

**Questions and Proposed Answers for the Department of Labor Staff for the
2014 Joint Committee of Employee Benefits Technical Session
Held on May 7, 2014**

The following questions and answers were based on informal discussions between private sector representatives of the Joint Committee on Employee Benefits (“JCEB”) and the Department of Labor (“DOL” or “Department”) staff. The questions were submitted by ABA members, and the responses were given at a meeting of JCEB and government representatives. The responses reflect only unofficial, nonbinding staff views as of the time of the discussion, and do not necessarily represent the official position of the DOL. Further, this report on the discussions was prepared by JCEB representatives, based on their notes and recollections of the meeting.

Question #1: Governmental Plan Definition: Proposed rule changes published by the Internal Revenue Service (“IRS”) (I.R.B. 211-51, December 19, 2011) would provide a qualifying test for the term “governmental plan” under the Internal Revenue Code (“Code” or “IRC”) §414(d). This new test for qualification as an IRC §414(d) “governmental plan” could impact the DOL’s interpretation of the term “governmental plan” for the purposes of the Employee Retirement Income Security Act of 1976, as amended (“ERISA”) §§3(32) and 4(b)(1). The rules proposed by the IRS could invalidate the DOL’s prior interpretations of ERISA §4(b)(1) which have historically allowed labor union plans to assert an exemption based on governmental funding and exclusive participation by governmental employees.

If enacted as currently stated, will the proposed rules for qualification of a “governmental plan” under IRC §414(d) alter or reverse the DOL’s historic position that benefit trusts and plans, which are operated by governmental law enforcement labor unions, provide benefits exclusively to governmental employees, and derive their funding exclusively from governmental employers and/or their employees, are exempt from ERISA under ERISA §4(b)(1)?

Initial Proposed Answer: The rules proposed by the IRS regarding IRC §414(d) will not alter the DOL’s interpretation of the term “governmental plan” under ERISA §§ 3(32) and 4(b)(1). It remains the view of the DOL that the term “governmental plan” as defined in ERISA §3(32) is not limited to plans established by the unilateral action of employers which are governmental agencies. The DOL interprets the term “governmental plan” to include plans established or maintained pursuant to a collective bargaining agreement between a governmental entity and a labor union where such plans are funded by, and cover only employees of, governmental entities. The term “governmental plan” may also include a plan that is established and maintained exclusively for the benefit of employees of a government, although the plan is administered by an “employee organization” (within the meaning of ERISA §3(4)) whose only members are the governmental employer’s own employees, provided that the plan

is funded by the governmental employer and/or the governmental employer's employees who make up the membership of the sponsoring employee organization. Therefore, a trust or plan which provides benefits exclusively to governmental employees, and is funded entirely by the governmental employers and/or the employees of such governmental employers, will remain exempt from ERISA pursuant to ERISA §4(b)(1).

DOL Answer: EBSA staff does not assume that proposals in the IRS ANPRM necessarily reflect any conflict with current or future DOL interpretations of the definition of a governmental plan under ERISA section 3(32). As stated in the IRS ANPRM preamble and appendix, the Agencies' stated intent is to develop "coordinated criteria for determining whether a plan is a governmental plan within the meaning of section 414(d) of the Code, section 3(32) of title I of ERISA, and section 4021(b) of title IV of ERISA." EBSA staff notes that the question references funding from governmental employers "and/or" their employees. See generally AO 83-13A (Denver Firefighters Protective Association plan was not a governmental plan where the only involvement of the governmental employer was payroll withholding of employee dues paid to the employee organization operating the plan, and no governmental entity had or exercised any control over the plan or plan funds and no governmental entity contributed any funds for the plan's operation).

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Question #2: Spouse Definition: In August 2013 the DOL's Wage and Hour Division issued Fact Sheet #28F entitled "Qualifying Reasons for Leave under the Family and Medical Leave Act" ("FMLA"). In this document the Wage and Hour Division defined spouse, for purposes of the FMLA, to mean "a husband or wife as defined or recognized under state law for purposes of marriage in the state where the employee resides, including common law and same-sex marriage." This is in contradiction to the definition of spouse issued by DOL in EBSA Technical Release 2013-04. Is the Department's Wage and Hour Division going to reconsider its definition of spouse and change its definition to apply a celebration, rather than residency, rule for purposes of the FMLA?

Initial Proposed Answer: Yes.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #3: Party in Interest Definition: ERISA §3(14) defines a "party in interest" as including a corporation of which 50% or more of the combined voting power of all classes of stock entitled to vote is owned by a fiduciary, among others. Many hedge funds and other passive investment funds are organized as Cayman Islands exempted companies and are treated as corporations for U.S. tax purposes. If 100% of the voting

power of such a Cayman Islands exempted company is held by a fiduciary of a plan, is the Cayman Islands exempted company a party in interest to that plan?

Initial Proposed Answer: Unclear. On the one hand, because the Cayman Islands exempted company is treated as a corporation for U.S. tax purposes and all of the voting power is held by a fiduciary to the plan, it seems to be a party in interest. On the other hand, its entity formation is an “exempted company” rather than a “corporation” and, therefore, one could argue that the exempted company should not be treated as a “corporation” for purposes of the definition.

DOL Answer: A Cayman Islands exempted company is an entity that is incorporated in the Cayman Islands but conducts the bulk of its business outside of the Cayman Islands. An exempted company, however, still takes the form of a corporation that issues stock. ERISA does not limit the definition of “stock” as used in section 3(14) to stock issued by U.S. corporations. Accordingly, it is the view of EBSA staff that if a fiduciary of a plan holds stock that has 100% of the voting power of a Cayman Islands exempted company, the exempted company is a party in interest to that plan.

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Question #4: Effective Date: Neither EBSA Technical Release 2013-04 nor the Wage and Hour Division’s Fact Sheet #28 F entitled “Qualifying Reasons for Leave under the Family and Medical Leave Act” has an effective date. Is the Department going to provide an effective date for either of these documents and, if so, what will it be?

Initial Proposed Answer: Yes, the Department will issue guidance indicating that both documents are effective June 26, 2013, the date of the Supreme Court decision in *Windsor*.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Questions #5 and #6: Effective Date: What is the Department’s position on retroactive application of the *Windsor* decision?

- a. To what extent will *Windsor* be permitted or required to be applied retroactively with respect to the operation of plans?
- b. Where actions were taken under the plan pursuant to the terms of the plan that were in effect at that time (prior to the *Windsor* decision), how should the *Windsor* decision apply? For example, how does the *Windsor* decision apply to plan distributions that have already occurred or where benefits are currently in pay status?

Initial Proposed Answers:

- a. Windsor should be *required* to apply retroactively only with respect to plan provisions that implement legal requirements that use the term “spouse” or “marriage” that were directly impacted by DOMA and *Windsor*.

- b. Where the Plan Administrator reasonably relied on the plan provisions that were in effect at the time that the plan distribution was made or the benefit payments commenced, the fact that a subsequent amendment was made (with retroactive effect) with respect to the definition of spouse or marriage pursuant to the *Windsor* decision should not have any impact upon plan distributions that have already been made and/or benefit payments that have already commenced.

DOL Answers: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #7: Plan Expenses: The plan administrator of a multiemployer pension fund also serves as business manager to the associated union. Pursuant to an expense sharing/allocation agreement between the fund and the union, a percentage of the administrator/business manager’s full-time salary is reimbursed by the plan to the union. The expense sharing/allocation agreement has been reviewed by a qualified auditor and certified as being reasonable based on the amount of work performed by the administrator/business manager on behalf of the fund (which is substantiated by written time records that support the allocation), and the fair market value of administrative services in the area. The arrangement is reviewed by the auditor and Board of Trustees at least annually.

Would this arrangement constitute a prohibited transaction under ERISA §406?

