

**Questions and Proposed Answers for the Department of Labor Staff for the
2008 Joint Committee of Employee Benefits Technical Session
Held on May 7, 2008**

The following questions and answers are based on informal discussions between private sector representatives of the Joint Committee on Employee Benefits (JCEB) and Department of Labor (DoL) 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: Assume a participant submits an appeal of an adverse benefit determination. Can the appeals committee refuse to consider his appeal unless he or she produces a large volume of documents that are unrelated to the issue(s) involved in the appeal (*e.g.*, documentation of claims for reimbursement incurred long *before* the contested charge was incurred)?

Proposed

Answer 1: No. Conditioning the consideration of the claimant's appeal upon his or her providing voluminous irrelevant documents violates the requirement of Section 2560.503-1(b)(3) that "[t]he claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits."

DoL

Answer 1: The Staff agrees that a plan administrator may not refuse to consider a claimant's benefits appeal based on a failure to produce requested documents. The period of time within which a benefit determination on review (appeal) is required to be made begins at the time an appeal is filed in accordance with the reasonable procedures of the plan, without regard to whether all of the information necessary to make a benefit determination on review accompanies the filing.

Staff notes, however, that, just as the plan administrator is permitted to make an initial benefit determination denying a claim on the basis that the plan does not have sufficient information to make a benefit determination due to the failure of a claimant to provide requested information, Staff believes that a plan is permitted to make a determination on review in the appeals process on the same basis. Whether the plan in fact did not have sufficient information due to the failure to provide requested information would be an issue for the next stage of the claims process, including litigation challenging the plan's adverse benefit determination.

Staff further points out, however, that although plans have considerable flexibility in defining the procedures to be followed for the initiation, processing, and appeal of benefit claims, the plan's claim procedures must be reasonable. See FAQ C-2 in the FAQs About The Benefit Claims Procedure Regulation. A plan's claims procedures will not be deemed reasonable if the procedures are administered in a way that unduly inhibits or hampers the processing of claims for benefits. 29 C.F.R. § 2560.503-1(b). In Staff's view, a request for a large volume of documents that are unrelated to the issue(s) involved in the appeal would not be consistent with this requirement.

Question 2: Can an appeals committee require that a claimant produce certain documents as a condition of considering his or her appeal, yet refuse to put this demand in writing?

Proposed

Answer 2: No. Refusing to reduce to writing a demand that the claimant produce certain documents may be a trick. Specifically, claimant may refuse or fail to produce the documents if he or she determines that they are irrelevant. By refusing to put its demand in writing, should litigation ensue, the employer could claim that it had actually demanded documents that are relevant, so that the claimant is at fault for not producing them. This violates the requirement of Section 2560.503-1(b)(3) that "[t]he claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits."

DoL

Answer 2: The Staff agrees that an appeals committee cannot require a claimant to produce documents as a condition of considering an appeal. The answer to the preceding question provides further details about the answer to this question. Further, under the Claims Procedure Regulation, a plan administrator must provide a claimant with a written or electronic notification of an adverse benefit determination, including a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. Staff thinks that it would not be appropriate during the course of the review of a claim on appeal for a plan to make an adverse benefit determination on review based on the failure of a claimant to produce required documents or information without having first put the request for documents or information in writing.

Question 3: Where there does not seem to be any logical connection between the documents demanded by the appeals committee, can the claimant require

that the appeals committee articulate why the appeals committee needs those particular documents to adjudicate the claim?

Proposed

Answer 3: Yes. Section 2560.503-1(b)(5) requires that “[t]he claims procedures contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents.” If the appeals committee bases its determination upon factors that cannot be justified by the terms of the plan document, that would violate this requirement.

Furthermore, the inability of the appeals committee to articulate a logical connection between its demand for documents and the terms of the plan would tend to show that they are trying to unduly thwart claimants from prosecuting their appeals, in violation of the requirement of Section 2560.503-1(b)(3) that “[t]he claims procedures do not contain any provision, and are not administered in a way, that unduly inhibits or hampers the initiation or processing of claims for benefits.”

DoL

Answer 3: Similar to question 2, section 2560.503-1(g)(iii) of the Claims Procedure Regulation requires that the plan administrator provide a claimant with written or electronic notification of an adverse benefit determination including a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. To the extent a further request is made during the review of the claim on appeal for additional material or information, Staff does not believe that it would be appropriate for the plan to deny the claim based on a failure to provide the additional requested information without first having provided the claimant with a written explanation of why the additional material or information is necessary. In Staff’s view, a request for voluminous irrelevant documents would not be consistent with the Claims Procedures Regulation.

Question 4: Assume that a third party submits documentation on behalf of a participant who has appealed an adverse benefit determination, as permitted by Section 2560.503-1(b)(4). Assume further that the appeals committee demands proof that the third party has been authorized to act on behalf of the claimant, but the third party fails to provide such proof. Can the appeals committee disregard any (legitimate) issues that were raised in the documentation submitted by the third party?

Proposed

Answer 4: No. The appeals committee must consider all legitimate arguments that are made on behalf of the claimant, whether they are posited by the

claimant, an authorized representative, or some other party. It would be a breach of fiduciary responsibility for the committee to disregard a legitimate argument that is raised on behalf of the claimant, regardless of its source.

On the other hand, for privacy reasons, the appeals committee should *not* correspond with the third party unless and until it has received documentation showing that the claimant has authorized the third party to act on his or her behalf. Thus, any correspondence from the appeals committee should be addressed solely to the claimant.

DoL

Answer 4: Staff believes that the answer would depend on relevant facts and circumstances and is unable to answer this question based on the information presented. Nonetheless, Staff believes that a plan's legitimate interest in a manageable administrative process for deciding claims would support the establishment of reasonable procedures for submitting information in support of individual claims. However, Staff would be concerned by a fiduciary's refusal to consider credible information or reasonable arguments submitted in support of a claim based merely on the fact that the source of information or arguments is a party other than the claimant or an authorized representative.

Question 5: How much advance notice must the employer provide of the annual increase in the COBRA premium?

Proposed

Answer 5: The employer should give as much advance notice as is practicable under the circumstances. Given the practicalities of the real world, it is not practical to impose a *fixed* minimum period of advance notice.

This problem is mollified (at least to some degree) by the requirement that participants must be permitted to make up any shortfall in the premium payment that might result from insufficient advance notice of the premium increase under the rules relating to underpayment of COBRA premiums. See Treasury Regulation § 54.4980B-8, Question and Answer 5.

DoL

Answer 5: The Staff acknowledges that neither the COBRA notice provisions in Part 6 of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA) nor the DoL's COBRA notice regulations (29 C.F.R. §§ 2590.606-1 through 2590.606-4) explicitly provide for advance notice of a COBRA premium increase. Nonetheless, Treasury regulations provide that if a COBRA premium payment is short by an amount that is insignificant, the qualified beneficiary must be provided notice of such

underpayment and a reasonable amount of time to make the payment difference. See Treasury Regulation § 54.4980B-8, Question and Answer 5. Likewise, both the statute and Treasury regulations include provisions requiring equal coverage and, to some extent, equal treatment between COBRA qualified beneficiaries and same similarly situated non-COBRA beneficiaries. See ERISA § 602(1) and Treasury Regulation § 54.4980B-5, Question and Answer 1. Accordingly, in the Staff's view, COBRA continuation coverage should not be terminated for insufficient payment if COBRA qualified beneficiaries are not provided a reasonable advance notice of increased premiums and a reasonable opportunity to pay the increased premium.

