and \$98 billion were determined. The Schedule A is used both for the reporting of assets in accounts used to provide benefits and for the reporting of assets in accounts used solely for investments. The Schedule A does not have a specific identifier for the type of policy being reported. Contracts were assumed to be purely investment contracts if the Schedule A showed no assets disbursed to pay benefits or purchase annuities during the year and the Form 5500

report indicated that all plan benefits were either paid from a trust or, in the case of a defined contribution plan, were paid through a combination of a trust and insurance carrier.<sup>12</sup> These filings were excluded from the analysis based on the assumption that they are most likely to be guaranteed investment contracts and would therefore not meet the definition of a Transition Policy. The remaining Schedule A's fell into two categories:

(1) If a Schedule A showed funds being disbursed from the account to pay benefits or purchase annuities or the Form 5500 report indicated that all benefits were provided through an insurance carrier, then the funds reported in Item 6 of the Schedule A were assumed to be held in policies meeting the definition of a Transition Policy. The total amount of such funds in 1995 was \$80 billion. This amount was used as the lower bound for estimating total general account assets held in Transition Policies.

(2) If a Schedule A showed no assets disbursed to pay benefits or purchase annuities and the Form 5500 report indicated that the plan was a defined benefit plan and benefits were paid both through the trust and an insurance carrier, then the type of contract funds reported in Item 6 of Schedule A was categorized as undeterminable. The total amount of such funds was \$18 billion.

The \$18 billion estimate of funds in the undeterminable category, combined with the \$80 billion in general account funds determined to be used to pay benefits, was used as the upper bound for estimating total general account funds in Transition Policies. There is no way of accurately estimating how much of the \$18 billion in the undeterminable category was held in Transition Policies. Therefore, in estimating the total amount of funds held in Transition Policies, the entire \$18 billion was added to the lower bound of \$80 billion to provide a total estimate of \$98 billion held in Transition Policies.<sup>13</sup> This

<sup>12</sup> It appears that defined contribution plans which check that benefits are provided through both a trust fund and an insurance carrier and which attach a Schedule A are generally trust funded plans (with investments in insurance products) that commonly offer participants the choice of a lump sum distribution or an annuity. For participants choosing the latter form of payment, the value of the participant's account is used to purchase an individual annuity. Thus, it was assumed that the assets reported on Schedule A were in investment accounts rather than Transition Policy accounts used to provide benefits.

<sup>13</sup> The DOL had developed an earlier estimate of \$40 billion held in Transition Policies. This estimate was based on data reported in Item 31c(16)—(Value of funds held in insurance company general account) and Item 32e(2)—(Payments to insurance carriers for the provision of

amount is in line with the \$100 billion estimate provided by the representatives of the insurance industry.

One commentator disagreed with the Department's use of an industry average, *i.e.*, slightly less than 3 percent of general account assets, to demonstrate the percent of total contracts potentially affected by the regulation. The commentator stated that this is inappropriate because many insurers have a significantly higher proportion of assets supporting contracts potentially affected by the regulation than the Department's estimate in the proposed regulation for the industry as a whole. In its re-estimate of the amount of assets affected based on the most recent complete Form 5500 data available (1995), the Department determined that approximately 104 insurance companies each managed \$25 million or more of private pension plan unallocated assets in insurance company general accounts and about 63 of those insurance companies managed \$100 million or more in such accounts.

To estimate the impact of the proposed regulation on both the insurance industry as a whole and on individual companies within the industry, the ratio of funds in Transition Policies (as reported on Schedule A of the Form 5500 series) to an insurer's general account funds was computed. This is one of a number of reasonable measures of insurer net exposure that could have been chosen. For example, the ratio of funds in Transition Policies to insurer net worth would be another reasonable measure.

The ACLI reports that at year-end 1995, a total of \$1.683 trillion was held in the general accounts of life insurance companies.<sup>14</sup> In order to estimate the total value of general account assets in the 104 companies which have issued Transition Policies with a total value of \$25 million or more, data from the 1996 and 1998 editions of the Best Insurance Reports and Standard & Poor's Claims-Paying Ability Reports were used along with information provided by insurance representatives. For a few companies for which data were not available from the above two sources, telephone calls were made to the companies to obtain general account asset information. The general accounts of these 104 companies in 1995 were estimated to be \$1.372

trillion. The \$98 billion estimated as held to support Transition Policies by the 104 companies represent 7.1 percent of total general account assets.

The percentage of general account assets held to support Transition Policies varied widely among insurance companies, ranging from a low of 0.1 percent to a high of 44 percent. For 74 percent of the companies (77 companies), the assets held in support of Transition Policies made up less than 10 percent of total general account assets. For 13 percent of the companies (14 companies), assets held in support of Transition Policies made up from 10 to 19 percent of total general account assets, and for the remaining 13 percent (13 companies), assets in Transition Policies made up 20 percent or more of general account assets, with a maximum percentage of 44 percent.

The Department estimates that the proposed regulation will have a significant impact on the 13 companies in which assets held in Transition Policies (as reported on Schedule A of the Form 5500 series) exceed 20 percent of the insurer's general account assets. While any threshold measure of impact is, to some extent, arbitrary, we believe that the 20 percent level is a reasonable measure, given the estimated costs of bringing contracts into compliance and any increased exposure represented by required changes in policy termination provisions.

## 2. Costs of Compliance

Insurance industry representatives disagreed with the Department's estimate of the aggregate cost of compliance with the proposed regulation of no more than \$2 to \$5 million per year, indicating that they believe the costs will be a significant multiple of this estimate. However, these insurance industry representatives indicated that they did not have specific information as to the aggregate cost of compliance with the regulation. The representatives did not provide any analysis of the sources and methodologies used to derive their cost bases. Thus, the Department could not replicate these estimates.

The Department now estimates based on the cost estimates provided by 6 insurance companies and from Form 5500 series reports that the average annual aggregate costs over the first 10 years of compliance with the regulation to be approximately \$37 million (initial costs plus the annual costs over 10 years divided by 10 years). This estimate includes initial costs to insurers for reviewing the language in current contracts concerning termination provision, drafting policy riders or

amendments, and mailing new policies to policyholders of \$1.7 million. The estimate also includes the initial cost to insurers of preparing the initial disclosure statement to give to employee benefit plans of \$52.7 million and an annual cost for disclosure in subsequent years of \$37 million. The basis for these estimates is provided in the Paperwork Reduction Act section of this preamble.

## Disclosure Provisions

The Department received several comments regarding the disclosure provisions in the proposed regulation. In response to these comments, the disclosure provisions have been modified in the final regulation, thus clarifying the requirements and reducing any potential burdens associated with these provisions. For example, the Department limited the disclosure requirements to those items relevant to the policyholder's ability to withdraw or transfer funds under the policy. In addition, the Department eliminated the requirement that the insurer make available upon request of a plan copies of the documents supporting the actuarial opinion of the insurer's Appointed Actuary. The Department has determined that these changes have no significant impact on the costs associated with the regulation.

## Termination Provisions

The proposed regulation included two forms of termination payment that would be available to transition policy holders—a lump sum payment with a market value adjustment and a book value payout, in essentially equal installments, over a period of no more than five years calculated using an interest rate of no less than 1 percent less than the rate currently crediting on the policy at the time of termination. The final regulation also includes the two forms of termination payment but, in response to comments received, lengthens the period for book value payouts to over no more than ten years and with a crediting rate of no more than 1 percent less than the current crediting rate. The Department based this change on a New York state insurance regulation. The New York regulation serves as the Department's model because most insurers of group annuity contracts are licensed to do business in New York. That regulation has applied since 1987 to insurers licensed to do business in New York. The New York regulation requires that unallocated group annuity contracts issued after 1987 provide that the policyholder can terminate the contract and receive either a lump sum payment with a market value adjustment or a

benefits) of the 1994 Form 5500 reports alone and did not make use of Schedule A data. The use of the Schedule A attachment in combination with data reported on the Form 5500 allows for a much more refined estimate to be developed, particularly for small plans which do not separately report assets held in insurance company general accounts.