Initial Proposed Answer: No. ERISA §408(b)(2) provides an exemption from the prohibitions of ERISA §406(a) if a plan contracts or makes reasonable arrangements with a party in interest, including a plan fiduciary, for office space or services necessary for the establishment or operation of the plan if no more than reasonable compensation is paid for the space or services. In the example above, administrative services are necessary for the operation of the plan and no more than reasonable compensation is being paid. Further, the administrator is not being paid a full-time salary by the union; rather, the union is being reimbursed for the fund’s allocable share of the single salary of the administrator/business manager. There is no double dipping, and the administrator is receiving no remuneration other than a bona fide salary for the services provided to the fund. This means that ERISA §408(c) and 29 CFR §2550.408c-2(c)(2), which prohibit a fiduciary who is already receiving a full-time salary from a union from receiving any further compensation, does not apply to the fact pattern described above.

This position is also supported by the legislative history of ERISA, and the Department's own guidance. In Advisory Opinion 85-19A, the Department noted that "[t]he legislative history of Section 408(c)(2) indicates that Congress' intention was to prevent double payment" and that "the predominant concern of Congress in promulgating ERISA § 408(c)(2) was that of prohibiting double payment." See also H. Rpt. 93-1280, 93d Cong., 2d Sess. at 312.

DOL Answer: EBSA staff disagrees with the proposed answer. This is a prohibited transaction under section 406(a) of ERISA. The Department has long expressed the view that "an employee who is compensated on an hourly basis and who suffers a loss of pay by reason of his absence from work while performing duties as a fiduciary does not receive full-time pay within the meaning of section 408(c)(2). In other circumstances, while a determination of whether a fiduciary receives full-time pay would be resolved on a case-by-case basis, it is the Department's view, that, in most cases, when an individual is paid a salary for his services for an employer he would be receiving full-time pay." See DOL Advisory Opinion 79-59 (August 27, 1979) and Information Letters to Lant A. Johnson (5/7/92), George E. Clark (6/4/93) and Jeffrey M. Lesser (1/7/92). These matters included situations where the fiduciary was paid directly by an employer or union and the employer or union was reimbursed by the plan for a portion of the fiduciary's salary.

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Question #8: Plan Expenses: A service provider contract signed by the employer (in its capacity as employer, not in its capacity as plan administrator) specifies that the employer agrees that the fees and expenses owed under the agreement for recordkeeping and/or administration services to the plan are an obligation and liability of the employer and will be paid by the employer. The service contract imposes an unconditional obligation on the employer to pay the fees and expenses. In another section of the contract, many pages removed from the description of employer's obligation, the contract specifies that if the employer does not pay the fees and expenses owed under the contract that the record keeper or service provider has the right to deduct the fees from the plan's assets. In addition, the contract includes wording even later in the agreement specifying that the employer may choose to have the plan pay the fees and expenses owed under the contract to the extent that the employer chooses not to pay them itself.

If the fees and expenses are reasonable and necessary for the administration of the plan and the employer chooses to have the plan pay the fees and expenses owed under the service provider contract, will the plan's use of its assets to pay the fees and expenses be a transaction prohibited by ERISA §406(a)(1)(D)?

Initial Proposed Answer: ERISA §3(14)(C) provides that an employer whose employees are covered by a plan is a party in interest and ERISA §406(a)(1)(D) specifies that a fiduciary shall not cause the plan to engage in a transaction if the transaction constitutes a use of the plan's assets for the benefit of a party in interest. In

the factual description, the employer has assumed the obligation to pay the expenses of the plan to the extent the expenses are generated under the specific contract that the employer has signed. As a result, if the plan's assets are used to pay the expenses under the service agreement, the plan will be using its assets to pay an obligation of the employer, and will have been involved in a prohibited transaction under ERISA §406(a)(1)(D).

DOL Answer: This question involves a contract that has internally inconsistent terms regarding the obligation of the employer. EBSA staff does not believe this is the appropriate forum in which to answer this question. The appropriate forum would be the advisory opinion process, which would allow more development of the facts and guidance.

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Question #9: Plan Expenses: Employer X sponsors a 401(k) plan that has participant-directed accounts. The plan provides that all plan expenses can be charged against participant accounts pro-rata. The plan's fee schedule with its third party administrator provides that if certain investment related revenue received by the third party administrator (*i.e.* processing fees, service fees, distribution fees and all other fees received from a mutual fund or collective trust provider) exceeds the plan's annual revenue requirement per participant (for instance, \$70 per participant with an account balance), then the third party administrator will remit the excess to the plan's trust as a rebate. The plan has an account, titled an "ERISA Account" set up for deposit of these expenses.

The plan's document provides that all reasonable and proper expenses of the plan and the trust for the plan can be paid from the trust, unless payment of such expense would constitute a prohibited transaction within the meaning of ERISA §406 or IRC §4975. The plan further provides that general administrative expenses of the plan and trust fund shall be paid from the forfeiture account or, to the extent that forfeitures are insufficient, the expenses shall be debited from the participants' accounts on a pro rata basis. The plan further provides that amounts in the forfeiture account may be allocated among the participants' accounts.

In 2013, the plan receives a rebate of fees from its third party administrator. The forfeiture account balance is \$0. At the time the rebate of fees is received, the plan's expenses include a bill for the 2012 plan audit required for the Form 5500. The plan's third party administrator has also offered the Plan the option of pre-paying for its 2013 plan audit in 2013.

Can the plan use the rebate of fees received and allocated to the ERISA Account in 2013 to pay for the 2012 plan audit, and to pre-pay for the 2013 plan audit? If the answer is yes and there are amounts left in the ERISA Account after the payment of the

audit expenses, can the plan continue to hold the excess amounts in the ERISA Account to pay future plan expenses, or must the excess amounts in the ERISA Account be allocated among the participant accounts?

Initial Proposed Answer: The rebate amounts held in the ERISA Account are plan assets, and the plan sponsor must act in the best interests of plan participants and beneficiaries with respect to amounts held in this account.

The plan can pay the fees associated with the 2012 plan audit from the rebate amounts held in the ERISA Account because the plan clearly provides that plan assets can be used to pay plan expenses. Further, the plan can pre-pay the fees associated with the 2013 plan audit from the rebate amounts held in the ERISA Account, again because the plan clearly provides that plan assets can be used to pay plan expenses. Moreover, if there are amounts remaining in the ERISA Account after payment of the 2012 audit expenses and prepayment of the 2013 audit expenses, the plan sponsor has the discretion to decide whether to hold the excess amounts in the ERISA Account for payment of future administrative expenses, or allocate the excess amounts to the participants' accounts. Any such decision will be subject to ERISA's fiduciary standards.

DOL Answer: Once the amounts rebated are placed in the plan's trust those amounts are plan assets. See Advisory Opinion 2013-03A. Any fiduciary issues that may arise from the allocation of revenue sharing among plan expenses or individual accounts would be more appropriately addressed in an advisory opinion request. EBSA staff expresses no view as to any tax issues that may be presented by this question. For example, EBSA staff notes that the IRS may have rules concerning the period of time assets can be held in a forfeiture or ERISA account before being used or allocated.

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Question #10: Reasonable Fees: We are aware that the Department undertakes investigations to review whether fees paid by plans to service providers are "reasonable." How does the DOL determine if fees are reasonable during an investigation?

Initial Proposed Answer: The Department does not make a determination as to whether the fees are reasonable by benchmarking but instead reviews whether the fees appear to be excessive given the facts and circumstances.

DOL Answer: A contract or arrangement is reasonable if the services are necessary for the establishment or operation of the plan and no more than reasonable compensation is paid for the services. Contracts or arrangements should be "reasonable" to satisfy the ERISA section 408(b)(2) statutory exemption. ERISA section 404(a) also obligates plan fiduciaries to obtain and carefully consider information

necessary to assess the services to be provided to the plan, the reasonableness of the compensation being paid for such services, and potential conflicts of interest that might affect the quality of the provided services.

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Question #11: Indemnification: The Department took the position in two advisory opinion letters (2009-03A and 2011-09A) that provisions in individual retirement account agreements that indemnify the custodian or provide the custodian with access to IRA customer personal accounts for unpaid IRA expenses are non-exempt prohibited transactions under ERISA §406. The Department has under consideration an amendment to existing exemption PTE 80-26 providing *limited* relief for IRA and qualified plans (as many qualified retirement plan service agreements have indemnification provisions covering expense obligations of the plan too). To make it clear, we understand the opinion letters cannot and do not reach indemnification provisions involving the fiduciary liability of the service provider. This is because fiduciary liability is not an obligation of the plan and, therefore, indemnification for it is not a prohibited transaction.