Question 6: Can two or more participants file a joint appeal if they believe the issues that are implicated are identical (*e.g.*, they were all affected by a plant shutdown)?

Proposed

Answer 6: Yes. If the joint claimants believe that the issues (and facts) are identical, they must be permitted to submit a joint appeal; there is no justification for redundant appeals as long as the appeal names all of the claimants.

However, this does not require that the appeals committee must prepare a joint response. In fact, for privacy reasons, it would be best if the appeals committee prepared a separate response for each claimant, particularly if they determine that some of the claimants must be treated differently. However, the committee may decide that it will issue a joint response to all claimants with respect to whom it reaches the same result.

DoL

Answer 6: The Staff does not believe that the Claims Procedure Regulation requires a plan to accept a joint appeal. However, it is Staff's view that, even if a plan's claims procedure were to provide for "joint appeals," claimants could not be required to submit joint appeals. Further, even if joint appeals are permitted, claimants filing joint appeals would have separate rights under the Claims Procedure Regulation, including the right to be provided a separate notification of the plan's benefit determination on review. See 29 C.F.R. § 2560.503-1(j) (The plan shall provide a claimant with written or electronic notification of a plan's benefit determination on review.)

The Staff also notes that filing and processing joint appeals in group health plans may present issues under the privacy rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which are subject to interpretation and enforcement by the Department of Health and Human Services.

Question 7: Prior to January 1, 2008, an employer forwarded voluntary contributions to three 403(b) providers – A, B, and C. The voluntary contributions satisfy the requirements of 29 C.F.R. section 2510.3-2(f). The employer has no control over the amounts forwarded to the 403(b) providers – the employer merely deducts the amounts from employee pay and forwards the amounts to the 403(b) providers. The employer did not and does not control the forms of distribution allowed by the 403(b) providers (including whether they permit loans or hardship distributions), the investments, or the administration of the amounts. The employer decides to terminate its practice of permitting voluntary contributions effective December 31, 2007. The employer notifies the 403(b) providers of the termination of contributions, and the employer’s board adopts resolutions terminating the practice. To assist the 403(b) providers in complying with section 403(b), the employer agrees to provide information regarding the employee’s employment status (*i.e.*, the employer enters into information sharing agreements with the 403(b) providers).

Due to the new 403(b) plan regulations under the Internal Revenue Code (Code), the employer decides to adopt a 403(b) plan over which it exercises control (and thus makes the plan subject to ERISA) effective as of January 1, 2008. The employer reviews 403(b) providers and selects Provider A as the 403(b) provider for the 403(b) plan. Provider A is one of the three 403(b) providers that received voluntary contributions prior to the adoption of the plan by the employer. Provider A will provide recordkeeping services, serve as the custodian, and otherwise assist the employer with the 403(b) plan. The employer, however, controls the design and administration of the 403(b) plan.

After the adoption of the 403(b) plan and the selection of Provider A, the employer still does not exercise any control over the voluntary contributions made to Provider A prior to the adoption of the 403(b) plan. Indeed, the contract between Provider A and the individuals who made voluntary contributions states that Provider A controls the investments offered to the individuals and the employer cannot force Provider A to move the assets. Does the selection of Provider A as the provider for the 403(b) plan cause the contributions made before the employer adopted the 403(b) plan to be subject to ERISA?

Proposed

Answer 7: No. Voluntary contributions that satisfy 29 C.F.R. § 2510.3-2(f) are not subject to ERISA. The mere selection of a provider that previously received voluntary contributions does not make those contributions subject to ERISA unless the employer exercises some type of control over the voluntary contributions.

DoL

Answer 7: The Staff expresses no opinion as to whether the employer's 403(b) arrangements described in Question 7 comply with Code section 403(b). The Internal Revenue Service/Treasury has authority to administer and interpret the rules pertaining to tax-sheltered annuities under section 403(b) of the Code.

DoL staff read Question 7 to describe a situation under which a tax-exempt employer has maintained a 403(b) arrangement (Plan I) designed to comply with the terms of the DoL's 403(b) safe harbor regulation at 29 C.F.R. section 2510.3-2(f), and therefore, not maintained as a pension plan under Title I of ERISA. Prior to January 1, 2008, the employer decided to cease permitting employees' voluntary salary reduction contributions into Plan I, while continuing to maintain information sharing agreements with the three 403(b) providers who have received the voluntary contributions and will continue to administer the annuity contracts or custodial accounts purchased under Plan I. Subsequently, the employer established a second 403(b) arrangement (Plan II) designed to be covered as a pension plan under Title I of ERISA. For Plan II, the employer selected one of Plan I's three providers (Provider A). Provider A will provide recordkeeping services, serve as custodian, and otherwise assist the employer with Plan II.

Staff does not believe there is enough information provided in the question to express a view on the application of the DoL's 403(b) safe harbor regulation. It is unclear whether the 403(b) arrangements described in the question are properly classified as one or two plans for purposes of ERISA. The answer to that question may be influenced by whether contributions under Plan II will be made to the same annuity contracts and custodial accounts that are described as being part of Plan I. However, as a general matter, Staff agrees that an employer's 403(b) arrangement that otherwise satisfies the DoL's safe harbor criteria does not become subject to Title I of ERISA merely because the employer contracts with the same provider to provide fiduciary or other administrative services for some other plan.

Question 8: Many employers have established wellness programs to promote health awareness and healthy lifestyles as a means to contain the increasing cost of health insurance. Wellness programs range widely in their design and sophistication. For example, a "health risk assessment" ("HRA") offers a questionnaire that employees complete to determine whether they are at risk for certain types of diseases. Employees answer a survey of questions about their exercise, eating and smoking habits, current health, etc. In a very basic wellness program, the HRA includes only a questionnaire (*i.e.*, it does not include any laboratory tests or follow up "health coaching")

and employees are given the results of the survey in the form of a report outlining their health risks with recommendations to contact their personal physicians or other referral for follow up. Educational materials on managing health may also be provided. Sometimes, HRAs are combined with mobile laboratories with doctors or nurses to perform laboratory tests or biometric screening (*i.e.*, body mass index, blood pressure, and blood test for glucose and cholesterol screening). An even more comprehensive wellness program may include "health coaching" and employees with identified health risks are called by health coaches and encouraged to address their risks (*e.g.*, stop smoking, exercise more, change diet, etc.). These changes may be further encouraged through programs designed to assist individuals in achieving the healthy behavior, such as smoking cessation or weight management programs. Financial incentives (either under a group health plan or in the form of cash outside the group health plan) may also be paid to participate in wellness programs.

Depending on the design, some employers offer their wellness programs outside of their group health plans. The goal of wellness programs is primarily to promote health awareness and healthy lifestyles, although the more comprehensive programs attempt to address individual conditions, at least to some extent. Are these wellness programs considered employee welfare benefit plans under ERISA and, if so, is there a test by which an employer can determine if its wellness program is subject to ERISA?