<sup>14</sup> "1996 Life Insurance Fact Book," American Council of Life Insurance, p. 89.

book value payout over no more than 10 years (including a 5 year payout option) with a crediting rate no less than 1.5 percent less than the current crediting rate.

For many group annuity contracts, the regulation will liberalize payout options that were previously available. For other contracts, it will create new payout options. These changes will have two principal effects: (1) In situations where contracts did not previously allow for a positive market value adjustment, they will increase payouts to some terminating group annuity policyholders, thus transferring value from insurance companies or their continuing policyholders to pension plans which terminate their arrangements, and (2) they will tend to change the investment policies for the assets supporting group annuity contracts because of the increased likelihood of early terminations of contracts, in particular shortening the maturity structure and shifting the asset mix toward a larger portion in marketable securities.

While the transfer of value in situations where contracts did not previously allow for a positive market value adjustment, may result in a loss to some insurance companies, at the level of the economy as a whole that effect will be offset by gains to some pension plans. The ultimate distributions of the burden and gain are difficult to determine. The gain may be realized by plan participants or shareholders of firms sponsoring pension plans and the loss borne by shareholders of insurance companies or by other purchasers of life insurance products. While any increase in an insurer's liabilities may increase the probability of a future insolvency, the Department is unable to quantify this effect. It believes, however, that those insurers for whom this regulation has the greatest impact will aggressively seek to lessen the effects on their financial structures by appropriate asset/liability matching techniques.

The decrease in insurers' group annuity liability duration is likely to trigger changes in the way insurers manage the assets supporting those contracts. That response is likely to take the form of shifting to assets that are less sensitive to interest rate changes (*i.e.*, assets with shorter durations). Life insurers will also likely shift their investments to assets with greater liquidity.

Many of the analyses supplied by the insurance industry in response to the proposed regulation assumed insurers would shorten their asset structure to correspond to the interest rate sensitivity of a 5 year payout of the book

value of their Transition Policies. Under the final regulation, a similar analysis would imply that insurers will shorten their asset structure to correspond to the interest rate sensitivity of a 10 year payout of the book value. The 10 year option would imply a small shortening of insurers' liabilities and thus probably of their assets. The shortening of the duration of assets would imply, under most circumstances, a decrease in portfolio rates of return. The 10 year option would require a relatively small reduction in the duration of the group annuity portfolio for most insurance companies. Because the yield curve for bonds with respect to maturity is usually fairly flat in the relevant range of maturities, the difference in the rates of return associated with such restructuring is fairly small. Thus the decrease in the portfolio rates of the return would be generally far smaller than the industry estimates of 50 to 100 basis points that were derived based on the 5 year book value payout required by the proposed regulation.

Some commentators have argued that plans will terminate contracts to take advantage of the upward market adjustments or the difference in value between the two termination payout options. The Department believes that few such terminations will occur because other contractual features, such as guaranteed annuity purchase rates, also have value. In addition, long-established business relationships are valuable and Transition Policy contract holders will attempt to negotiate mutually beneficial agreements for continuing relationships.

Further, as indicated earlier, New York state insurance regulation requires for recently issued unallocated group annuity contracts issued by insurers licensed to do business in New York termination provisions similar to those of this regulation. Most of the major issuers of group annuity products are licensed to do business in New York. The Department notes that while there has been more than a decade of experience with the New York regulation, no written or oral testimony was submitted to indicate that experience with respect to termination of such contracts differs from that of other contracts with less favorable termination provisions.

#### Cure Provision

As described earlier in this preamble, the Department has added a cure provision to the final regulation in response to public comment. This cure provision would allow insurers that have made reasonable and good faith efforts to comply with the requirements

of the regulation up to 60 days from either the date of the insurers' detection of the problem or the date of the receipt of written notice of non-compliance from the plan to comply with the requirements of the regulation. In addition, interest must be credited on any amounts due the policyholder on termination or discontinuance of the policy if not paid within 90 days of receipt of notice from the policyholder.

In order for an insurer to make use of the cure, it must have established written procedures that are reasonably designed to assure compliance and to detect instances of noncompliance. While the Department is unable to quantify the benefit of the cure provision, it is anticipated that the cure provision will allow insurers to avail themselves of the protections of the regulation with somewhat greater administrative flexibility. Although there may be certain expenses associated with the establishment of written compliance procedures, the Department believes that many insurers would implement such procedures as part of their usual management practices, and would satisfy the conditions for use of the cure only if the provision offered a net benefit to the insurer.

#### Indirect Costs

The indirect costs associated with the regulation are negative effects of the regulation on the functioning of capital markets. Some commentators have argued that the regulation will affect long-term lending and the availability of capital in the national economy. The discussion that follows provides details of the indirect costs associated with the regulation.

#### Effect on Long-Term Lending and the Availability of Capital in the National Economy

Several commentators have argued that a shortening of insurers' portfolios (reducing the investment duration of debt holdings) would reduce the overall amount and raise the price of long-term lending in the economy. They further assert that insurers are one of the major providers of long-term capital, and that if insurers choose in the future to invest more of their portfolios in shorter term debt securities, the effect could be a significant reduction in the amount of capital invested in long-term projects overall.

They support their premise by reporting that the total dollar figure of insurance industry investment in long-term corporate debt is \$531 billion dollars as of year end 1996 (\$885 billion invested in corporate debt of which 60

percent is long-term). This figure is minimal when considered in terms of the total long-term debt outstanding in the capital markets.

The Department disagrees with the commentators' above assessment of the impact of the insurance industry's investment in long-term securities. According to a recent Federal Reserve statistical release titled, "Flow of Funds Accounts of the United States, Flows and Outstanding, Third Quarter 1998," life insurance and other insurance companies provide a relatively small proportion of total capital compared to other major participants in the economy. Of the \$22.630 trillion Total Credit Market Debt<sup>15</sup> Outstanding at September 30, 1998, Life insurance and Other insurance companies holdings represented a total of \$2.342 trillion, or 10.35 percent of the total market. While this report does not specify what percentage of the \$2.3 trillion are in general account assets, nor break out the debt holdings by maturity, the general information does help to present a broad and balanced picture of the insurance industry's influence on the long term debt and private placement markets, when analyzed in conjunction with statistics available from other sources.

Regarding the potential effects on the availability of financing for small business entities and on the private placement markets, further comments are addressed in the Regulatory Flexibility Act section of this preamble.

#### **Paperwork Reduction Act**

The Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3507(d)(2), and 5 CFR 1320.11(f) require Federal agencies to publish collections of information contained in final rules for the public in the **Federal Register**. Modifications have been made to the collection of information that appeared in the Notice of Proposed Rulemaking (NPRM). These modifications are in response to comments received to the NPRM and reflect the availability of more recent Form 5500 data. The basis for these modifications is described in detail in the Economic Analysis section of this preamble.

The Department of Labor submitted the information collection as modified to the Office of Management and Budget (OMB) for its review in accordance with 44 U.S.C. 3507 (d) and OMB has

approved the information collection request included in this final rule under control number 1210-0114.