The proposed amendment to PTE 80-26 that would provide full retroactive relief and temporary prospective relief (six months from the date of grant of the exemption to re-order existing agreements) for the transactions described in the advisory opinions to IRAs and plans but only if the agreements are with financial institutions. The six-month period is too short for affected documents and arrangements to be revised. The exemption does not apply to non-financial institution service agreements and with respect to welfare benefit plans. This leaves these arrangements vulnerable to prohibited transaction excise taxes. Nor does the proposed amendment recognize that the practice of providing plan sponsor indemnification of service providers is in the best interests of the affected plans because it (i) facilitates the establishment of employee benefit plans, (ii) enables plans to negotiate agreements with service providers at lower costs than would otherwise apply, and (iii) enables plans to participate in investments that would not otherwise be available to the plans (because the potential loss of the investment could exceed the principal invested). In short the limited relief provided in the proposed amendment leaves many normal business relationships extremely disrupted.

Will the Department (i) extend the six-month period to a two-year period; (ii) extend the relief provided in the exemption to non-financial institution service agreements and (iii) consider granting a permanent exemption for the transactions described in the proposed amendment to PTE 80-26 and to plan sponsor indemnification of non-financial institution service providers for plan obligations to the extent that liability exceeds plan assets and extend the relief to welfare benefit plans?

Initial Proposed Answer: The Department will (i) extend the six-month period to a two-year period; (ii) include non-financial institution service providers and welfare benefit plans in the proposed amendment; and (iii) consider granting a permanent exemption for (A) the transactions described in the proposed amendment to PTE 80-26; and (B)

plan sponsor indemnification of non-financial institution service providers for plan obligations but only to the extent those obligations exceed plan assets.

DOL Answer: EBSA staff does not believe this is the appropriate forum in which to answer this question.

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Question #12: Plan Assets: Can an “operating company” be exempt from the plan asset regulation treatment under 29 CFR §2510.3-101(c)(1) if it is not a “venture capital operating company” or a “real estate operating company?”

Initial Proposed Answer: Yes. An “operating company” is an entity that is primarily engaged, directly or through a majority owned subsidiary or subsidiaries, in the production or sale of a product or service other than the investment of capital. The term “operating company” includes an ‘entity which is not described in the preceding sentence, but which is a “venture capital operating company” described in paragraph (d) or a “real estate operating company” described in paragraph (e).

On its face, an operating company should include more than just a venture operating company or a real estate operating company. The Preamble to the Final Regulations, 29 CFR §2510.3-101 (“Plan Asset Regulation”), 51 FR 41262 (November 13, 1986) (“Preamble”), specifically provide that the DOL would not further define what operating company meant in the context of the Plan Asset Regulation, and there has been no further elaboration on this rule we could find in any cases. The comments to the Plan Asset Regulation specifically asked for the DOL to “clarify how companies engaged in various kinds of business would be treated under the general operating company definition.” See the Preamble; see *also* ERISA Opinion Letter 96-26A. The DOL indicated in the Preamble that it would be impractical to provide detailed guidance regarding the types of entities which might constitute an operating company.

DOL Answer: An entity that is not a “venture capital operating company” or a “real estate operating company” may nonetheless qualify for the “operating company” exception under the look-through regulation. Paragraph (c) of the regulation defines an “operating company” as an entity that is primarily engaged, directly or through a majority owned subsidiary or subsidiaries, in the production or sale of a product or service other than the investment of capital. The provision further provides that the term “operating company” includes an entity that does not meet this definition, but that is a “venture capital operating company” within the meaning of paragraph (d) or a “real estate operating company” within the meaning of paragraph (e).

Question #13: Plan Assets: Assuming the answer immediately above is yes, we pose the following facts: An investment is made by “benefit plan investors” (as defined in the Plan Asset Regulation) (“Investors”) by purchasing the shares of stock of a holding company (“HoldCo”). HoldCo owns 100% of a bank or trust company (“Bank”). The Bank in turn invests deposits or accounts of Investors as directed by such Investors and provides other trustee or custodial services to such Investors and others individuals who do not own any portion of HoldCo. The Investors own 30% of HoldCo, which is not publicly traded under the Plan Asset Regulation, and the majority of the revenue of the Bank and HoldCo is received from the provision of custodial and trustee services provided to customers, including, but not limited to the Investors.

Assuming the Bank would otherwise qualify as an operating company, will the Bank be an operating company for purposes of the Plan Asset Regulation if the majority of its revenue is received from such services described in the immediately preceding paragraph?

Initial Proposed Answer: The answer is a facts and circumstances determination, but if the majority of revenue of the Bank and HoldCo is received as a result of the provision of services, then it is possible that the Bank and HoldCo could be an operating company, as “primarily” can reasonably and potentially be interpreted to mean a majority of a revenue earned by HoldCo as determined based upon a plain meaning of such term.

DOL Answer: Whether an entity is primarily engaged in the production or sale of a product or service other than the investment of capital, as required by the operating company definition, is an inherently factual question on which we will not ordinarily opine. EBSA staff notes that this fact pattern could raise prohibited transaction / fiduciary responsibility issues involving the selection of the Bank as a service provider. EBSA staff believes that an advisory opinion request would be the more appropriate forum to address these issues.

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Questions #14: Plan Assets: Will co-investment by a disqualified person with “benefit plan investors” (as defined in the Plan Asset Regulation) automatically result in a prohibited transaction under Code §4975 (“Prohibited Transaction”)?

Initial Proposed Answer: No. Depending on the facts, the co-investment of “plan assets” and disqualified persons (e.g., IRA owners who are also fiduciaries) into a particular investment option or entity could, but does not necessarily run afoul of the Prohibited Transaction rules, provided that the disqualified persons are not relying or dependent upon the investment of plan assets, and that the arrangement is not part of some larger arrangement designed to somehow benefit the disqualified persons. See

DOL Advisory Opinion 2000-10A (“Opinion 2000-10A”), in which the DOL allowed the owner of an IRA to direct the IRA to invest in a limited partnership in which relatives and the IRA owner (in his individual capacity) were partners. One of the key facts in Opinion 2001-10A was that no IRA or owner of an IRA was a disqualified person with respect to that partnership (e.g., in that the IRA and IRA owner did not own at least 50% owner of the applicable partnership). See *also* DOL Individual Prohibited Transaction Exemption D-4950, 52 Fed. Reg. 30977 (Aug. 18, 1987), approved as IPTA 99-93, 53 Fed. Reg. 38803 (October 3, 1988), in which a footnote reveals the DOL’s view that a “disqualified person” does not violate the Prohibited Transaction rules “merely because he derives some incidental benefit from a transaction involving plan assets.” See *further* DOL Prohibited Transaction Exemption 2003-08; Exemption Application Number D-11107, 68 FR 23765, 23766 (May 5, 2003), in which the DOL provided that if “the acquisition of the [real property] through the co-investment of Plan assets and assets provided by [the daughter of a fiduciary] ... such transaction does not require additional relief” if with respect to the initial co-investment, “(1) [t]he fiduciary (or its designee) does not rely upon, and is not otherwise dependent upon, the participation of the plan in order to undertake its share of the investment; and (2) the terms of the transaction that are applicable to the plan are identical to the terms applicable to the party in interest.”

DOL Answer: Advisory Opinion 2000-10A consolidates the views of the Department on this issue and provides, with caveats, that the mere equity co-investment by a plan and a plan fiduciary is not necessarily a prohibited transaction. If the questioner needs further guidance, an advisory opinion request based upon the facts above would be the most appropriate forum.

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Question #15: Plan Assets: If a service provider’s contract provides for the payment of the service provider’s fees and expenses from plan assets, is there a violation of ERISA § 406(a)(1)(D)? Specifically, the service provider’s contract specifies that its fees for recordkeeping and/or administrative services will be paid by the employer, but other parts of the contract provide that, if the employer does not pay such fees, the service provider will deduct such fees from plan assets.