Proposed

Answer 8:

It depends on whether the wellness program is established or maintained for the purpose of providing "medical care or benefits" or "benefits in the event of sickness" for its participants or their beneficiaries. The terms "employee welfare benefit plan" and "welfare plan" are defined in section 3(1) of ERISA to include plans providing "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident..." If a wellness program is restricted to referrals or consists only of a health questionnaire and report with no follow-up medical treatment, the plan will generally not be considered an ERISA plan. (The DoL's analysis of whether ERISA applies to employee assistance programs is helpful in evaluating the question as applied to wellness programs. See DoL Adv. Op. 83-35, 88-04A, 91-26A.) However, a wellness program meets the standard of an "employee welfare plan" under ERISA to the extent the program provides "medical care" in the form of programs that are diagnostic or preventive, or that "coach" for certain identified health risks. DoL Information Letter to Joseph Dunn (November 17, 1993).

DoL

Answer 8: The DoL's Field Assistance Bulletin 2008-02 provides a checklist to help determine what types of programs must comply with the DoL's wellness program regulations and, if the rules apply, whether the program complies with the regulations.

A wellness program is only subject to Part 7 of ERISA if it is part of a group health plan. See FAB 2008-02's threshold question C. Although this question raises specific factual scenarios upon which the DoL is unable to opine, the Staff agrees that the analytical framework provided by the DoL in Advisory Opinions addressing employee assistance programs would be appropriate in determining whether a particular wellness program is an ERISA-covered group health plan.

Additional guidance regarding the applicability of the DoL's wellness program regulations, as well as tips for compliance, are provided in the FAB.

Question 9: May a defined benefit plan offset post-NRA benefit accruals with credited actuarial adjustments where the plan does not provide for such offset? Does it make a difference if the Plan includes a valid suspension of benefits rule but fails to comply with the notice requirement?

Proposed

Answer 9: No. Code section 411(b)(1)(H)(i) provides that "a defined benefit plan shall be treated as not satisfying the requirements of this paragraph if, under the plan, an employee's benefit accrual is ceased, or the rate of an employee's benefit accrual is reduced, because of the attainment of any age." Subparagraph (iii) of that section states that "in the case of any employee who . . . has attained normal retirement age. . . – . . . (II) if distribution of benefits . . .with respect to such employee has not commenced as of the end of such year in accordance with section 401(a)(14)(C), and the payment of benefits under such plan . . . is not suspended during such plan year pursuant to [section 411(a)(3)(B)], then any requirement of this subparagraph for continued accrual of benefits under such plan with respect to such employee during such plan year shall be treated as satisfied to the extent of any adjustment in the benefit payable under the plan during such plan year attributable to the delay in the distribution of benefits after the attainment of normal retirement age."

Although offsetting post-normal retirement age accruals with actuarial increases does not violate Code section 411(b)(1)(H), such offset must be provided by the plan document. In other words, Code section 411(b)(1)(H)(i) simply allows a plan to provide, without violating the age-discrimination restrictions in that section, that post-NRA benefit accruals

may be offset by actuarial adjustments which are credited on account of a deferred benefit commencement. Without language in the plan providing for such offset, a participant's post-NRA benefit accruals may not be offset, as there is no basis in the plan document for doing so. The kind of employer discretion that would necessarily be given to employers if the plan document was not required to provide for the offset (if accruals are to be offset) is inconsistent with the fundamental requirement in Treasury Regulation section 1.401-1(b)(1) that benefits be definitely determinable.

Furthermore, whether actuarial adjustments are credited to a participant's account pursuant to a plan provision or as a result of non-compliance with the Code's and ERISA's rules governing suspension of benefits is irrelevant for purposes of determining whether the plan document must provide that post-normal retirement benefits are offset by credited actuarial adjustments. Therefore, whether the actuarial increase results from a failure to timely furnish a suspension notice or is credited in accordance with a plan term providing for the actuarial increase due to the delay in commencement makes no difference for purposes of determining whether benefit accruals may be offset by actuarial adjustments without a plan provision that so specifies.

The language in Proposed Treasury Regulation 1.411(b)-2(b)(4)(i) is consistent with this interpretation. It states:

(4) Certain adjustments for benefit distributions. (i) In general. Under section 411(b)(1)(H)(iii)(I), a defined benefit plan may provide that the requirement for continued benefit accrual under section 411(b)(1)(H)(i) and this paragraph (b) for a plan year is treated as satisfied to the extent of the actuarial equivalent of benefits distributed, as provided in this paragraph (b)(4). Distributions made before the participant attains normal retirement age or during a period that is not "section 203(a)(3)(B) service," as defined in 29 C.F.R. 2530.203-3(c) of the regulations of the Department of Labor, may not be taken into account under this paragraph (b)(4). (Emphasis added).

DoL

Answer 9: Staff declines to respond to this question because it requires application of provisions of the Code over which the Treasury Department has interpretive authority.

Question 10: May Affected Employees, who receive WARN payments, also receive 60 days' eligibility and vesting credit, and be permitted to make elective deferral contributions from the WARN payments, under their Employer's 401(k) plan?

Proposed

Answer 10: Provided that the Affected Employees are not party to an employment or union contract that governs the Employees' 401(k) benefits, then the answer is yes to both. Explained more fully below, the statute and its legislative history indicate that the damages provision of WARN is intended to provide compensation and benefits to affected employees that they would have received had their employment continued for 60 additional days (provided that such benefits are not in addition to benefits provided under a contract). Because the back pay awarded to the Affected Employees in lieu of notice would have been paid to them had they continued their employment, such pay is included in the definition of "compensation" for the purposes of elective deferrals under Code section 415 regulations.

An employer (the "Employer") is engaging in a reduction in force of its employees (the "Affected Employees") that will trigger notice requirements under the Workers' Adjustment and Retraining Notification Act ("WARN"). Under WARN, an employer must provide 60 days' written notice of a mass layoff or plant closing to Affected Employees. An employer that fails to provide the requisite WARN notice is liable, with respect to each day of the violation up to 60 days, for back pay, welfare plan benefits and pension plan benefits. In lieu of providing the requisite WARN notice, the Employer intends to make WARN payments, consisting of back pay, to the Affected Employees.

Remedies, Section 2104: WARN states that employers failing to provide the requisite notice are liable for "back pay for each day of violation . . . **and benefits under an employee benefit plan** described in section 1002(3) of this title [defined as pension plans and welfare plans], including the cost of medical expenses incurred during the employment loss which would have been covered under an employee benefit plan if the employment loss had not occurred." Further, the statute provides, "any liability incurred . . . **with respect to a defined benefit pension plan may be reduced by crediting the employee with service** for all purposes under such a plan for the period of the violation." 29 U.S.C. Sects. 2104(a)(1) & (2) (emphasis added).