**Estimated Reporting and Recordkeeping Burden:** The Department estimates that there are approximately 123,500 Transition Policies for private employer pension plans currently in effect. These policies have been issued by an estimated 104 different insurance companies. While the burden on the pension plans holding Transition Policies is expected to be minimal, the final regulation will impose costs in the following two areas on insurance companies which have issued Transition Policies:

(1) The regulation would require that policies provide that a policyholder must be able to terminate or discontinue a policy upon 90 days notice to an insurer. The policy must also offer the policyholder the option to select either a lump sum payment or a series of installments over a period of no more than ten years. Insurance companies that have policies not already in compliance with these requirements will incur costs in preparing riders or amending these policies and in providing copies of these riders or amendments to policyholders.

(2) The regulation would require that insurers disclose to each policyholder certain information, including the methods used by the insurer to allocate any income and expenses of the insurer's general account to the policy during the term of the policy and upon its termination. Disclosure would consist of an initial statement to the policyholder, either as part of the amended Transition Policy, or as a separate written document, and an annual statement to the policyholder as long as the Transition Policy is in effect. The direct cost of compliance will be borne by the 104 insurance companies estimated to have Transition Policies and is as follows:

#### **1. Policy Statement**

The insurance industry has indicated that the relevant contracts typically already permit the termination and withdrawal of plan assets. The final regulation will require they change any policies in which the language of the provision on the right of the policyholder to terminate the contract does not meet the minimum requirements of the regulation. Each insurance company affected is expected to develop a standard statement to be added to or to replace the existing termination provision in each contract. The Department estimates that a total of 40 person hours of professional time per insurance company will be required to

review whether existing policy termination provisions meet the proposed requirements and, if not, to develop a standard termination statement. Total estimated time for all affected insurers would be 4,160 hours (104 insurers  $\times$  40 hrs.)

The Department assumes that one-half of all policies will require a statement on termination rights of the policyholder to be added in place of existing language. Insertion of the statement into each policy and the mailing to policyholders is estimated to require  $\frac{1}{2}$  hour per policy, or a total of 30,875 hours (61,750 policies  $\times$   $\frac{1}{2}$  hr.). We assume that the average of  $\frac{1}{2}$  hour per policy would be split evenly between professional and clerical staff.

For purposes of estimating total costs to insurers of reviewing the language in current contracts and drafting policy statements, the costs of professional staff time are estimated to be \$75 per hour and the costs of clerical staff time are estimated to be \$12 per hour. Costs are therefore estimated to be \$312,000 (4,160 hrs.  $\times$  \$75) to develop a standard termination statement and \$1.3 million (30,875 hrs.  $\times$  \$43.50 (average of the \$75 per hour professional rate and the \$12 per hour clerical rate)) to insert the statement into each contract and mail the contracts to policyholders. Mailing costs are estimated at \$.50 per policy, or a total of \$30,875 (61,750 policies  $\times$  \$.50). Total costs to insurers would be approximately \$1.7 million.

#### **2. Disclosure Statements**

The documentation needed by each insurer for the disclosure material should currently exist, either as data prepared for other reporting requirements or as data needed for internal computations by the insurer to allocate income and expenses. However, the time needed by each insurer to collect and incorporate the data into disclosure packages is expected to vary widely among insurers. While only one standard disclosure statement will likely be needed for prototype contracts, data for some individualized contracts will have to be customized on a contract-by-contract basis. Insurers with a large number of individualized policies will require more time to prepare the disclosure material than insurers making use of prototype contracts for all or most of their policies. The time needed and costs to develop the initial and annual statements are therefore dependent upon both the total number of policies and the number of individualized policies.

In response to the Department's request for information regarding the costs and benefits of the proposed

<sup>15</sup> As Defined in Table L.1, Credit Market Debt includes these federal government securities: mortgage pool securities, U.S. government loans, and government-sponsored enterprise securities, and these private financial sector instruments: open market paper, corporate bonds, bank loans (not elsewhere classified), other loans and advances, and mortgages.



regulation, cost estimates to meet the proposed disclosure requirements were provided for 6 insurance companies. These cost estimates varied. Most of the estimates broke out the costs into three components: The costs of preparing the initial statements; the costs for system changes to facilitate the development of annual statements; and the ongoing costs of preparing the annual statements.

The data provided on total insurer costs, together with Department estimates from Form 5500 reports on the total number of policies for each of the 6 insurers providing the cost data, were used to estimate the average costs per policy of the disclosure statement. The estimates for providing the initial disclosure among the 6 insurers ranged from a low of \$68 per policy to a high of \$1,962 per policy. The average cost per policy was \$427. The average of \$427 per policy times the estimate of 123,500 policies yields an estimated total cost for the initial disclosure statement of \$52.7 million. This amounts to .05 percent of the total asset value of the policies.

Ongoing cost estimates for the annual disclosure statements ranged from a low of \$21 per policy to a high of \$1,226 per policy. This reflects both the direct annual costs estimated for the disclosure statements and the estimate for the costs of system changes, amortized over a 10-year period. The average annual cost for the 6 companies was \$283 per policy. Total annual costs would be \$35 million. (This annual cost estimate assumes that no policies are terminated.)

The combined costs for the policy statements and the disclosure statements are estimated to be \$54.4 million in the initial year following adoption of the regulation and \$35 million in each succeeding year.

The cost data provided by the six insurance companies did not include any estimates of the hourly burden involved in preparing the disclosure statements. The Department assumes that the preparation of the statements will require professional staff time. Based on an average of \$75 per professional staff hour, the total hour estimate for preparing the initial disclosure statement will be 702,667 hours (\$52.7 million/\$75 per hour). Total estimated combined hours for the policy statements and disclosure statement in the initial year will be 737,702 hours (35,035 hours for policy statements plus 702,667 hours for disclosure statements). Total estimated hours in each subsequent year for the annual disclosure statement would be 466,667 hours (\$35 million/\$75).

Representatives of the insurance industry indicated that based on a survey of 14 member companies, the cost per company of creating the initial disclosure information would be \$7,600,000. However, unlike the estimates of the six insurance companies, the basis for this estimate was not disclosed. Therefore the Department was unable to factor this estimate into its calculations.

The Department appreciates the comment informing us that contracts may be customized and that our earlier estimates did not take into account this customization. However, the Department disagrees with commentators' contention that our estimates did not account for the costs of preparation and distribution of standardized disclosure forms. More accurately, the Department's current estimate reflects the fact that some contracts allow for standardized disclosure and others must be customized on a contract-by-contract basis. In addition, the current analysis takes into consideration the Department's modifications to the disclosure requirements outlined earlier.

Respondents to these new information collection requirements are not required to respond unless this collection displays a currently valid OMB control number.

### Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA), imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and likely to have a significant economic impact on a substantial number of small entities. If an agency determines that a final rule is likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

PWBA has conducted a final regulatory flexibility analysis which is summarized below.

(1) PWBA is promulgating this regulation because it is required to do so under section 1460 of the Small Business Job Protection Act of 1996 (Pub. L. 104-188).

(2) The objective of the regulation is to provide guidance on the application

of ERISA to policies held in insurance company general accounts. The legal basis for the regulation is found in ERISA section 401(c); an extensive list of authorities may be found in the Statutory Authority section, below.

(3) The direct cost of compliance will be borne by insurance companies. As noted in the proposed regulation, the Department estimates that no "small" insurance companies (as defined by the Small Business Administration at 61 FR 3280, January 31, 1996) offer the types of policies regulated here. The Department received no comments to the proposed regulation disagreeing with this conclusion. In addition, no small governmental jurisdictions, as defined in 5 U.S.C. section 601, will be affected.