Initial Proposed Answer: No, there is no violation of ERISA § 406(a)(1)(D) if the service provider’s contract provides for the payment of the service provider’s fees and expenses from plan assets in the event that the employer fails to pay for such fees. By signing the service provider’s contract, the employer and plan administrator are authorizing the use of plan assets to pay for the service provider’s fees that are not paid by the employer. As long as such fees and expenses are reasonable pursuant to ERISA § 404, there is no violation of ERISA § 406(a)(1)(D) for the service provider to deduct the portion of its fees that have not been paid by the employer from plan assets.

DOL Answer: See DOL answer to question 8 above. This question also raises issues regarding potential fiduciary discretion and self-dealing by service providers that unilaterally deduct their fees from plan assets. Further guidance may be sought through a request for an advisory opinion on this issue.

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Questions #16: Expense Ratios: DOL Regulation 29 CFR §2550.404a-5 requires participant fee disclosures to include the total annual operating expenses expressed as a percentage (i.e., expense ratio). If a plan establishes a menu of custom funds as designated investment alternatives with no operating history, does it have to provide this information in the initial participant fee disclosure? If no, can the plan provide an estimate of the expense ratio?

Initial Proposed Answer: No. DOL Regulation 29 CFR §2550.404a-5(h)(5) defines “total annual operating expenses” for a designated investment alternative that is not registered under the Investment Company Act of 1940 as the sum of the fees described in the regulation “for the alternative’s most recently completed fiscal year, expressed as a percentage of the alternative’s average net asset value for that year.” Although such disclosure is not required for the initial fee disclosure, it would be permissible for the plan to provide an estimate of the total annual operating expenses expressed as a percentage as long as the disclosure was not misleading.

DOL Answer: The purpose of the regulation is to make sure that participant investors have sufficient information to make informed investment decisions. EBSA staff does not see how that basic purpose can be achieved if participants fail to receive the total annual operating expenses (expense ratio) of each fund available under the plan before making their investment decisions. To the extent that the definition in paragraph (h)(5)(ii) of the regulation does not specify how to calculate the expense ratio for a fund with no history, staff expects that plan administrators should provide a reasonable estimate of such expenses. Plan administrators may follow the methodology in paragraph (h)(5)(i) of the regulation for this purpose. This paragraph sets forth the method to calculate the expense ratio for funds that are registered under the Investment Company Act of 1940, including the “new fund” rules set forth in Form N-1A (specifically Item 3, instruction 6).

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Question #17: Benefit Claims: At the *Heimeshoff* oral argument, the Court asked a series of questions concerning the scope of the DOL’s authority to establish the date of accrual of a benefit claim as well as the DOL’s authority to regulate more generally in the benefit claims area. Does the DOL believe it has the authority to establish an accrual rule for benefit claims?

Initial Proposed Answer: No. The DOL does not believe it has the authority to establish either a statute of limitations or an accrual rule for benefit claims. However,

the Department does believe that it has the authority to require that a plan provide certain types of notices to participants concerning the statute of limitations and the accrual of claims.

DOL Answer: EBSA staff notes that the Department of Labor has a project on its regulatory agenda under section 503 of ERISA and will consider this issue in the context of its rulemaking project.

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Question #18: Benefit Claims: Despite the best efforts of disability claims adjudicators operating under an ERISA claims procedure, there is often little time remaining for final appellate deliberations consistent with 29 CFR §2560.503(i)(3) following late breaking evidence such as an Independent Medical Evaluator's ("IME's") report or a pre-decision committee analysis based upon an IME's report. Such delays often are the result of the need to obtain the independent professional's evaluation of late submitted evidence from the claimant or his or her treating physicians. Regardless of the cause, it is all too frequently the case that even with the delays because of legitimate prior utilization of the final decision maker's extension opportunities little time remains until the deadline for a final decision when that decision maker receives an IME report or other pre-decision analysis that the claimant has also not yet seen. In such circumstances, the final stage adjudicators are increasingly following the practice of sharing the late breaking report or analysis with the claimant and offering the claimant an opportunity to comment or otherwise respond, including an offer to delay the decision if the claimant requests an extension of the then immanent decision deadline. Where the report is adverse to the claimant, the claimant ordinarily requests additional time to respond, which is a permitted reason for delaying the decision deadline under the ERISA claims procedure regulations.

A problem arises where fairness requires that the claimant be afforded additional time to respond, but for whatever reason he or she fails to request an extension of the decision deadline.

In this circumstances, where a late breaking report is adverse to the claimant, may the final decision date be extended by unilateral action of the final adjudicator to afford the claimant a reasonable opportunity to respond even if the adjudicator has already used its other opportunities to delay the deadline granted under the regulations due to reasonable or unavoidable delays while the IME or other pre-decision analysis was being prepared.

Initial Proposed Answer: Even though it would be reasonable for the final adjudicator to delay the decision deadline under these circumstances, the regulations do not permit such additional extensions without a request by the claimant. If the final adjudicator delays its decision unilaterally in this circumstance, there is no assurance that the delay beyond the regulatory deadline will not have negative consequences such as forfeiture of the failure to exhaust jurisdictional objection to federal or state court benefit claim

action under ERISA §502(a)(1)(B).

DOL Answer: A unilateral delay by the final adjudicator is not permitted. EBSA staff notes that the Department has a project on its regulatory agenda under ERISA section 503 and will consider this issue as part of that rulemaking process.

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Question #19: Benefit Claims: Occasionally claimants pursuing benefits through an ERISA plan's ERISA claim procedure assert a claim based in whole or in part upon representations made to them by the plan sponsor or a member of its staff. Conscientious claims adjudicators consider all grounds and theories advanced by the claimant in weighing their claims. In those cases where the adjudicator determines the claim is supported by the plan's terms, the adjudicator is required to uphold the claim. If the plan document does not support the claim, a conscientious claims adjudicator may nonetheless consider whether the claim based upon an alleged representation constitutes a sufficient claim of promissory estoppel under prevailing legal standards. What steps should the claims adjudicator take if it believes the claimant has presented evidence satisfying the elements of an enforceable promissory estoppel claim? May plan assets be used to satisfy such a claim?

Initial Proposed Answer: A misrepresentation of the terms of the plan by a plan sponsor that satisfies the elements of promissory estoppel may give rise to an enforceable claim against the plan sponsor. Plan assets should not be used to satisfy the claim if the claims adjudicator does not believe the benefit is payable under the terms of the plan since doing so would divert assets required to fund benefits actually payable to other participants under the terms of the plan.

Some claims adjudicators facing this situation will advise the plan sponsor of their conclusion and encourage the plan sponsor either to pay the claim out of plan sponsor assets or amend the plan to improve benefits in a manner consistent with the representation for the claimant and others similarly situated. If the plan sponsor refuses to do so, the adjudicator should issue its final decision, including disclosure of its conclusion regarding promissory estoppel. If the plan sponsor amends the plan, plan assets may be used to pay the claim.

DOL Answer: EBSA staff does not believe this to be the appropriate forum in which to answer this question.

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Question #20: Participant Threat: A nurse practitioner whose job it is to field telephone calls from an ERISA plan's disability claimants received a voicemail message from a claimant who had been informed in an earlier call that he needed to supply certain medical records in support of his claim. In that message, the claimant expressed anger and made a threat to come to the office where the nurse practitioner works and

“kill everybody.” Under the plan’s procedure in such circumstances, the nurse practitioner’s supervisor contacted local law enforcement concerning the threat. The claimant’s disability claim will be processed in the ordinary course without any other consequences due to the threat. Does the call to law enforcement that may result in adverse consequences to the claimant violate the ERISA §§510 or 511 prohibitions against interference with his exercise of protected rights.

Initial Proposed Answer: As long as the participant’s disability claim is adjudicated on its merits despite the threat of physical harm, the claim adjudicator’s policy intended to protect the health and safety of its employees will not be deemed a violation of either ERISA §§510 or 511.

DOL Answer: EBSA staff notes that ERISA section 511 provides a criminal penalty but no private right of action for the claimant. With respect to ERISA section 510, as long as the reporting of the threat is consistent with the general workplace policies of the nurse practitioner’s employer and the participant’s claim is afforded a full and fair review and is processed and handled in accordance with the plan’s claims procedures, it is the staff’s view that the procedure for responding to the described threats does not implicate the prohibitions of ERISA section 510. Death threats are not protected under ERISA section 510 and calling the police under the circumstances described is not a violation of section 511.