Limitation on Remedies, Section 2105: Section 2105 of WARN provides that the rights and remedies provided under WARN "are in addition to, and not in lieu of, any other contractual or statutory rights and remedies of the employees, and are not intended to alter or affect such rights and remedies." 29 U.S.C. § 2105. WARN's legislative history indicates that

the “benefits” provision of the liability section is intended to provide benefits that an employee would have received if his or her employment had continued.” H.R. Rep. No. 100-576. If the Affected Employees are not party to any employment or union contract, then under the statute and legislative history, the Employer should provide the Affected Employees with 60 days’ credit for eligibility and vesting, matching employer contributions, if any, and the right to make elective deferrals from the WARN payments under its 401(k) plan. Although no published opinion, in which the benefits provision of WARN is analyzed in the context of a defined contribution plan, could be located, offering such 401(k) benefits would comport with the statute’s language and intent.

If, however, the Affected Employees are party to an agreement, such as a collective bargaining agreement, that governs their benefits, the Employer could argue that such benefits are subject to the governing agreement, rather than WARN, pursuant to section 2105. This position is supported by Midwest Coal Co., a district court case published in 2001. In that case, the court found that section 2105 of WARN precluded the remedies provision in section 2104 from determining whether benefits should be provided. In that case, the court decided that an employer was not obligated to provide health or defined benefit pension credits to union employees when a collective bargaining agreement covering those employees provided health care benefits for 12 months following layoff and contributions to a pension plan at a rate of .07 per hour for each hour worked. The court reasoned that it could not enforce, through WARN, rights that were created solely by contract. Thus, the employees received no service credit under the pension plan following their termination of employment. United Mine Workers of Am., Int’l Union, UMWA District 12 v. Midwest Coal Co., No. TH 99-C-141-T/H, 2001 U.S. Dist. LEXIS 18180, at *30 (S.D. In. 2001).

The court, in Midwest Coal Co., had declined to follow an earlier district court ruling that reached the opposite result. In that case, the court ruled that service credit should be awarded under the defined benefit plan pursuant to WARN even though a collective bargaining agreement contractually promised such benefits. The court reasoned that “aggrieved employees are entitled to be made whole, and to receive their wages and benefits as if they had continued working for the two month period.” United Mine Workers of Am. Int’l Union v. Martinka Coal Co., 45 F. Supp. 2d 521, 528 (N.D.W. Va. 1999).

Based on the foregoing, if the Affected Employees’ benefits are not governed by an employment or union contract, then the statute and its

history indicate that the Employer should provide full benefits under its 401(k) plan. If, however, the Affected Employees' benefits are subject to an employment or union contract, then the Employer may take the position, under Midwest Coal Co., that such benefits fall within section 2105, and not section 2104, of WARN. Whether such benefits would be provided in addition to back pay would depend on the language of the governing contract.

DoL

Answer 10: The Employee Benefits Security Administration does not have the authority to interpret the WARN provisions. Employment & Training Administration (ETA) has the authority to interpret WARN, and ETA does not provide unofficial guidance. However, ETA does provide WARN guidance on its webpage. Finally, as a general matter, WARN does not provide for payment in lieu of notice.

Question 11: Section 411(a)(3)(B) of the Code and section 203(a)(3)(B) of ERISA allow suspension of the payment of benefits during the period in which the employee, subsequent to the commencement of payment of benefits, is employed "by an employer who maintains the plan under which such benefits were being paid."

DoL regulations limit the suspension of benefits to a period in which the rehired retiree "completes 40 or more hours of service . . . for an employer which maintains the plan, including employers described in sections 2530.210(d) and (e), as of the time that the payment of benefits commenced or would have commenced if the employee had not remained in or returned to employment..." 29 CFR § 2530.203-3(c)(1). (29 CFR § 2530.210(d) discusses controlled groups of corporations; 29 CFR § 2530.210(e) discusses commonly controlled trades or businesses.)

How are these rules applied in the following situations, where Company A maintains a single employer defined benefit plan, Plan A, and an unrelated employer Company B maintains a single employer defined benefit plan, Plan B. The plans include provisions that suspend benefits to the extent permitted by ERISA section 203 and related regulations. Employee E terminated employment and commenced distribution of a pension benefit from Plan B at the normal retirement age of 65, prior to the date of any of the transactions described below. All required notices are given pursuant to the regulations under ERISA section 203.

After Employee E commences distribution of a pension benefit from Plan B, Company A acquires Company B, and another unrelated company,

Company D, both in stock transactions. Plan A is not merged with Plan B. Company D does not participate in either Plan A or Plan B.

Following the acquisition of Company B by Company A, Employee E is rehired by Company B into a position covered by Plan B. May benefits to Employee E be suspended? May benefits be suspended if Company A acquired the entire Company B controlled group? May benefits be suspended if instead of being rehired by Company B, Employee E is hired by Company A in a position covered by Plan B? May benefits be suspended if Employee E is instead hired by Company D?

Proposed

Answer 11: Yes, Employee E's pension may be suspended upon rehire by Company B. A strict reading of the regulations would have the effect of limiting suspendible reemployment based on a snapshot of the controlled group as of the date benefit payments commenced, and would not accommodate even minor changes in the composition of the controlled group. Using the preamble to interpret the regulations, however, permits suspension on a more reasonable basis.

The underlying principle as expressed in the preamble appears to permit suspension if reemployment is with a "group" in which any pre-retirement service with that "group" would have been taken into account for purposes of determining vesting and eligibility for the prior benefit. (The preamble refers to service required to be counted "for purposes of participation, vesting and benefit accrual." However, regulations under ERISA section 210 acknowledge that benefit accrual is required only for employment in "covered service," which means service within a job classification or class of employees covered by the plan.) Using this concept, when Employee E is reemployed by Company B in a position covered by Plan B, provisions of a qualified plan would assure that Employee E retains all prior vesting and eligibility service previously credited under Plan B.

Benefits may be suspended if Company A acquired the entire controlled group of Company B. Even though the controlled group of Company A is not identical to the controlled group under which Employee E commenced distribution of benefits from Plan B, every member of the controlled group under which Employee E earned service is a member of the new Company A controlled group. Moreover, as discussed above, it is not necessary that the controlled group of Company A include the entire controlled group of Company B.

Benefits may be suspended if Employee E is hired by Company A in a position covered by Plan B. Using the language of the preamble to

interpret the regulations resolves the treatment of an individual who is rehired by a company that is a participating company, when that participating company was not a part of the controlled group at the time benefit payments commenced. Suspension while employed with a participating company is consistent with the provision of the statute itself, which does not include any reference to “the time that the payment of benefits commenced.” A reasonable interpretation of the regulations, when read in conjunction with the statutes and the preamble would be one that would apply the modifying phrase only for the purposes of determining the entities described in 29 CFR § 2530.210(d) and (e), but not the entities actually participating in the plan. A careful reading of the preamble shows that reference to the phrase is made following a discussion of sections 2530.210(d) and (e), followed by the statement that “this provision has been modified to include only those employers maintaining the plan at the time the retiree’s benefits commenced.” Such an interpretation of the regulations would permit suspension in any case in which the employee is rehired by any company that “maintains” the plan.