With respect to employee benefit plans, the results of this analysis remain valid regardless of whether one uses the most applicable definition found in the regulations issued by the Small Business Administration (13 CFR section 121.201) or one defines small entity on the basis of section 104(a)(2) of ERISA as a plan with fewer than 100 participants. All employee benefit plans that purchased the regulated policies will receive the benefit of the enhanced disclosure provided by the regulation. Some of the costs of the disclosure may be passed on to the plans by the insurers. However, assuming that all disclosure costs are passed on to plans by the insurers, the Department estimates that these costs would be on average \$441 per policy for providing initial disclosures (including the cost of amending policies) and \$283 per policy for annual disclosures. This estimate assumes an equal distribution of the costs to all plans, both large and small.

A few commentators expressed concern that the start-up costs associated with disclosure requirements can be significant to a small plan. For example, one commentator indicated that the Department's original estimate of \$100 to \$200 per contract ignores the amortization of costs associated with the initial development of reporting capabilities. They argued that, for example, their firm services several plans with general account balances of \$10,000 or less. They argue therefore, that if the annual disclosure cost is \$150, this amounts to 1.5 percent of assets annually for a \$10,000 contract; whereas for a \$50,000 contract the cost would be 0.3 percent annually. The result will be that insurers that are forced to incur these costs will ultimately pass them on to the plan sponsor, and that for a small plan these costs are unaffordable. This assumes that insurers will pass on their aggregate

costs for compliance with the regulation by charging each plan the same dollar amount per contract, regardless of the size or nature of the contract or contracts involved, rather than a different method which may comport with the insurer's business plan.

While insurance companies may pass along costs to plan sponsors, the Department believes that such costs will be passed on, if at all, on the basis of the cost of compliance with respect to a particular contract or type of contract. In this regard, the Department believes that the cost of compliance will be low for the types of policies most commonly held by small plans. Compliance cost estimates we received from insurance companies varied widely. The cost estimates, along with comments received from industry representatives, indicate a particular concern about high costs in the case of individualized policies which may require customized amendments and disclosure statements. Individualized policies generally appear to be limited to older contracts which tend to have large dollar values (generally \$5 million or more) and are held by larger, long-established plans. These contracts are the result of numerous amendments of the original contract forms which are no longer issued. Except for large value contracts, more recent contracts are prototypes rather than individually drafted. These prototype policies are more cost effective for contracts with smaller dollar values. For example, of the estimated 100,000 policies issued to plans with fewer than 100 participants, the average value in 1995 was \$240,000. The Department understands that most small plans are likely to hold prototype contracts. This is because prototype policies are more cost effective than individualized policies for contracts with small dollar values. For example, of the 123,000 Transition Policies issued to all plans, an estimated 100,000 policies were issued to plans with fewer than 100 participants. The average value of such policies in 1995 was only \$240,000. An estimated 17,000 policies were issued to plans with between 100 and 500 participants. The average value in 1995 was \$1.8 million. For the remaining 6,000 plans, which had more than 500 participants, the average value was \$7.2 million. The average contract value for all policies is only \$800,000. It is evident that only a few (less than 5%) of plans holding Transition Policies are likely to hold individualized policies and these are the largest plans.

For each type of prototype policy only a single standard amendment to bring policies into compliance with the termination requirements of the

regulation (for policies not already in compliance) and a single standard disclosure statement need be developed. The cost of the disclosure statement and any needed rider or amendment can be spread across a large number of contracts, thus minimizing the cost per contract of compliance. These costs, even if passed on to the plan sponsors by the insurers, are expected to be a minimal percentage of the asset value of the contracts.

As noted in the initial regulatory flexibility analysis of the proposed regulation, no significant alternatives which would minimize the impact on small entities have been identified. Although the Department considered whether it would be appropriate to reduce the costs that might be passed on to small plans by providing fewer disclosures or termination rights for small plans than is provided by large plans, such an approach was not adopted. The nature of the protective provisions is such that it would make little sense to provide a lower level of protections to contracts held by small plans in an effort to minimize the cost impact to those plans. The policies involved, although of lesser total value than policies issued to large plans, often represent a significant proportion of the assets of the plans that hold them. They also guarantee all or most of the benefits of the participants whose pensions they cover. Finally, the fiduciaries of small plans may be less knowledgeable of insurance products and may have less bargaining power in dealing with insurers. Therefore, the protections in the regulation may be more important to the participants of small plans than to those of large plans. No comments received by the Department suggested that the regulation should provide small plans a lower level of protections than large plans.

In addition, no alternatives were identified by the commentators or have otherwise come to the attention of the Department. As discussed previously, in response to comments received, the Department made several modifications to the requirements of the proposed regulation. These modifications include relaxation of the disclosure requirements, an increase in the book value payout period in the termination provisions from 5 years to 10 years, and the introduction of the "cure" provision. These modifications are designed to minimize the impact of the regulation on small and large entities alike, consistent with the objectives of the requirements of the Small Business Job Protection Act of 1996 and ERISA. It would be inconsistent with these statutory requirements to create an

alternative with lower compliance criteria, or an exemption from the regulation, for small plans because these are the entities that have the greatest need for the disclosure and other protections afforded by the regulation.

(4) The Department received one comment from representatives of the insurance industry regarding the initial regulatory flexibility analysis in the proposed regulation. They stated that the regulation will have collateral and potentially serious adverse effect on small businesses. In addition, they argue that the regulation, as proposed, will create a preferred class of policyholders and hurt the participants and beneficiaries of a large number of small plans that purchase insurance arrangements backed by insurance company general accounts. They further state that the termination requirements would seriously restrict an important source of capital for small businesses.

As described in the Economic Analysis section of this preamble, the termination requirements may result in transfer of value from some insurance companies or their continuing policyholders to pension plans that terminate their arrangements in situations where contracts otherwise did not previously allow for positive market value adjustments. However, despite the assertion by insurance industry representatives that this will adversely affect participants and beneficiaries in a large number of small plans, no statistical evidence has been provided to substantiate this claim. The Department finds no reason to assume, for example, that small plans would be less likely than large plans to terminate these contracts and thus suffer the adverse impact (if any) of transfers to the terminating policyholders.

(5) Several commentators have stated, without any supporting analysis, not only that the insurance industry is an important provider of long-term capital, but also that small and medium sized businesses rely heavily on insurance companies as a source of long-term credit. The Department disagrees with the above statements, based on its analysis of several prominent sources of data regarding small business financing<sup>16</sup>; its findings are summarized below.

<sup>16</sup> The studies analyzed include the Federal Reserve Board's, "Report to the Congress of Availability of Credit to Small Businesses," issued in October 1997; "New Information on Lending to Small Businesses and Small Farms: the 1996 CAR Data," published in the Federal Reserve Bulletin in January 1998; and "Bank and Nonbank Competition for Small Business Credit: Evidence from the 1987 and 1993 National Surveys of Small Business

The Federal Reserve Board's 1997 "Report to the Congress on the Availability of Credit to Small Business," indicates that small business credit needs continue to be met primarily by commercial banks. The report also documents that business debt growth has risen steadily since 1993, at an average rate of 5 percent, and that the increasing credit demands of small companies seem to have been easily accommodated by financial intermediaries and in the capital markets overall.

Assuming the insurance industry's supply of long-term lending is somewhat less than their 10 percent participation in the credit market overall, it appears from these recent debt growth trends that other financial institutions and suppliers of capital would be able to fill any gap left by an insurance retrenchment in long-term lending/investment.

The Federal Reserve Board's 1998 report, "New Information on Lending to Small Businesses and Small Farms: the 1996 CAR Data," indicates that a vast majority of the reported small business loans were either originated or purchased by commercial banks or their affiliates. As of year-end 1996, of the total dollar amount of \$146.98 billion loaned, commercial banks originated or purchased 95.6 percent, or \$140.5 billion. Other institutions originated the remaining 4.4 percent.