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Question #21: Participant Communications: Although participant communications from plan fiduciaries and plan sponsors are ordinarily sufficient if a reasonable participant or beneficiary could understand the message being conveyed, as participants increasingly learn to appreciate the need to keep assets accumulating in a 401(k) or other defined contribution plan until age 70 or beyond, there is an increasing need for a focus on participants’ and beneficiaries’ actual comprehension of those messages. This touches on the delicate issue of diminished capacity and the duties of fiduciaries when they become aware of a participant’s or beneficiary’s actual lack of financial decision making capacity. A related issue arises if a fiduciary becomes aware of elder abuse.

Does the Department have any thoughts to share regarding the strategies fiduciaries should follow in such circumstances? Does the Department agree that a fiduciary may properly expend plan assets seeking advice from professionals, including expert evaluators of individual decision making capacity to address the special needs of participants and beneficiaries experiencing a diminishment of their capacity to appreciate and act upon plan administration, plan investment and plan distribution communications?

Initial Proposed Answer: The Department has studied this issue and will continue to do so. The Department welcomes suggestions.

Within reason, the expenditure of plan assets in such circumstances could be appropriate.

DOL Answer: The Department appreciates the importance and sensitivities of these issues. The 2011 ERISA Advisory Council studied Privacy and Security Issues Affecting Employee Benefit Plans. The Council focused on the privacy and security of benefit data and personal information in light of the dramatic changes in technology and its use in the last decade in employee benefit plan management. In its report, the Council recommended that the Department include in its outreach and educational materials information regarding elder abuse related to benefit plans. The Department would welcome any suggestions for further guidance in this area.

Question #22: DOL Model COBRA Notices: The model DOL COBRA election notice provides as follows:

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Describe Plan provisions for requiring notice of disability determination, including time frames and procedures.*] Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

This language specifically refers to notice of the SSA disability determination being provided to the Plan within 30 days after SSA's determination. However, the language does not include the statutory rule that notice needs to be provided before the end of the 18 month COBRA period that is otherwise applicable. Specifically, ERISA §602(2)(A)(viii) provides that:

(viii) Special rule for disability. In the case of a qualified beneficiary who is determined, under title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continuation coverage under this part, any reference in clause (i) or (ii) to 18 months is deemed a reference to 29 months (with respect to all qualified beneficiaries), but only if the qualified beneficiary has provided notice of such determination under section 1166 (3) before the end of such 18 months. (Emphasis added.)

Does the lack of a reference to SSA notice being provided before the end of the 18-month COBRA coverage period reflect a DOL view that this condition does not apply?

Initial Proposed Answer: No. The DOL’s model notices are simply model notices and are not intended to reflect any interpretation of the substantive COBRA requirements. Employers and plan administrators are not required to use the DOL model language and may permissibly modify the notices in a manner that deviates from the model to include the rule governing the timing of SSA notification otherwise required by ERISA §602(2)(A)(viii).

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #23: DOL Model COBRA Notices: The model DOL COBRA election notice includes a section entitled “Paperwork Reduction Act Statement.” It also includes an OMB Control Number and expiration date. These statements reflect no substantive COBRA provisions. Is the DOL’s view that a COBRA notice intending to conform to the “model” COBRA notice must include the section entitled “Paperwork Reduction Act Statement” and the OMB Control Number with expiration date?

Initial Proposed Answer: No. The DOL’s model notices are simply model notices and are not intended to reflect any interpretation of the substantive COBRA requirements. Elimination of the section entitled “Paperwork Reduction Act Statement” and the OMB Control Number will not cause the notice to deviate impermissibly from the model COBRA notice.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #24: National Medical Child Support Notice: A large employer sponsors a self-insured group health plan that offers dependent coverage. Dependent coverage extends to children of the employee and includes biological, adopted, foster and step children. Dependent coverage does not include grandchildren, nieces, nephews – even if those individuals might be considered a dependent under Code §152. The employer as plan administrator has procedures for reviewing medical child support orders that include verifying whether the “child” listed is actually part of the eligible dependent category under the group health plan; some orders have been rejected (not qualified) on this basis. When the employer receives a National Medical Support Notice (NMSN), however, there is no mechanism for rejecting the notice based on whether the child is an eligible dependent under the group health plan. The four responses in Part A of the

NMSN do not address this issues; the assumption is that the child is eligible if there is dependent coverage offered. Response 5 of Part B of the NMSN assumes that the child or children named are eligible if dependent coverage is offered. The employer has received several NMSNs where they have actual knowledge that the child named is not a dependent under the plan. This is a particular issue with grandchildren; the orders and notices may be issued incorrectly. When the employer questioned the issuing agency, the employer was told that it had to take the NMSN “at face value” and could not reject the NMSN on that basis. Can the employer follow its QMCSO procedures for the NMSN? If yes, how can the NMSN be rejected for this reason since the form does not contemplate this response?

Initial Proposed Answer: Yes, the employer can follow its QMCSO procedures for processing the NMSN. The NMSN should be returned with Box 1 checked and a further explanation that the “child” listed is not an eligible dependent.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #25: Missing Participant: Upon the termination of a defined contribution plan, is the plan fiduciary, in order to fulfill its fiduciary obligations under ERISA, required to use the SSA’s letter forwarding service as one of its steps to locate a missing participant or beneficiary before the plan fiduciary determines that the plan participant or beneficiary cannot be found and distributes benefits accordingly?

Initial Proposed Answer: No, there is not a requirement to use the SSA’s letter forwarding service as one of the steps used by a plan fiduciary to locate a missing participant or beneficiary in order for the plan fiduciary to fulfill its fiduciary obligations under ERISA.

DOL Field Assistance Bulletin 2004-02 (FAB 2004-02) requires that a plan fiduciary must use either the IRS or SSA letter-forwarding service as one of the steps used to locate a missing participant or beneficiary in order for the plan fiduciary to fulfill its fiduciary obligations under ERISA. At the time that the FAB 2004-02 was issued, this requirement was reasonable, as the IRS letter-forwarding service was offered at a minimal cost. (At the time that the FAB 2004-02 was issued, the IRS letter-forwarding service was free for fewer than 50 participants and subject to a fee for 50 or more participants. In contrast, the SSA letter-forwarding service at the time was subject to a fee of \$25.00 per participant for letters informing the missing person of money or property due to him or her.)

However, in 2012, the IRS discontinued its letter-forwarding service. In addition, the SSA increased the cost of its letter-forwarding service to \$35.00 per participant letter. Further, the SSA indicates that its letter-forwarding service is only to be used if a “large amount of money” is due to the missing participant. Based upon these changes, the

only letter-forwarding service available to the plan fiduciary is the SSA letter-forwarding service and it is only available in circumstances where a significant plan benefit is due to the missing participant. In addition, the cost of the SSA letter-forwarding service is in itself significant and would not be a prudent cost to incur for all missing participants. Instead, the plan fiduciary should consider the size of the participant's account balance in relation to the cost of using the SSA letter-forwarding service and determine if it is prudent to use the SSA letter-forwarding service as one step in the plan fiduciary's effort to locate the missing participant or beneficiary. For these reasons, the use of the SSA letter-forwarding service is no longer a required step that a plan fiduciary must undertake in its effort to locate the missing participant or beneficiary. Instead, the plan fiduciary may consider the use of the SSA letter-forwarding service as one of several search methods available to use, if deemed prudent, in its effort to locate the missing participant or beneficiary.

DOL Answer: EBSA staff is aware of this issue and is working on updating its guidance. Further, the Social Security Administration has just announced that the SSA letter-forwarding program will cease operation on May 19, 2014.

Subsequent Event: On August 14, 2014, the Department issued FAB 2014-01, to take into account important changes that have occurred in the ten years since the publication of FAB 2004-02, including the discontinuance of the IRS and SSA letter-forwarding programs for plan fiduciaries searching for missing participants or beneficiaries.

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Question #26: Settlement Agreements: In its investigations, when does the Department use settlement agreements rather than working with the subject of an investigation to correct any violations found by the Department?