Benefits may be suspended if Employee E is instead hired by Company D. The underlying principle as expressed in the preamble appears to permit suspension if reemployment is with a “group” in which any pre-retirement service with that “group” would have been taken into account for purposes of determining vesting and eligibility for the prior benefit. Using this concept, it would appear that adding new entities to the prior controlled group should not eliminate the right to suspend pension benefits – the new employer includes the prior controlled group, where service was indeed credited for vesting and participation, and in some cases benefit accrual. Thus, for example, when Employee E is hired by Company D, pension benefits may be suspended under Plan B, because for purposes of Plan B, Employee E retains prior vesting and eligibility service earned in the original Company B controlled group.

DoL

Answer 11: a. May benefits to Employee E be suspended where, following the acquisition of Company B by Company A, Employee E is rehired by Company B into a position covered by Plan B?

Yes. Without addressing the analysis set forth in Proposed Response 11, Staff notes that because Employee E is rehired by an employer (Company B) which both maintains the plan under which benefits are being paid and which was maintaining the plan at the time Employee E’s benefits commenced, Employee E’s benefits may be suspended pursuant to ERISA section 203(a)(3)(B) and 29 C.F.R. section 2530.203-3(c).

b. May benefits be suspended if Company A acquired the entire Company B controlled group?

Yes. Without commenting on the analysis set forth in Proposed Response 11, Staff notes that Employee E is rehired by an employer (Company B) which both maintains the plan under which benefits are being paid and which was maintaining the plan at the time Employee E's benefits commenced. Thus, Employee E's benefits may be suspended pursuant to ERISA section 203(a)(3)(B) and 29 C.F.R. section 2530.203-3(c), without regard to whether or not Company A acquired the entire Company B controlled group.

c. May benefits be suspended if instead of being rehired by Company B, Employee E is hired by Company A in a position covered by Plan B?

The DoL has not issued guidance specifically addressing the issues set forth in this hypothetical, and the fact pattern set forth therein does not provide sufficient information to support an evaluation in this format. Thus, Staff declines to respond to this portion of Question 11.

d. May benefits be suspended if Employee E is instead hired by Company D?

The DoL has not issued guidance specifically addressing the issues set forth in this hypothetical, and the fact pattern set forth therein does not provide sufficient information to support an evaluation in this format. Thus, Staff declines to respond to this portion of Question 11.

Question 12: An employer sponsors Health Reimbursement Arrangements (HRA) for their employees. (Assume the HRA is subject to ERISA and is in compliance with all applicable requirements). The employer permits employees to pay for all qualified medical expenses including individual health insurance premiums through the HRA. The only health insurance option available to employees is to purchase individual policies using the HRA funds. Because the individual insurance policies are reimbursed through the HRA (which is funded with employer contributions) would the individual policies constitute a group health plan subject to ERISA and if so, would such policies (which are underwritten individually based on health factors) potentially violate HIPAA nondiscrimination provisions with respect to a group health plan?

Proposed

Answer 12: Likely yes, the individual policies would constitute a group welfare plan subject to ERISA and the additional group health plan provisions under Part 7 including HIPAA nondiscrimination. Employer contributions are

used to pay for the individual insurance policies. Generally the employer's payment of insurance premiums to provide ERISA benefits to employees will be enough to create an ERISA plan. There may be an exception to ERISA if the plan satisfies the voluntary safe harbor under 2510.3-1(j) – however the presence of employer contributions would negate the availability of the safe harbor. Because HRA dollars are employer contributions, the safe harbor would not be available in this scenario. It would appear that individual policies paid through employer HRA contributions would constitute an ERISA plan.

Further, the preamble to the Final HIPAA portability regulations addressed this issue. Coverage provided by an employer through two or more individual policies may be considered a group health plan subject to HIPAA nondiscrimination rules. *Preamble to Final HIPAA Portability Regulations 68 Fed. Reg. 78719 , 78733 (Dec. 20, 2004)*. The preamble further states “one significant factor in establishing whether there is a group health plan is the extent to which the employer makes contributions to health insurance premiums”. *Id.* Therefore it would be likely that using HRA dollars to pay for individual health insurance premiums would cause the individual policies to constitute a group health plan.

If the individual policies constitute a group health plan under ERISA and are subject to HIPAA, it is likely that the plan would not comply with HIPAA's nondiscrimination requirements. Individual policies generally establish eligibility and premium amounts based specifically on the health factors of the individual. Therefore a group health plan made up of individual policies would appear to violate the requirements of the HIPAA nondiscrimination rules.

DoL

Answer 12: The Staff agrees that a Health Reimbursement Arrangement (HRA) is a group health plan generally subject to ERISA requirements. The Staff also agrees that individual policies purchased with HRA funds would not meet the voluntary safe harbor under 29 CFR section 2510.3-1(j) due to the presence of employer contributions. Moreover, HIPAA's nondiscrimination requirements appear in ERISA, the Code, and the Public Health Service Act. The term “group health plan” is defined differently in ERISA and the Code (the PHS Act follows the ERISA definition). As such, the applicability of the HIPAA nondiscrimination requirements to individual insurance policies funded through an HRA would need to be resolved jointly by DoL, Treasury/IRS, and HHS. The DoL has not addressed the application of the nondiscrimination requirements under HIPAA, including the extent to which underwritten individual health insurance policies purchased and reimbursed by an HRA

are treated as health insurance coverage offered under a group health plan. See IRS Notice 2002-45.

Question 13: The Pension Protection Act added a new section 514(e) to ERISA, providing that ERISA shall preempt any state law that would prohibit or restrict an automatic contribution arrangement (“ACA”). In order to benefit from this preemption provision, ACAs (including qualified automatic contribution arrangements (“QACAs”) and eligible automatic contribution arrangements (“EACAs”)), must satisfy the notice requirements of ERISA section 514(e)(3). The final rule regarding default investment alternatives under participant directed individual account plans, 72 Fed. Reg. 60,452 (Oct. 24, 2007), provides that: “[t]he administrator of an automatic contribution arrangement within the meaning of paragraph (f)(1) of this section shall be considered to have satisfied the notice requirements of section 514(e)(3) of the Act if notices are furnished in accordance with paragraphs (c)(3) and (d) of this section.” 29 CFR § 2550.404c-5(f)(3). This language suggests a safe harbor, i.e., ACAs may, but are not required to, furnish notice in accordance with the final rule regarding default investment alternatives. However, the preamble to the proposed rule regarding civil penalties under ERISA Section 502(c)(4) provides that: “[n]otice under section 514(e)(3) of ERISA must be furnished within such time period as prescribed in section 2250.404c-5(c)(3)” 72 Fed. Reg. 71,842 (Dec. 19, 2007) (emphasis added). This language suggests that 29 C.F.R. section 2550.404c-5(f)(3) is not a safe harbor, in which case an ACA (other than an EACA that allows 90-day permissive withdrawals) must give initial notice 30 days in advance of plan eligibility, which is very problematic for ACAs that provide for immediate eligibility upon date of hire.

Is 29 C.F.R. section 2550.404c-5(f)(3) a safe harbor or the exclusive means for an ACA to comply with the notice requirements of section 514(e)(3) of ERISA?

Proposed

Answer 13: 29 C.F.R. section 2550.404c-5(f)(3) is a safe harbor, and there may be other methods of timely providing notice under ERISA section 514(e)(3). As required by ERISA section 514(e)(3), the plan administrator of an ACA must provide initial notice within a reasonable time before a first elective contribution is made, and in certain circumstances, giving the notice on the date of eligibility could be reasonable.