The Federal Reserve Board's 1996 study, "Bank and Nonbank Competition for Small Business Credit: Evidence from the 1987 and 1993 National Surveys of Small Business Finances," reported on the competition for small business credit, and the sources of credit used by small firms, including credit lines, mortgage loans, equipment loans, motor vehicle loans, and "other" loans.<sup>17</sup> The survey reports that as of 1993, insurance and mortgage companies together provided a 1.9 percent dollar share of the outstanding credit lent to small businesses by nonbank institutions (nonbanks provided 38.7 percent of all outstanding credit, versus 61.3 percent provided by banks).

In sum, the Department believes that the statistics included in the above-discussed Federal Reserve reports and surveys point to the conclusion that commercial banks are the major supplier of credit financing to small

businesses. The reports further show that the insurance industry's participation is not large in the long-term credit markets overall, nor is the insurance industry a large provider of financing for small to medium-sized firms. Therefore, we do not believe an insurance industry retrenchment from longer term debt investing will adversely affect capital investments or small business financing.

Several commentators stated that not only are insurers a major source of long-term lending, but further posited that if insurers retrenched from the long-term debt market, the results would be a decrease in the amount of capital allocated to long-term projects, which in turn could have a detrimental impact on the private placement markets, which predominantly serve small and medium-sized businesses. Ultimately, this would have a negative effect on the availability of financing for small businesses. One commentator in the investment banking field supported this argument by stating that of the \$20 billion total the commentator placed in private securities in 1997, life insurance companies bought 80 percent, or \$16 billion of the offerings.

This statistic does not present a full picture of the private placement market, nor does it shed any light about the magnitude, influence or significance of insurers' participation in the market. It further does not provide any pertinent information about small business' dependence on or utilization of this source of capital.

The Department has found significant evidence to refute the commentators' above concerns. A study conducted specifically on the private placement markets, published in August, 1998<sup>18</sup> gives an overview of the nature of the private equity and debt markets<sup>19</sup> in which small businesses are financed.

This study reports data on the distribution of private financing for U.S. small businesses. Generally, it shows that within the private placement markets, small firms depend on both private equity (49.6 percent) and private debt (50.4 percent).

The largest source of private equity financing is the "principal owner" (typically the person who has the largest ownership share and has the primary authority to make financial decisions) at 31.3 percent of the total market, which represents 66 percent of total private

equity. The next biggest equity category is "other equity" at 12.86 percent, which includes members of the start-up team other than the owner, family and friends. "Angel finance" accounts for an estimated 3.59 percent. ("Angels" are high net worth individuals who provide direct funding to early-stage new businesses). Venture capital provides 1.86 percent of small business private equity financing.

There are nine categories of debt which are divided into three categories of funding that are provided by financial institutions—commercial banks providing 18.75 percent of total finance, finance companies 4.91 percent and other financial institutions<sup>20</sup> 3.00 percent; the six other categories funded by nonfinancial and government sources make up the remainder of private debt funding.

In summary, insurance companies at most may provide some portion of the 1.86 percent in small business equity financing funded by the venture capital sector. Alternatively, they at most may provide some portion of the 3% funded by "other" financial institutions to the small business private debt market, which includes 4 other types of institutional investors.

The Department believes that these figures clearly show the commentators' concerns about the regulation's effect on the private placement market, and ultimately, small business financing, to be unfounded.

### **Small Business Regulatory Enforcement Fairness Act**

The final rule being issued here is subject to the provisions of the Small Business Regulatory Enforcement Act of 1996 (5 U.S.C. 801 *et seq.*) (SBREFA) and has been transmitted to the Congress and the Comptroller General for review.

### **Unfunded Mandates Reform Act**

For purposes of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), as well as Executive Order 12875, this final rule does not include any Federal mandate that may result in the expenditure by state, local and tribal governments in the aggregate, or by the private sector, of \$100,000,000 or more in any one year.

### **Statutory Authority**

The regulation set forth herein is issued pursuant to the authority contained in sections 401(c) and 505 of ERISA (Pub. L. 93-406, Pub. L. 104-188,

Finances," published in the Federal Reserve Bulletin in November 1996.

<sup>17</sup> "Other" loans refer to loans not elsewhere classified, primarily unsecured term loans and loans collateralized by assets other than real estate, equipment loans, motor vehicles and loans not taken down under credit lines.

<sup>18</sup> "The Economics of Small Business Finance: The Roles of Private Equity and Debt Markets in the Financial Growth Cycle," Journal of Banking and Finance, Volume 22.

<sup>19</sup> Private equity and debt are also referred to as private placements, and make up the private placement market.

<sup>20</sup> "Other" financial institutions include thrift institutions, leasing companies, brokerage firms, mortgage companies and insurance companies.

88 Stat. 894; 29 U.S.C. 1101(c), 29 U.S.C. 1135) and section 102 of Reorganization Plan No. 4 of 1978 (43 FR 47713, October 17, 1978), effective December 31, 1978 (44 FR 1065, January 3, 1979), 3 CFR 1978 Comp. 332, and under Secretary of Labor's Order No. 1-87, 52 FR 13139 (April 21, 1987).

#### List of Subjects in 29 CFR Part 2550

Employee benefit plans, Employee Retirement Income Security Act, Employee stock ownership plans, Exemptions, Fiduciaries, Insurance Companies, Investments, Investment foreign, Party in interest, Pensions, Pension and Welfare Benefit Programs Office, Prohibited transactions, Real estate, Securities, Surety bonds, Trusts and Trustees.

For the reasons discussed in the preamble, 29 CFR Part 2550 is amended as follows:

#### PART 2550—[AMENDED]

1. The authority for part 2550 is revised to read as follows:

**Authority:** 29 U.S.C. 1135. Section 2550.401b-1 also issued under sec. 102, Reorganization Plan No. 4 of 1978, 3 CFR, 1978 Comp., p. 332. Section 2550.401c-1 also issued under 29 U.S.C. 1101. Section 2550.404c-1 also issued under 29 U.S.C. 1104. Section 2550.407c-3 also issued under 29 U.S.C. 1107. Section 2550.408b-1 also issued under sec. 102, Reorganization Plan No. 4 of 1978, 3 CFR, 1978 Comp., p. 332, and 29 U.S.C. 1108(b)(1). Section 2550.412-1 also issued under 29 U.S.C. 1112. Secretary of Labor's Order No. 1-87 (52 FR 13139).

2. New § 2550.401c-1 is added to read as follows:

#### § 2550.401c-1 Definition of "plan assets"—insurance company general accounts.

(a) *In general.* (1) This section describes, in the case where an insurer issues one or more policies to or for the benefit of an employee benefit plan (and such policies are supported by assets of an insurance company's general account), which assets held by the insurer (other than plan assets held in its separate accounts) constitute plan assets for purposes of Subtitle A, and Parts 1 and 4 of Subtitle B, of Title I of the Employee Retirement Income Security Act of 1974 (ERISA or the Act) and section 4975 of the Internal Revenue Code (the Code), and provides guidance with respect to the application of Title I of the Act and section 4975 of the Code to the general account assets of insurers.

(2) Generally, when a plan has acquired a Transition Policy (as defined in paragraph (h)(6) of this section), the plan's assets include the Transition

Policy, but do not include any of the underlying assets of the insurer's general account if the insurer satisfies the requirements of paragraphs (c) through (f) of this section or, if the requirements of paragraphs (c) through (f) were not satisfied, the insurer cures the non-compliance through satisfaction of the requirements in paragraph (i)(5) of this section.

(3) For purposes of paragraph (a)(2) of this section, a plan's assets will not include any of the underlying assets of the insurer's general account if the insurer fails to satisfy the requirements of paragraphs (c) through (f) of this section solely because of the takeover of the insurer's operations from management as a result of the granting of a petition filed in delinquency proceedings in the State court where the insurer is domiciled.