Initial Proposed Answer: The Department uses settlement agreements only when the Department brings a legal action in court against the subject of the investigation and the Department and the subject negotiate a settlement to dismiss the court action.

DOL Answer: Settlement agreements are an efficient tool that the Department may use in its discretion to memorialize and potentially enforce the terms of correction. The Department uses settlement agreements in its voluntary compliance process when the parties reach a negotiated understanding regarding the corrective actions that will be taken to remedy violations identified by the Department.

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Question #27: Fund Liabilities: A multiemployer defined benefit pension plan is amended to accept direct rollovers of eligible rollover distributions from a multiemployer defined contribution plan. The defined benefit plan provides an annuity that is determined by converting the amount directly rolled-over into an annuity that is the

actuarial equivalent of the amount rolled over. The defined benefit plan is in endangered status.

Is the amendment a violation of ERISA §305, which prohibits endangered plans from increasing the liabilities of the plan?

Initial Proposed Answer: No. Since the annuity is the actuarial equivalent of the amount rolled over to the defined benefit plan, there is no increase in the liabilities of the plan as a result of the amendment.

DOL Answer: This question is within the jurisdiction of the Department of the Treasury.

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Question #28: Medical Reimbursement Account: The San Francisco Health Care Security Ordinance requires that employers spend at least \$2.44 per hour worked by an employee in the City. One of the options for this expenditure is for an employer to make contributions for an employee to a medical reimbursement account administered by the City. As described on the [website](#) for the City's Health Care Security Ordinance:

What do my employees receive if I contribute to the City Option on their behalf?

The City Option allows you to deposit money with the City on behalf of your employees. Based on the information you provide, your employees will be provided one of two health benefits:

- For an employee who is an uninsured San Francisco resident and meets Healthy San Francisco eligibility requirements, the Employer's payment is applied towards the Employee's enrollment in Healthy San Francisco. The Employee may receive a discount on Healthy San Francisco program participation fees.
- For an Employee who has doesn't qualify for Healthy San Francisco, the Employer's payment will be deposited into a Medical Reimbursement Account (MRA). The Employee can use the funds in the MRA to get reimbursed for eligible health care expenses.

Please visit sfcityoption.org for more information.

Are the San Francisco medical reimbursement accounts an employer payment plan as described in Technical Release 2013-03?

Initial Proposed Answer: Yes. Employer contributions on behalf of employees are credited to medical reimbursement accounts that reimburse medical expenses incurred by those employees and their family members. The fact that the employer funds the medical reimbursement accounts makes this an employer payment plan. The fact that the City administers the reimbursements from the medical reimbursement accounts does not change the character of the arrangement.

If this sort of arrangement were not deemed to be an employer payment plan, other cities (or even states) could adopt similar laws. That would allow employers and employees to participate in arrangements functionally equivalent to health reimbursement arrangements without the restrictions and limitations that Technical Release 2013-03 places on health reimbursement arrangements.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #29: Automatic Enrollment: When will automatic enrollment of all new full-time employees in health coverage and the continued enrollment of current employees be required for employers with 200 or more full-time employees?

Initial Proposed Answer: The Department will issue guidance for Fair Labor Standards Act §18A sometime in late 2014, which likely become effective in for Plan Years 2016 and thereafter.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #30: Plan Year: A plan has an October 1-September 30 plan year. The plan would like to extend the current plan year through December 31, 2014, which means that the plan year will run from October 1, 2013 to December 31, 2014. The plan is taking this action in order to simplify compliance with PPACA requirements, calculations and fees going forward. The plan will eliminate the pre-existing condition exclusion and annual/maximum out of pocket limits as of January 1, 2015. The plan does not want to have a short plan year because the plan does not want participants to have to satisfy one deductible and out of pocket maximum for the October 1, 2014-December 31, 2014 plan year and then start the deductible and out of pocket maximum over on January 1, 2015. Is this permissible?

Initial Proposed Answer: Yes, because the plan would have been permitted to have a short plan year that commenced October 1, 2014 to December 31, 2014 and because it would allow participants to avoid satisfying multiple deductible and out of pocket maximum amounts within a short time period.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #31: Fund Benchmarking: Company A maintains a 401(k) plan providing participants with investment discretion of their accounts in a manner intended to satisfy ERISA §404(c). Among the designated investment alternatives offered under the plan is a family of target date funds. In providing the investment performance disclosures required under regulation section § 2550.404a-5(d), the plan administrator is considering whether to utilize a set of target date fund indices as a benchmark. Assume that (1) for each target date fund offered by the plan, an index based on the performance for target date funds having the same target dates would be used, and (2) the set of indices is not administered by an affiliate of the issuer of the target date funds used by the plan, or such issuer's investment adviser, or one of its principal underwriters. Further assume that, for any given target date, the index is developed by a method which effectively averages either the performance, or the glide paths, of target date funds offered in the marketplace, so that there is likely to be some deviation between the glide path utilized by the target date fund offered by the plan and the glide path that is implicit in the index.

May such a target date fund index be used as the "broad-based securities market index" in providing an investment return comparison for plan participants under the regulations?

Initial Proposed Answer: Such a target date fund index may be used as the "broad-based securities market index" in providing an investment return comparison for plan participants under the regulations. The regulations use the term "broad-based securities market index" but do not define it. In this regard, the preamble to the regulations refers to "broad-based indices contemplated Instruction 5 to Item 27(b)(7) of Form N-1A," issued by the SEC. That instruction merely states that an "appropriate broad-based securities market index" is one that is administered by an organization that is not an affiliated person of the Fund, its investment adviser, or principal underwriter, unless the index is widely recognized and used." Thus, it provides only limited guidance regarding what a broad-based securities market index actually is. Some further gloss is provided by Instruction 5 to Item 27(b)(7), which states that a "Fund is encouraged to compare its performance not only to the required broad-based index, but also to other more narrowly based indexes that reflect the market sectors in which the Fund invests." In this context, it appears that indices which are "broad-based" are those reflecting a broad range of market sectors, rather than a particular sector (such as sectors based on company size or type of industry). Although target date funds are specialized investment vehicles, they commonly invest in securities representing a broad range of sectors. Similarly, target date fund indices are also reflective of a broad range of sectors. Consequently, it is reasonable to construe regulations § 2550.404a-5(d) as permitting a target date fund index be used as the "broad-based securities market index." This would appear even more appropriate where the prospectus for the target date fund involved uses a target date fund index as its broad-based securities market index. Moreover, this should be the case even though the model disclosure form

issued as part of the regulations uses, as an example, the S&P 500 Index as an appropriate broad-based securities market index for the “Generations 2020 Lifestyle Fund” listed in the sample form.

DOL Answer: The Department’s regulatory standard, set forth in § 2550.404a-5(d)(1)(iii), is meant to be consistent with the Securities and Exchange Commission’s standard for prospectuses and Form N–1A. Accordingly, absent coordination with the SEC, we are not prepared to conclude that the target date fund index you describe would be an acceptable primary benchmark under our regulation. However, we recognize that target date funds have special characteristics that sometimes can call into question the utility of a comparison to traditional single asset-class benchmarks. EBSA staff, therefore, note that plan administrators probably could use the target date fund index described above as a secondary benchmark.

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Question #32: Fund Benchmarking: As an alternative to the question immediately above, may the plan administrator utilize such a target date index as an alternative index? Will the fact that the glide path for the index may vary at least some extent from the glide path utilized by the target date funds offered by the plan preclude use of the index as an alternative index the purposes of the participant investment disclosures?