DoL

Answer 13: This question implicates issues concerning the DoL’s open regulatory initiative on civil penalties that may be assessed under ERISA section 502(c)(4) for failure to provide the notice required by ERISA section

514(e)(3). Accordingly, the Staff believes it is premature to provide an answer at this time. Comments received on the DoL's ERISA section 502(c)(4) proposed regulation are publicly available on the Employee Benefits Security Administration's website.

Question 14: A recordkeeper's affiliate serves as directed trustee of an individual-account retirement plan that is not governed by a minimum-funding standard. The plan and trust documents allocate to another person (unassociated with the trustee or the recordkeeper, and other than the employer) fiduciary responsibility to determine and collect contributions. The recordkeeper knows that amounts expected as participant contributions have not been paid to the trustee, and that this situation persists three months after the payday from which the contributions were expected. The trustee assumes that its affiliate's knowledge is imputed to the trustee. But the trustee does not know what the contribution-collecting fiduciary did in response to the employer's failure to pay over the uncollected contributions.

It's possible that the responsible fiduciary made a good-faith finding that a discounted recovery - the uncollected amount multiplied by the probability that the employer could and would obey the court's order to pay - is less than what the fiduciary anticipates as the plan's attorney's fees and costs for pursuing the plan's remedies (after allowing assumptions about the likelihood that the court would order the employer to pay the plan's attorney's fees and costs, along with assumptions that the employer might be or become unable to pay, or might refuse to pay, according to the court's order). The trustee does not know that contribution-collecting fiduciary didn't make such a finding.

Does the trustee "ha[ve] knowledge of a breach" such that it must "make[] reasonable efforts under the circumstances to remedy the breach"?

Proposed

Answer 14: If, in similar circumstances, a careful person, acting in the capacity of directed trustee of an ERISA-governed plan of the same kind, would obtain the other fiduciary's explanation of his or her reasons for inaction, a directed trustee must obtain such an explanation.

- If the explanation reveals that the other fiduciary did not act and did not affirmatively decide not to act (or that he or she so decided, but not in good faith), a directed trustee must assume that the other fiduciary's breach is likely and thus act as a co-fiduciary must act in response to knowledge of another fiduciary's breach.
- Conversely, if the explanation would persuade a careful directed

trustee that the other fiduciary acted in good faith and made a conscious decision, the trustee does not have knowledge that its co-fiduciary breached (unless the decision is so obviously wrong that a reasonable person could not believe that the decision could be consistent with the other fiduciary's duties).

In considering whether the other fiduciary's explanation of his or her decisions (including a decision not to act) persuades the trustee that it does not know that its co-fiduciary breached his or her responsibility, a directed trustee must prudently consider any information that suggests that the other fiduciary is under an improper influence.

DoL

Answer 14: ERISA section 405(a)(2) provides that a fiduciary is liable for another fiduciary's breach if the fiduciary's failure to comply with ERISA section 404(a)(1), including the duty of prudence, in the administration of its fiduciary responsibilities enables the other fiduciary to commit a breach. Furthermore, ERISA section 405(a)(3) provides that a fiduciary is liable for a breach of another fiduciary if the fiduciary has knowledge of the breach, unless the fiduciary takes reasonable efforts under the circumstances to remedy the breach.

Under the facts presented, it is the view of Staff that, in order to be prudent, a trustee, even a directed trustee, who knows that participant contributions have not been forwarded to the plan and knows that the fiduciary responsible for collecting such contributions has taken no action must inquire into such fiduciary's reasons, if any, for not taking any action.

If, after making such an inquiry, the trustee concludes that the responsible fiduciary acted prudently and in the interests of the plan's participants and beneficiaries in not pursuing the contributions, Staff would not view the trustee as having failed to comply with ERISA section 404(a)(1) in a way that enabled the other fiduciary to commit a breach or as having knowledge of a fiduciary breach under ERISA section 405. If, however, the fiduciary's response to the trustee's inquiry indicates that the fiduciary did not act prudently and in the interests of the participants and beneficiaries, the trustee may have knowledge of a breach that would require it to take reasonable efforts to remedy the breach.

Staff emphasized that it expresses no view as to whether, or under what circumstances, an affiliate's knowledge of facts should be imputed to a trustee.

Question 15: An employer maintains an individual-account retirement plan that provides only elective salary-reduction contributions. The plan's named

fiduciary and administrator is a non-bank corporation unrelated to the employer. The plan and trust documents provide that each participant is a trustee, and provide an allocation of responsibilities so that each trustee is responsible for assets allocated or allocable to his or her participant account. The plan and trust documents provide that a plan expense incurred by a trustee is allocated to the individual account for which a restoration or other recovery is obtained or sought.

Each of Faith and Larry is a participant and a trustee. All amounts deducted from Faith's wages were collected by the plan trust, and were allocated to Faith's account. However, amounts deducted from Larry's wages were not collected by the plan trust. Faith knows this, knows that Larry knows, and knows that Larry did not pursue the plan trust's right to collect these contributions.

It's possible that Larry made a good-faith finding that a discounted recovery - the uncollected amount multiplied by the probability that the employer could and would obey the court's order to pay - is less than what Larry anticipates as his plan account's attorney's fees and costs for pursuing the plan trust's remedies (after allowing assumptions about the likelihood that the court would order the employer to pay the trustee's attorney's fees and costs, along with assumptions that the employer might be or become unable to pay, or might refuse to pay, according to the court's order). Faith does not know that Larry didn't make such a finding.

Does Faith have knowledge of Larry's breach such that she must "make[] reasonable efforts under the circumstances to remedy the breach"?

Proposed

Answer 15: If, in similar circumstances, a careful person, acting in the capacity of an allocated co-fiduciary of an ERISA-governed plan of the same kind, would obtain the other fiduciary's explanation of his or her reasons for inaction, Faith must obtain such an explanation.

- If the explanation would persuade a careful co-fiduciary that the other fiduciary acted in good faith and made a conscious decision, Faith does not have knowledge that Larry breached (unless the decision is so obviously wrong that a reasonable person could not believe that the decision could be consistent with the other fiduciary's duties).
- Conversely, if the explanation reveals that Larry did not act and did not affirmatively decide not to act (or that he so decided, but not in good faith), Faith must assume that the Larry's breach is likely and thus act as a co-fiduciary must act in response to knowledge of another fiduciary's breach. Because the plan and trust documents provide that a trustee's

expense is allocated to the account for which a recovery is sought, Faith may direct investment providers to redeem assets allocated to Larry's account to raise money to pay Faith's attorneys' fees reasonably incurred to pursue a recovery for Larry's account.

In considering whether Larry's explanation of his decisions (including a decision not to act) persuades Faith that she does not know that Larry breached his responsibility, Faith must prudently consider any information that suggests that Larry is under an improper influence.

DoL

Answer 15: The DoL answer to JCEB Q & A 10 from 2007 indicated that the staff is unwilling to answer questions regarding the propriety of a plan design that designates each participant as the trustee, named fiduciary, and plan administrator to the extent of his or her account. DoL would consider issuing an advisory opinion on this issue.