(b) *Approval by fiduciary independent of the issuer.* (1) *In general.* An independent plan fiduciary who has the authority to manage and control the assets of the plan must expressly authorize the acquisition or purchase of the Transition Policy. For purposes of this paragraph, a fiduciary is not independent if the fiduciary is an affiliate of the insurer issuing the policy.

(2) Notwithstanding paragraph (b)(1) of this section, the authorization by an independent plan fiduciary is not required if:

(i) The insurer is the employer maintaining the plan, or a party in interest which is wholly owned by the employer maintaining the plan; and

(ii) The requirements of section 408(b)(5) of the Act are met.<sup>1</sup>

(c) *Duty of disclosure.* (1) *In general.* An insurer shall furnish the information described in paragraphs (c)(3) and (c)(4) of this section to a plan fiduciary acting on behalf of a plan to which a Transition Policy has been issued. Paragraph (c)(2) of this section describes the style and format of such disclosure. Paragraph (c)(3) of this section describes the content of the initial disclosure. Paragraph (c)(4) of this section describes the information that must be disclosed by the insurer at least once per year for as long as the Transition Policy remains outstanding.

(2) *Style and format.* The disclosure required by this paragraph should be clear and concise and written in a manner calculated to be understood by

<sup>1</sup> The Department notes that, because section 401(c)(1)(D) of the Act and the definition of Transition Policy preclude the issuance of any additional Transition Policies after December 31, 1998, the requirement for independent fiduciary authorization of the acquisition or purchase of the Transition Policy in paragraph (b) no longer has any application.

a plan fiduciary, without relinquishing any of the substantive detail required by paragraphs (c)(3) and (c)(4) of this section. The information does not have to be organized in any particular order but should be presented in a manner which makes it easy to understand the operation of the Transition Policy.

(3) *Initial disclosure.* The insurer must provide to the plan, either as part of an amended policy, or as a separate written document, the disclosure information set forth in paragraphs (c)(3)(i) through (iv) of this section. The disclosure must include all of the following information which is applicable to the Transition Policy:

(i) A description of the method by which any income and any expense of the insurer's general account are allocated to the policy during the term of the policy and upon its termination, including:

(A) A description of the method used by the insurer to determine the fees, charges, expenses or other amounts that are, or may be, assessed against the policyholder or deducted by the insurer from any accumulation fund under the policy, including the extent and frequency with which such fees, charges, expenses or other amounts may be modified by the insurance company;

(B) A description of the method by which the insurer determines the return to be credited to any accumulation fund under the policy, including a description of the method used to allocate income and expenses to lines of business, business segments, and policies within such lines of business and business segments, and a description of how any withdrawals, transfers, or payments will affect the amount of the return credited;

(C) A description of the rights which the policyholder or plan participants have to withdraw or transfer all or a portion of any accumulation fund under the policy, or to apply the amount of a withdrawal to the purchase of guaranteed benefits or to the payment of benefits, and the terms on which such withdrawals or other applications of funds may be made, including a description of any charges, fees, credits, market value adjustments, or any other charges or adjustments, both positive and negative;

(D) A statement of the method used to calculate any charges, fees, credits or market value adjustments described in paragraph (c)(3)(i)(C) of this section, and, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request:

(1) The formula actually used to calculate the market value adjustment, if any, to be applied to the unallocated

amount in the accumulation fund upon distribution of a lump sum payment to the policyholder, and

(2) The actual calculation, as of a specified date that is no earlier than the last contract anniversary preceding the date of the request, of the applicable market value adjustment, including a description of the specific variables used in the calculation, the value of each of the variables, and a general description of how the value of each of those variables was determined.

(3) If the formula is based on interest rate guarantees applicable to new contracts of the same class or classes, and the duration of the assets underlying the accumulation fund, the contract must describe the process by which those components are ascertained or obtained. If the formula is based on an interest rate implicit in an index of publicly traded obligations, the identity of the index, the manner in which it is used, and identification of the source or publication where any data used in the formula can be found, must be disclosed;

(ii) A statement describing the expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees;

(iii) A description of the rights of the parties to make or discontinue contributions under the policy, and of any restrictions (such as timing, minimum or maximum amounts, and penalties and grace periods for late payments) on the making of contributions under the policy, and the consequences of the discontinuance of contributions under the policy; and

(iv) A statement of how any policyholder or participant-initiated withdrawals are to be made: first-in, first-out (FIFO) basis, last-in, first-out (LIFO) basis, pro rata or another basis.

(4) *Annual disclosure.* At least annually and not later than 90 days following the period to which it relates, an insurer shall provide the following information to each plan to which a Transition Policy has been issued:

(i) The balance of any accumulation fund on the first day and last day of the period covered by the annual report;

(ii) Any deposits made to the accumulation fund during such annual period;

(iii) An itemized statement of all income attributed to the policy or added to the accumulation fund during the period, and a description of the method used by the insurer to determine the precise amount of income;

(iv) The actual rate of return credited to the accumulation fund under the policy during such period, stating whether the rate of return was calculated before or after deduction of expenses charged to the accumulation fund;

(v) Any other additions to the accumulation fund during such period;

(vi) An itemized statement of all fees, charges, expenses or other amounts assessed against the policy or deducted from the accumulation fund during the reporting year, and a description of the method used by the insurer to determine the precise amount of the fees, charges and other expenses;

(vii) An itemized statement of all benefits paid, including annuity purchases, to participants and beneficiaries from the accumulation fund;

(viii) The dates on which the additions or subtractions were credited to, or deducted from, the accumulation fund during such period;

(ix) A description, if applicable, of all transactions with affiliates which exceed 1 percent of group annuity reserves of the general account for the prior reporting year;

(x) A statement describing any expense, income and benefit guarantees under the policy, including a description of the length of such guarantees, and of the insurer's right, if any, to modify or eliminate such guarantees. However, the information on guarantees does not have to be provided annually if it was previously disclosed in the insurance policy and has not been modified since that time;

(xi) A good faith estimate of the amount that would be payable in a lump sum at the end of such period pursuant to the request of a policyholder for payment or transfer of amounts in the accumulation fund under the policy after the insurer deducts any applicable charges and makes any appropriate market value adjustments, upward or downward, under the terms of the policy. However, upon the request of a plan fiduciary, the insurer must provide within 30 days of the request the information contained in paragraph (c)(3)(i)(D) as of a specified date that is no earlier than the last contract anniversary preceding the date of the request; and

(xii) An explanation that the insurer will make available promptly upon request of a plan, copies of the following publicly available financial data or other publicly available reports relating to the financial condition of the insurer:

(A) National Association of Insurance Commissioners Statutory Annual Statement, with Exhibits, General

Interrogatories, and Schedule D, Part 1A, Sections 1 and 2 and Schedule S—Part 3E;

(B) Rating agency reports on the financial strength and claims-paying ability of the insurer;

(C) Risk adjusted capital ratio, with a brief description of its derivation and significance, referring to the risk characteristics of both the assets and the liabilities of the insurer;

(D) Actuarial opinion of the insurer's Appointed Actuary certifying the adequacy of the insurer's reserves as required by New York State Insurance Department Regulation 126 and comparable regulations of other States; and

(E) The insurer's most recent SEC Form 10K and Form 10Q (stock companies only).

(d) *Alternative separate account arrangements.* (1) *In general.* An insurer must provide the plan fiduciary with the following additional information at the same time as the initial disclosure required under paragraph (c)(3) of this section:

(i) A statement explaining the extent to which alternative contract arrangements supported by assets of separate accounts of insurers are available to plans;

(ii) A statement as to whether there is a right under the policy to transfer funds to a separate account and the terms governing any such right; and

(iii) A statement explaining the extent to which general account contracts and separate account contracts of the insurer may pose differing risks to the plan.