Initial Proposed Answer: Such a target date index may permissibly be used as an alternative index under the regulations. In 29 CFR §2550.404a-5(d)(2)(ii), the final regulation permits the disclosure of information that is in addition to that which is required by this final regulation, so long as the additional information is not inaccurate or misleading. The preamble to the final regulation states in this regard that “in the case of designated investment alternatives that have a mix of equity and fixed income exposure (e.g., balanced funds or target date funds), a plan administrator may, pursuant to paragraph (d)(2)(ii) of the final rule, blend the returns of more than one appropriate broad-based index and present the blended returns along with the returns of the required benchmark, provided that the blended returns proportionally reflect the actual equity and fixed-income holdings of the designated investment alternative.” Although the glide path implicit in the index may vary from that utilized by the target date funds offered by the plan, any variation should not be considered to be inaccurate or misleading for participants because (1) such differences would be inherent in any method a provider might use to create a target date fund index, (2) such differences would likely be relatively small, and (3) the information provided to participants through such an index ultimately would be superior to the information supplied by a more generic securities index such as the S&P 500 index, because it would reflect an underlying investment strategy which is likely to be far closer to that utilized by the target date fund offered by the plan than such a generic index would do (despite variations in the glide path). This should be the case even though the model disclosure form issued as part of the final regulations uses, as an example, such a precisely

tailored index as an example of a permissible alternative benchmark for the “Generations 2020 Lifestyle Fund” listed in the sample form. If such an index were not permitted as an alternative index (nor as a broad-based securities market index), then the only method of providing indices more relevant to a plan’s target date funds would be the complex and expensive undertaking of having the plan administrator or an investment advisor create an index precisely tailored on the specific glide path used by the target date fund involved, both in terms of the current mix of investments and how that mix has varied over the timeframe for which the benchmark must be provided (1, 5, and 10 calendar years, or if shorter, since inception).

DOL Answer: See DOL Answer to question 31.

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Question #33: Annuity Conversion: Upon the termination of a 403(b) plan, is each plan participant required to approve and authorize the conversion of a 403(b)(1) annuity contract to an individual annuity contract and the distribution of the individual annuity contract to the participant or may the plan administrator approve and authorize such conversion and distribution in order to fully distribute the 403(b) plan assets upon plan termination? Similarly, upon the termination of a 403(b) plan, is each plan participant required to approve and authorize the lump sum distribution to the participant of the plan assets held in the 403(b) custodial account or may the plan administrator approve and authorize such lump sum distribution in order to fully distribute the 403(b) plan assets upon plan termination?

Initial Proposed Answer: In the event of the termination of a 403(b) plan, there is no requirement for the plan participant to approve and authorize the conversion of a 403(b)(1) annuity contract to an individual annuity contract and the distribution of the individual annuity contract to the participant. The plan administrator may approve and authorize such conversion and distribution in order to distribute the 403(b) plan assets upon plan termination. Similarly, in the event of the termination of a 403(b) plan, there is no requirement for the plan participant to approve and authorize the lump sum distribution to the participant of the plan assets held in the 403(b) custodial account. The plan administrator may approve and authorize such lump sum distribution in order to fully distribute the 403(b) plan assets upon plan termination.

DOL Answer: The Department defers to the Internal Revenue Service on questions involving permissible distributions from 403(b)(1) and 403(b)(7) plans as with all questions involving interpretation of the Internal Revenue Code section.

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Question #34: Fee Disclosure: Is it acceptable to disclose a range of fees in an ERISA § 408(b)(2) fee disclosure?

Initial Proposed Answer: Yes, it is acceptable under ERISA § 408(b)(2) to disclose a range of fees in an ERISA § 408(b)(2) fee disclosure, provided that the disclosure generally describes the minimum and maximum range of services that would be provided within that fee range and all amounts within such fee range would be considered reasonable compensation for such minimum and maximum range of services.

DOL Answer: We have heard that some service providers may be using generic disclosures that list the full range of fees for all of their services without any regard to the actual services likely to be provided under the specific contract or arrangement and that, for some or all of these services, compensation or costs is being expressed as a broad range of possible basis points. We struggle to see how this kind of disclosure is helpful or compliant.

The use of a range of fees is appropriate in circumstances where there is some uncertainty about the precise fees the customer will likely incur because the fees vary based on investment experience, plan customer decisions, or other circumstances. In such cases, a range can be a reasonable way to convey to the customer a good sense of the likely expense, while acknowledging the uncertainties. The disclosure always needs to be tied to a reasonable assessment of the range of fees the customer is likely to incur under the specific contract or arrangement.

A range should never be used if the service provider knows the actual amount of the fees in advance and could just disclose the correct number – to give the customer a range in that circumstance would be unhelpful at best and probably misleading since all the numbers in the “range” except the correct one are false. Similarly, if a range is going to be used, it should never include improbable highs or lows, and it shouldn’t be slanted to give undue weight to the highs or lows.

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Question #35: Fiduciary Disclosure: In its enforcement efforts, is the DOL looking solely at the adequacy of the plan fiduciary’s disclosure or whether the plan fiduciary properly analyzed the disclosure?

Initial Proposed Answer: In its enforcement efforts, the DOL is reviewing the adequacy of the plan fiduciary’s disclosure.

DOL Answer: EBSA staff notes that EBSA investigators are interested in looking at whether the plan fiduciary is properly using the disclosed information, as well as whether the information was disclosed in the first place.

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Question #36: Service Providers List: Will the DOL publicly provide a list of service providers with known ERISA § 408(b)(2) failures?

Initial Proposed Answer: Yes, the DOL will publicly provide a list of service providers with known ERISA § 408(b)(2) failures.

DOL Answer: EBSA staff notes that there is no plan to publish such a list at this time.

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Question #37: Rollover Limit: Can plan design limit in-plan Roth rollovers to participants who are 100% vested, assuming no Code §401(a)(4) non-discrimination problems?

Initial Proposed Answer: Yes, in-plan Roth rollovers can be limited by plan design to participants who are 100% vested, assuming no Code §401(a)(4) non-discrimination violations.

DOL Answer: This appears to be a question that should be directed to the Internal Revenue Service.

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Question #38: Preemption: In light of the 2008 Golden Gate Restaurant Association litigation, would the San Francisco Health Care Security Ordinance be preempted under ERISA?

Initial Proposed Answer: The decision in *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F. 3d 639 (9th Cir. 2008), which held that ERISA does not preempt the San Francisco ordinance requiring covered employers to make required health care expenditures each quarter on behalf of most of their employees, is not binding on the current San Francisco Health Care Security Ordinance. The current San Francisco Health Care Security Ordinance has been significantly changed since the *Golden Gate Restaurant Association* decision and it is not in the same form as it was at the time that the decision was rendered. At the time of the decision, the Ninth Circuit determined that the ordinance in its form at that time did not require that an employer establish an ERISA plan or that an ERISA plan provide any particular level of benefit. In contrast, in its current form, the San Francisco Health Care Security Ordinance is very specific and prescriptive and very specifically defines what types of ERISA plans do and do not fulfill the mandates of the ordinance. For these reasons, the *Golden Gate Restaurant Association* decision is no longer binding on the current form of the San Francisco Health Care Security Ordinance and it is possible that the current form of the ordinance is preempted by ERISA.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #39: Disclosure Guide: On March 12, 2014, DOL published in the Federal Register a proposed amendment to the disclosure rules under the 408(b)(2) regulation which would, when adopted, require covered service providers to furnish a guide to assist plan fiduciaries in reviewing disclosures that are contained in multiple or lengthy documents. The proposed effective date is 12 months after publication of a final amendment in the Federal Register.

Would the amendment, when adopted, apply the guide requirement to previously-furnished disclosures, or would it apply only to disclosures made after the effective date? Even if it does not apply to previously-provided disclosures, would it apply in the event of changes to prior disclosures? To apply the guide requirement to prior disclosures could, depending on the threshold set for a “lengthy” document, potentially require plan service providers to incur substantial expenses in re-sending disclosure documents to current clients.

Initial Proposed Answer: The Department intends that the guide requirement would apply only to disclosures made after the effective date, even in the event those prior disclosures are changed. The Department would revise the final amendment accordingly.

DOL Answer: EBSA staff acknowledges this issue relating to the effective date of the guide proposed under the 408(b)(2) regulation and will consider it along with other issues that are raised. If the JCEB has views on whether the requirement should apply to disclosures made prior to the effective date of an amendment to the regulation, EBSA staff invites JCEB to share those views.

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Question #40: Separate SPD: Must an ERISA covered group health plan have a separate SPD and plan document?