Question 16: An employer sponsors an individual-account plan that provides participant-directed investment. The employer selected a set of funds to comprise a "core" menu that, by itself, meets all conditions of the ERISA section 404(c) regulations. Subject to some conditions (described below), the plan also permits a participant to direct investment of his or her account in any security issued in the United States.

The summary plan description (SPD) warns, in super-conspicuous and plain language, that no one has evaluated, or will evaluate, any "non-core" investment or any person who or that issues, or is in any way involved regarding, a "non-core" investment. The SPD similarly explains that each participant, beneficiary, or alternate payee who directs investment is the named fiduciary responsible for all decisions concerning a "non-core" investment. As a part of this explanation, the SPD affirmatively cautions that the directing person has a legal duty to the plan to make a careful, diligent, and prudent investigation and evaluation to ensure that each purchase or sale of a "non-core" investment is not a prohibited transaction. The SPD explains, in plain language, what a prohibited transaction is, and includes an explanation of the opportunity to exempt a transaction under a statutory, class, or individual exemption. Along with this, the SPD explains that only the participant-fiduciary has any responsibility or authority to pursue restoration of a prohibited transaction, and that a restoration is allocated to the individual account of the participant-fiduciary who directed the prohibited transaction. The SPD explains that a fiduciary has a legal duty to act at least as carefully, diligently, and prudently as an expert would act. The SPD explains that a fiduciary who can't, without help, perform to that standard of care has a legal duty to get the advice of unbiased experts who have no interest other than helping the

fiduciary make the right decision. The SPD explains that any direction concerning a “non-core” investment includes the directing person’s acceptance of his or her position as a named fiduciary with legal and fiduciary duties to the plan and under applicable law.

Under these facts, is it clear that the employer or a fiduciary other than the participant does not have a *primary* duty to consider whether a transaction is a prohibited transaction?

Proposed

Answer 16: The facts described above suggest an allocation of fiduciary responsibilities, consistent with ERISA section 405, such that a fiduciary other than the participant need not consider whether a transaction concerning a “non-core” investment is a prohibited transaction until such a fiduciary has knowledge that a directing fiduciary failed to meet his or her duty.

DoL

Answer 16: DoL staff disagrees with the proposed answer. See answer to question 15 regarding the propriety of a plan design that designates each participant as the named fiduciary.

Under ERISA section 404(c)(1)(A)(ii), in the case of an individual account plan that permits a participant or beneficiary to exercise control over the assets in his or her account, if a participant or beneficiary exercises control over the assets in their account, he or she is not deemed to be a fiduciary by reason of such exercise. The preamble to the ERISA section 404(c) regulation states that, as a result, the participant or beneficiary does not violate the prohibited transaction provisions of section 406 of Title I of ERISA if he exercises control over assets in his account to engage in a transaction with a party in interest. A non-fiduciary participant or beneficiary therefore would not have a duty to consider whether a transaction is a prohibited transaction.

Moreover, ERISA section 404(c) does not provide general relief for a plan’s fiduciaries from the prohibited transaction rules of ERISA section 406. The regulation interpreting ERISA section 404(c) also states that it provides no relief from the excise taxes imposed under Code section 4975 which would apply to the disqualified person defined under section Code 4975(e)(2). 29 C.F.R. § 2550.404c-1(d)(3). Therefore, the fiduciary that is responsible for carrying out a participant’s investment directions would be exposed to potential liability for causing the plan to engage in a prohibited transaction.

Further, ERISA section 410 generally prohibits a provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty as void as against public policy.

Question 17: An employer seeks to meet a State's or its municipality's statute (for example, San Francisco's Health Care Security Ordinance) if it is law; but also wants to avoid any unnecessary obligation if the Ordinance is preempted. The employer adopts a written plan that states:

- 1) The plan is void from the beginning if the Ordinance is preempted.
- 2) If the Ordinance is not preempted, the plan reimburses covered health-care expenses.
- 3) If the plan pays a claim when the effectiveness of the plan is unsettled, the participant is obliged to restore the amount (without interest) to the employer no later than 30 days after the date of the plan administrator's demand that is made after the final court decision that finds that the Ordinance is preempted.

Assume that the plan and summary plan description explain these conditions in language that meets or exceeds the plain-language standards of ERISA section 102 and every other relevant ERISA provision.

Does anything about the plan's conditional nature cause it to fail to meet a written-plan requirement or any other requirement of ERISA section 402?

We recognize that preemption questions are politically controversial and in litigation, and don't expect any comment about preemption issues. Rather, this question is meant only to ask about this one way that an employer might respond to a temporary uncertainty.

Proposed

Answer 17: No. ERISA section 402(a)(1) requires that “[e]very employee[-]benefit plan ... be established and maintained pursuant to a written instrument.” But nothing in ERISA section 402 requires that a benefit provided by a plan be unconditional. ERISA's vesting rule applies to a pension plan, but not to welfare plans.

DoL

Answer 17: Staff notes that the DoL recently filed an amicus brief in the case of Golden Gate Restaurant Association v. City and County of San Francisco, currently pending before the Ninth Circuit Court of Appeals. See Brief for the Secretary of Labor as Amicus Curiae Supporting Appellee [Golden Gate Restaurant Association]. The brief is available on the DoL's website. The DoL expressed the view in the amicus brief that ERISA

preempts the employer health care spending requirements in San Francisco's Health Care Security Ordinance.

Staff declines to express a view on whether the sort of conditional reimbursement arrangement described in the question would comply with either ERISA or the San Francisco Health Care Ordinance requirements.

Question 18: An individual-account retirement plan provides participant-directed investment and specifies that the investment options are only those named in the plan document. Further, the plan specifies that no plan fiduciary has any authority to add or remove any plan investment option.

Is this specification of plan investment options a settlor decision such that a plan fiduciary need not (and must not) select plan investment options?

Proposed

Answer 18: Yes, this is a settlor decision, and a plan fiduciary must not act beyond the plan's terms. A plan fiduciary must administer a plan and discharge its duties "in accordance with the documents and instruments governing the plan" unless the fiduciary finds that a plan provision is void because it violates ERISA.

DoL

Answer 18: The DoL staff disagrees with the proposed answer. The selection and monitoring of investment alternatives in a participant-directed plan is a fiduciary responsibility, regardless of whether the investment options are specified in the plan document. Plan fiduciaries remain responsible under ERISA section 404(a) for the prudent selection and monitoring of investment alternatives in a participant-directed plan, even if the plan specifically provides that the plan's investment options are only those specified in the plan document. Further, ERISA section 404(a)(1)(D) requires that a fiduciary must discharge his duties with respect to a plan in accordance with the documents and instruments governing the plan *insofar as such documents and instruments are consistent with the provisions of Title I and Title IV*. A settlor cannot relieve the fiduciaries of the responsibility to monitor and, if need be, change the plan's investment options merely by specifying the investment options in the plan document and including a provision prohibiting any changes to them. *See also*, preambles to the final ERISA section 404(c) and Qualified Default Investment Arrangement regulations, and Advisory Opinion 98-04A.