(2) An insurer will be deemed to comply with the requirements of paragraph (d)(1)(iii) of this section if the disclosure provided to the plan includes the following statement:

a. Contractual arrangements supported by assets of separate accounts may pose differing risks to plans from contractual arrangements supported by assets of general accounts. Under a general account contract, the plan's contributions or premiums are placed in the insurer's general account and commingled with the insurer's corporate funds and assets (excluding separate accounts and special deposit funds). The insurance company combines in its general account premiums received from all of its lines of business. These premiums are pooled and invested by the insurer. General account assets in the aggregate support the insurer's obligations under all of its insurance contracts, including (but not limited to) its individual and group life, health, disability, and annuity contracts. Experience rated general account policies may share in the experience of the general account through interest credits, dividends, or rate adjustments, but assets in the general account are not segregated for the exclusive benefit of any particular policy or obligation. General

account assets are also available to the insurer for the conduct of its routine business activities, such as the payment of salaries, rent, other ordinary business expenses and dividends.

b. An insurance company separate account is a segregated fund which is not commingled with the insurer's general assets. Depending on the particular terms of the separate account contract, income, expenses, gains and losses associated with the assets allocated to a separate account may be credited to or charged against the separate account without regard to other income, expenses, gains, or losses of the insurance company, and the investment results passed through directly to the policyholders. While most, if not all, general account investments are maintained at book value, separate account investments are normally maintained at market value, which can fluctuate according to market conditions. In large measure, the risks associated with a separate account contract depend on the particular assets in the separate account.

c. The plan's legal rights vary under general and separate account contracts. In general, an insurer is subject to ERISA's fiduciary responsibility provisions with respect to the assets of a separate account (other than a separate account registered under the Investment Company Act of 1940) to the extent that the investment performance of such assets is passed directly through to the plan policyholders. ERISA requires insurers, in administering separate account assets, to act solely in the interest of the plan's participants and beneficiaries; prohibits self-dealing and conflicts of interest; and requires insurers to adhere to a prudent standard of care. In contrast, ERISA generally imposes less stringent standards in the administration of general account contracts which were issued on or before December 31, 1998.

d. On the other hand, State insurance regulation is typically more restrictive with respect to general accounts than separate accounts. However, State insurance regulation may not provide the same level of protection to plan policyholders as ERISA regulation. In addition, insurance company general account policies often include various guarantees under which the insurer assumes risks relating to the funding and distribution of benefits. Insurers do not usually provide any guarantees with respect to the investment returns on assets held in separate accounts. Of course, the extent of any guarantees from any general account or separate account contract will depend upon the specific policy terms.

e. Finally, separate accounts and general accounts pose differing risks in the event of the insurer's insolvency. In the event of insolvency, funds in the general account are available to meet the claims of the insurer's general creditors, after payment of amounts due under certain priority claims, including amounts owed to its policyholders. Funds held in a separate account as reserves for its policy obligations, however, may be protected from the claims of creditors other than the policyholders participating in the separate account. Whether separate account funds will be granted this protection will

depend upon the terms of the applicable policies and the provisions of any applicable laws in effect at the time of insolvency.

(e) *Termination procedures.* Within 90 days of written notice by a policyholder to an insurer, the insurer must permit the policyholder to exercise the right to terminate or discontinue the policy and to elect to receive without penalty either:

(1) A lump sum payment representing all unallocated amounts in the accumulation fund. For purposes of this paragraph (e)(1), the term penalty does not include a market value adjustment (as defined in paragraph (h)(7) of this section) or the recovery of costs actually incurred which would have been recovered by the insurer but for the termination or discontinuance of the policy, including any unliquidated acquisition expenses, to the extent not previously recovered by the insurer; or

(2) A book value payment of all unallocated amounts in the accumulation fund under the policy in approximately equal annual installments, over a period of no longer than 10 years, together with interest computed at an annual rate which is no less than the annual rate which was credited to the accumulation fund under the policy as of the date of the contract termination or discontinuance, minus 1 percentage point. Notwithstanding paragraphs (e)(1) and (e)(2) of this section, the insurer may defer, for a period not to exceed 180 days, amounts required to be paid to a policyholder under this paragraph for any period of time during which regular banking activities are suspended by State or federal authorities, a national securities exchange is closed for trading (except for normal holiday closings), or the Securities and Exchange Commission has determined that a state of emergency exists which may make such determination and payment impractical.

(f) *Insurer-initiated amendments.* In the event the insurer makes an insurer-initiated amendment (as defined in paragraph (h)(8) of this section), the insurer must provide written notice to the plan at least 60 days prior to the effective date of the insurer-initiated amendment. The notice must contain a complete description of the amendment and must inform the plan of its right to terminate or discontinue the policy and withdraw all unallocated funds without penalty by sending a written request within such 60 day period to the name and address contained in the notice. The plan must be offered the election to receive either a lump sum or an installment payment as described in paragraph (e)(1) and (e)(2) of this section. An insurer-initiated

amendment shall not apply to a contract if the plan fiduciary exercises its right to terminate or discontinue the contract within such 60 day period and to receive a lump sum or installment payment.

(g) *Prudence.* An insurer shall manage those assets of the insurer which are assets of such insurer's general account (irrespective of whether any such assets are plan assets) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims, taking into account all obligations supported by such enterprise. This prudence standard applies to the conduct of all insurers with respect to policies issued to plans on or before December 31, 1998, and differs from the prudence standard set forth in section 404(a)(1)(B) of the Act. Under the prudence standard provided in this paragraph, prudence must be determined by reference to all of the obligations supported by the general account, not just the obligations owed to plan policyholders. The more stringent standard of prudence set forth in section 404(a)(1)(B) of the Act continues to apply to any obligations which insurers may have as fiduciaries which do not arise from the management of general account assets, as well as to insurers' management of plan assets maintained in separate accounts. The terms of this section do not modify or reduce the fiduciary obligations applicable to insurers in connection with policies issued after December 31, 1998, which are supported by general account assets, including the standard of prudence under section 404(a)(1)(B) of the Act.

(h) *Definitions.* For purposes of this section:

(1) An *affiliate* of an insurer means:

(i) Any person, directly or indirectly, through one or more intermediaries, controlling, controlled by, or under common control with the insurer,

(ii) Any officer of, director of, 5 percent or more partner in, or highly compensated employee (earning 5 percent or more of the yearly wages of the insurer) of, such insurer or of any person described in paragraph (h)(1)(i) of this section including in the case of an insurer, an insurance agent or broker thereof (whether or not such person is a common law employee) if such agent or broker is an employee described in this paragraph or if the gross income received by such agent or broker from such insurer exceeds 5 percent of such agent's gross income from all sources for the year, and

(iii) Any corporation, partnership, or unincorporated enterprise of which a person described in paragraph (h)(1)(ii) of this section is an officer, director, or a 5 percent or more partner.

(2) The term *control* means the power to exercise a controlling influence over the management or policies of a person other than an individual.

(3) The term *guaranteed benefit policy* means a policy described in section 401(b)(2)(B) of the Act and any regulations promulgated thereunder.

(4) The term *insurer* means an insurer as described in section 401(b)(2)(A) of the Act.

(5) The term *accumulation fund* means the aggregate net considerations (i.e., gross considerations less all deductions from such considerations) credited to the Transition Policy plus all additional amounts, including interest and dividends, credited to such Transition Policy less partial withdrawals, benefit payments and less all charges and fees imposed against this accumulated amount under the Transition Policy other than surrender charges and market value adjustments.