Initial Proposed Answer: No. ERISA § 402(a) requires only that an employee benefit plan must be “established and maintained pursuant to a written instrument.” Under Section 402, such written instrument must: (1) identify the named fiduciaries; (2) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan; (3) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan; (4) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan; (5) include a DOL compliant procedure for addressing claims and appeals; (6) specify the basis on which payments are made to and from the plan; and (7) include a procedure for the distribution of plan assets upon plan termination. If a group health plan SPD includes all of the information required under Section 402 of ERISA, the SPD content required under 29 CFR 2520.102-3, and the HIPAA

information required pursuant to Sections 701-734 of ERISA, such document will also be considered the written instrument governing the operation of the plan for purposes of ERISA §402.

DOL Answer: The JCEB and the DOL had a separate meeting for discussion about health reform issues and implementation generally.

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Question #41: Form 5500 Schedule A: Does monetary and non-monetary incentive compensation constitute “commissions and fees” as defined in the Instructions for Schedule A (Form 5500) and DOL Advisory Opinion 2005-2A under the following circumstance:

An insurance company issuing a group annuity, life insurance or disability income contract (the “Issuing Insurance Company”) does not pay commissions or fees to insurance agents or brokers, but instead employs its own salaried sales staff and compensates them with (a) annual salaries; and (b) monetary and non-monetary incentive compensation where such incentive compensation is based on three factors (1) aggregate team sales performance that is not directly tied to the sale of a contract to a particular ERISA plan by the Issuing Insurance Company; (2) individual sales achievement that exceeds preset aggregate annual individual sales goals that are not tied directly to the sale of a contract to a particular ERISA plan client; and (3) overall corporate performance.

Initial Proposed Answer: No. Annual salaries and incentive compensation that is paid to each sales employee of the Issuing Insurance Company in the manner described above would not constitute “commissions and fees” for Schedule A (Form 5500) purposes. The intention of this disclosure is to include sales and base commissions paid to sales employees of the Issuing Insurance Company that are directly related to the sale of a contract to a particular ERISA plan client and all monetary and non-monetary forms of compensation paid to a third party insurance broker or agent.

DOL Answer: The Department agrees that category (a) above, sales employees’ annual salaries generally do not constitute commissions and fees for Schedule A of Form 5500 purposes. However, the Department does not agree with respect to all of the compensation described in (b) above. Although more facts are needed, generally employee incentive compensation based on team and/or individual sales performance, when based on a book of business including ERISA-covered plans, is reported on Schedule A. However, reporting incentive compensation paid to the insurer’s salaried staff based on overall corporate performance would not necessarily need to be reported on Schedule A, depending on the facts and circumstances.

As described in the Instructions for Schedule A of the Form 5500 and Advisory Opinion 2005-02A, insurers must provide plan administrators with a proportionate allocation of such commissions and fees attributable to each contract or policy reported. Any

reasonable method of allocating commissions and fees to policies or contracts is acceptable, provided the method is disclosed to the plan administrator.

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Questions # 42, #43 and #44: Self-Correction of Late Employee Contributions: A plan sponsor determines that employee 401(k) deferrals were deposited to the plan's trust a few days late though an inadvertent payroll error. The sponsor recognizes that the error can be corrected in conjunction with a filing through the Voluntary Fiduciary Correction Program; however, the sponsor believes that self-correction and paying the excise tax on Form 5330 is a more appropriate action in these circumstances.

- a. If the sponsor self-corrects by restoring affected participants' accounts to the exact position they would have been in if the deferrals were deposited timely and paying the excise tax and the plan was later audited by the DOL, would the DOL accept these actions as appropriate self-correction?
- b. Would the sponsor be able to use the DOL's online calculator in connection with a self-correction?
- c. If the sponsor takes action within a limited period of time, would the sponsor be able to self-correct without paying the excise tax on Form 5330?

Initial Proposed Answers: The DOL would accept the actions in a. above as appropriate self-correction. While the same would not currently be true with respect to self-correction using the online calculator or without paying the excise tax, the DOL is continuing to consider whether to amend VFCP to include a self-correction component for late deposit of employee deferrals.

DOL Answers: While the Department always encourages the correction of fiduciary breaches, under the current VFCP, there is no self-correction feature and therefore no relief from potential civil actions and civil penalties under ERISA for the described correction. Parties have asked that the Department consider adding a self-correction element to the VFCP program. The Department is considering such requests.

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Questions #45, #46 and #47: Termination Lump Sum Distributions: Assume that a PBGC-covered single-employer plan is in the process of terminating in a standard termination, and that consensual lump sums are available as part of the termination. After the NOIT is issued, it is determined that if distributions are delayed to be made during a later time during the permitted distribution period, the lump sums payable would be significantly lower. That might happen, for example, if the permitted distribution period for the standard termination runs from late in Plan Year X to early in Plan Year Y; the stability period governing the applicable interest rate to be used for purposes of calculating lump sums is the plan year; the look back month for this purpose is the fifth full calendar month preceding the first day of the plan year; and the

applicable interest rate for Plan Year Y is significantly lower than it was for Plan Year X, so that lump sums will be significantly higher if the annuity starting date for a lump sum is in Plan Year Y than if it is in Plan Year X.

(a) Is the decision as to the timing of the distributions a fiduciary decision or a sponsor decision? Does it matter whether or not the documentation terminating the plan or a plan amendment adopted on or before the termination date of the plan specifies that the annuity starting date will, if administratively feasible, be during the stability period that would result in the lower lump sums?

(b) If the answer to (a) is that the decision is a fiduciary decision:

(1) Does that mean that the fiduciary may be required to delay distributions to the later time during the permitted distribution period where lump sums would, as a result of that delay, be significantly higher as a result of a lower applicable interest rate?

(2) Are there any Title I restrictions on the sponsor's decision to withdraw the standard termination if the sponsor learns that the fiduciary's decision as to the timing of the distribution will increase the cost for the standard termination to a level that is not acceptable to the sponsor?

Initial Proposed Answers:

(a) The timing of distributions as part of a standard termination, provided that the timing is compliant with PBGC rules governing standard termination distributions, is part and parcel of the decision as to whether and when to terminate a plan in a standard termination, and is a sponsor rather than a fiduciary decision.

(b) (1) Not applicable.

(b) (2) Not applicable.

DOL Answers: EBSA staff believes that these questions are best addressed through the advisory opinion process where the Department can examine and address the specific facts of the particular question.

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Question # 48: Portfolio Turnover Rate: The participant fee disclosure regulations under 29 CFR § 2550.404a-5(d)(1)(v) requires that an internet website be maintained that, among other things, requires each designated investment alternative to disclose its portfolio turnover rate "in a manner consistent with Securities and Exchange Commission Form N-1A or N-3, as appropriate." Those forms do not provide specific guidance as to how to calculate the portfolio turnover rate in the case of certain designated investment alternative (such as in the case of a target risk fund that invests in other funds). If the plan administrator makes a good faith determination as to how the

portfolio turnover rate is determined under those Forms, will the plan administrator be deemed to comply with the requirement of the regulation described above?

Initial Proposed Answer: Yes, the Department understands that Securities and Exchange Commission Form N-1A and N-3 may not specifically address the determination of portfolio turnover rate in respect of every type of designated investment alternative. Therefore, if the plan administrator calculates the portfolio turnover rate for each designated investment alternative in accordance with its good faith interpretation of the rules described in those Forms, the Department will treat the requirement to disclose the portfolio turnover rate as satisfied and will not take any action against the plan administrator for non-compliance.

DOL Answer: The Department generally agrees with the proposed answer. As acknowledged in the preamble to the final rule, the Department recognizes that not all designated investment alternatives (DIAs) previously were required to calculate a portfolio turnover rate. Further, the instructions in Securities and Exchange Commission Form N-1A or N-3 may not provide specific directions that will work for all DIAs. Accordingly, the requirement in the final rule was phrased to provide that such rates must be calculated “in a manner *consistent with*” the Commission’s Form instructions. In the absence of more specific guidance for DIAs that are not subject to (or directly addressed by) the Commission’s requirements, the Department believes that a plan administrator’s reasonable and good faith determination as to an appropriate calculation methodology for portfolio turnover rate that is not inconsistent with the principals set forth in the Commission’s instructions will be compliant with 29 CFR § 2550.404a-5(d)(1)(v)(D).