(6) The term *Transition Policy* means:

(i) A policy or contract of insurance (other than a guaranteed benefit policy) that is issued by an insurer to, or on behalf of, an employee benefit plan on or before December 31, 1998, and which is supported by the assets of the insurer's general account.

(ii) A policy will not fail to be a Transition Policy merely because the policy is amended or modified:

(A) To comply with the requirements of section 401(c) of the Act and this section; or

(B) Pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).

(7) For purposes of this section, the term *market value adjustment* means an adjustment to the book value of the accumulation fund to accurately reflect the effect on the value of the accumulation fund of its liquidation in the prevailing market for fixed income obligations, taking into account the future cash flows that were anticipated under the policy. An adjustment is a *market value adjustment* within the meaning of this definition only if the insurer has determined the amount of the adjustment pursuant to a method which was previously disclosed to the

policyholder in accordance with paragraph (c)(3)(i)(D) of this section, and the method permits both upward and downward adjustments to the book value of the accumulation fund.

(8) The term *insurer-initiated amendment* is defined in paragraphs (h)(8)(i), (ii) and (iii) of this section as:

(i) An amendment to a Transition Policy made by an insurer pursuant to a unilateral right to amend the policy terms that would have a material adverse effect on the policyholder; or

(ii) Any of the following unilateral changes in the insurer's conduct or practices with respect to the policyholder or the accumulation fund under the policy that result in a material reduction of existing or future benefits under the policy, a material reduction in the value of the policy or a material increase in the cost of financing the plan or plan benefits:

(A) A change in the methodology for assessing fees, expenses, or other charges against the accumulation fund or the policyholder;

(B) A change in the methodology used for allocating income between lines of business, or product classes within a line of business;

(C) A change in the methodology used for determining the rate of return to be credited to the accumulation fund under the policy;

(D) A change in the methodology used for determining the amount of any fees, charges, expenses, or market value adjustments applicable to the accumulation fund under the policy in connection with the termination of the contract or withdrawal from the accumulation fund;

(E) A change in the dividend class to which the policy or contract is assigned;

(F) A change in the policyholder's rights in connection with the termination of the policy, withdrawal of funds or the purchase of annuities for plan participants; and

(G) A change in the annuity purchase rates guaranteed under the terms of the contract or policy, unless the new rates are more favorable for the policyholder.

(iii) For purposes of this definition, an insurer-initiated amendment is material if a prudent fiduciary could reasonably conclude that the amendment should be considered in determining how or whether to exercise any rights with respect to the policy, including termination rights.

(iv) For purposes of this definition, the following amendments or changes are not insurer-initiated amendments:

(A) Any amendment or change which is made with the affirmative consent of the policyholder;

(B) Any amendment or change which is made in order to comply with the requirements of section 401(c) of the Act and this section; or

(C) Any amendment or change which is made pursuant to a merger, acquisition, demutualization, conversion, or reorganization authorized by applicable State law, provided that the premiums, policy guarantees, and the other terms and conditions of the policy remain the same, except that a membership interest in a mutual insurance company may be eliminated from the policy in exchange for separate consideration (e.g., shares of stock or policy credits).

(i) *Limitation on liability.* (1) No person shall be subject to liability under Parts 1 and 4 of Title I of the Act or section 4975 of the Internal Revenue Code of 1986 for conduct which occurred prior to the applicability dates of the regulation on the basis of a claim that the assets of an insurer (other than plan assets held in a separate account) constitute plan assets. Notwithstanding the provisions of this paragraph (i)(1), this section shall not:

(i) Apply to an action brought by the Secretary of Labor pursuant to paragraphs (2) or (5) of section 502(a) of ERISA for a breach of fiduciary responsibility which would also constitute a violation of Federal or State criminal law;

(ii) Preclude the application of any Federal criminal law; or

(iii) Apply to any civil action commenced before November 7, 1995.

(2) Nothing in this section relieves any person from any State law regulating insurance which imposes additional obligations or duties upon insurers to the extent not inconsistent with the provisions of this section. Therefore, nothing in this section should be construed to preclude a State from requiring insurers to make additional disclosures to policyholders, including plans. Nor does this section prohibit a State from imposing additional substantive requirements with respect to the management of general accounts or from otherwise regulating the relationship between the policyholder and the insurer to the extent not inconsistent with the provisions of this section.

(3) Nothing in this section precludes any claim against an insurer or other person for violations of the Act which do not require a finding that the underlying assets of a general account constitute plan assets, regardless of whether the violation relates to a Transition Policy.

(4) If the requirements in paragraphs (c) through (f) of this section are not met



with respect to a plan that has purchased or acquired a Transition Policy, and the insurer has not cured the non-compliance through satisfaction of the requirements in paragraph (i)(5) of this section, the plan's assets include an undivided interest in the underlying assets of the insurer's general account for that period of time for which the requirements are not met. However, an insurer's failure to comply with the requirements of this section with respect to any particular Transition Policy will not result in the underlying assets of the general account constituting plan assets with respect to other Transition Policies if the insurer is otherwise in compliance with the requirements contained in this section.

(5) Notwithstanding paragraphs (a)(2) and (i)(4) of this section, a plan's assets will not include an undivided interest in the underlying assets of the insurer's general account if the insurer made reasonable and good faith attempts at compliance with each of the requirements of paragraphs (c) through (f) of this section, and meets each of the following conditions:

(i) The insurer has in place written procedures that are reasonably designed to assure compliance with the requirements of paragraphs (c) through (f) of this section, including procedures reasonably designed to detect any instances of non-compliance.

(ii) No later than 60 days following the earlier of the insurer's detection of an instance of non-compliance or the receipt of written notice of non-compliance from the plan, the insurer complies with the requirements of paragraphs (c) through (f) of this section. If the insurer has failed to pay a plan the amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must make all corrections and adjustments necessary to restore to the plan the full amounts that the plan would have received but for the insurer's non-compliance within the applicable 60 day period; and

(iii) The insurer makes the plan whole for any losses resulting from the non-compliance as follows:

(A) If the insurer has failed to comply with the disclosure or notice requirements set forth in paragraphs (c), (d) and (f) of this section, then the insurer must make the plan whole for any losses resulting from its non-compliance within the earlier of 60 days of detection by the insurer or sixty days following the receipt of written notice from the plan; and

(B) If the insurer has failed to pay a plan any amounts required under paragraphs (e) or (f) of this section within 90 days of receiving written notice of termination or discontinuance of the policy, the insurer must pay to

the plan interest on any amounts restored pursuant to paragraph (i)(5)(ii) of this section at the "underpayment rate" as set forth in 26 U.S.C. sections 6621 and 6622. Such interest must be paid within the earlier of 60 days of detection by the insurer or sixty days following receipt of written notice of non-compliance from the plan.

(j) *Applicability dates.* (1) *In general.* Except as provided in paragraphs (j)(2) through (4) of this section, this section is applicable on July 5, 2001.

(2) Paragraph (c) relating to initial disclosures and paragraph (d) relating to separate account disclosures are applicable on July 5, 2000.

(3) The first annual disclosure required under paragraph(c)(4) of this section shall be provided to each plan not later than 18 months following January 5, 2000.

(4) Paragraph (f), relating to insurer-initiated amendments, is applicable on January 5, 2000.

(k) *Effective date.* This section is effective January 5, 2000.

Signed at Washington, D.C. this 21st day of December, 1999.

**Leslie Kramerich,**

*Acting Assistant Secretary for Pension and Welfare Benefits Administration, U.S. Department of Labor.*

[FR Doc. 00-32 Filed 01-04-00; 8:45 am]

**BILLING CODE 4510-29-P**