Question 19: A corporation and its directors and officers are aware of the view that a person who or that has a discretionary power to appoint a fiduciary is, to the extent of that power, a fiduciary – with some responsibility to monitor

his, her, or its appointee's performance to the extent needed in evaluating whether to remove the appointee.

In establishing a *new* pension plan, the corporation, by its governing board, adopts a plan document that specifies that a particular named person is the plan's administrator, trustee, and named fiduciary. Although the plan document includes an amendment provision, that provision states that an amendment that purports to change or remove the administrator, trustee, or named fiduciary is void. The plan document also provides that no person other than a court can remove the plan's administrator, trustee, or named fiduciary, and that any such purported removal is void.

Is it clear that the corporation and its directors and officers need not monitor the fiduciary's performance?

Proposed

Answer 19: Yes. A person can't have a duty to consider whether to perform an act that would be void.

DoL

Answer 19: The DoL staff disagrees with the proposed answer. The selection of plan fiduciaries, such as a plan's administrator, trustee, or named fiduciary, is a fiduciary function and those who appoint the fiduciaries remain responsible for monitoring those whom they have selected, regardless of any plan language to the contrary. Any amendment that would purport to eliminate a plan fiduciary's responsibility to monitor, and, if need be, change or remove the plan's administrator, trustee, or named fiduciary would be contrary to ERISA.

See also ERISA section 404(a)(1)(D) – A plan fiduciary shall discharge his duties with respect to a plan in accordance with the documents and instruments governing the plan *insofar as such documents are consistent with the provisions of Title I and title IV*. *See also* 29 C.F.R. § 2509.75-8, Q D-4, Amicus Brief of DoL in Tittle v. Enron, In the United States District Court for the Southern District of Texas, Houston Division, Civil Action No. H-01-3913 and Consolidated Cases, Aug. 30, 2002.

Question 20: The rule on when a plan administrator must offer foreign-language assistance turns on whether a plan covers a particular number of participants who “are literate only in the same non-English language[.]” 29 C.F.R. § 2520.104b-10(e).

Although some jobs require literacy in English, other jobs don't – and for those jobs, an employer usually doesn't require literacy in any language. (For some service jobs, an employer prefers or requires that its employee

speaks a non-English language, but doesn't need an employee to *read* that language.) Because an efficient and nondiscriminatory employer doesn't ask for information that's irrelevant to a job's requirements, an employer ordinarily would have no way of knowing whether an employee is literate in a language other than English. In these circumstances, how (if at all) would a plan administrator know the number of participants who are literate only in a language other than English?

Proposed

Answer 20: If a plan administrator knows that the triggering number of participants “are literate only in the same non-English language”, the plan administrator must furnish the foreign-language assistance notice according to the rule. A plan administrator that has received a participant's, beneficiary's, alternate payee's, or the Secretary's request asserting that a foreign-language-assistance notice is required must promptly conduct a reasonable investigation into whether the triggering number of participants “are literate only in the same non-English language[.]” In doing this investigation, the plan administrator must obey ERISA, other Federal laws, and State laws that are not preempted. Nothing in the rule requires a plan administrator to assume that a person who *speaks* a non-English language is *literate* in that language. The expense of this investigation is a proper plan-administration expense.

If the rule does not require foreign-language assistance, a plan administrator may provide foreign-language assistance if it finds that the plan's expense in providing that assistance is no more than “reasonable expenses of administering the plan” as evaluated by the exclusive purpose of providing the plan's benefits to participants. See ERISA § 404(a)(1)(A)(i)&(ii).

DoL

Answer 20: Staff agrees that the plan administrator for a plan covered by ERISA has an obligation to provide a notice of foreign language assistance in the circumstances set forth in 29 C.F.R. section 2520.102-2(c) and 29 C.F.R. section 2520.104b-10(e). These regulations require that a Summary Plan Description and a Summary Annual Report contain a notice of foreign language assistance in a foreign language where a certain percentage or number of participants are literate only in this same foreign language. A plan must provide such a notice in these materials in the particular foreign language (for a plan that covers fewer than 100 participants at the beginning of a plan year) where 25% or more of all plan participants are literate only in this language. A plan that covers 100 or more participants must provide such a notice where the lesser of at least 500 participants or 10% or more of participants are literate only in this language.

A plan with a population that meets the foreign language tests in 29 C.F.R. section 2520.102-2(c) and 29 C.F.R. section 2520.104b-10(e), and does not provide the foreign language notice, would not comply with the regulations. A plan administrator has an obligation to comply with the regulations' requirements without regard to there being a request from a participant, beneficiary, alternate payee, or the Secretary asserting that foreign language assistance is required.

Staff agrees that the regulations do not require a plan administrator to assume that a person who speaks a non-English language is literate only in that language. However, nothing in ERISA precludes a plan administrator from deciding to provide foreign language assistance in circumstances where such assistance may not technically be required under the regulation. If plan assets are to be used, Staff believes that to ensure that the expense is a reasonable expense of administering the plan, the administrator should compare the cost of voluntarily providing foreign language assistance versus the cost of conducting an investigation or taking other steps to determine whether the regulations require foreign language assistance.

Question 21: It seems clear enough that the payment required to buy fidelity-bond insurance at a coverage limit that's the amount required by ERISA section 412 is a proper expense of plan administration. Because the required coverage is less than what a knowledgeable person might estimate as the amount of plan assets that an insured malefactor might steal at one time, some plan fiduciaries consider it wise to buy greater coverage. Is the portion of the "premium" that's allocable to the above-the-requirement portion of the coverage a proper expense to be charged against plan assets?

Proposed

Answer 21: A casualty-insurance contract is a plan asset, and a decision about whether to invest in this or an alternative asset is an investment decision. The plan fiduciary who makes this insurance-buying decision must consider the plan's risks of a theft loss, how likely or unlikely it is that the plan would obtain restoration in the absence of fidelity-bond insurance, and (following these considerations and related analysis) whether the plan's use of plan assets to pay insurance premiums would, under modern portfolio theory, be an appropriate diversification against the risk of potential theft losses.

DoL

Answer 21: ERISA section 412 does not prohibit additional bonding beyond that required by its terms or mandate the form for any additional protection. As long as a bond meets the statutory coverage and minimum amount

requirements, additional coverage may be purchased on the same bond or a separate bond. 29 C.F.R. § 2580.412-20(a).

The decision to purchase coverage with plan assets greater than that which is required by the bonding rules is a fiduciary act governed by the fiduciary standards of ERISA. ERISA section 404(a)(1)(A) of ERISA requires a plan fiduciary to discharge his or her duties prudently and for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan.

Additionally, when evaluating the propriety of the payment of plan assets for certain expenses, plan fiduciaries must consider the provisions of ERISA section 403 of ERISA which provides, in relevant part, that the assets of an employee benefit plan shall never inure to the benefit of any employer and shall be held for the exclusive purpose of providing benefits to participants and beneficiaries and defraying reasonable expenses of administering the plan. ERISA section 403(c)(1). It is the responsibility of appropriate plan fiduciaries to determine whether a particular expense is a reasonable administrative expense under ERISA sections 403(c)(1) and 404(a)(1)(A).

Question 22: A charitable-organization employer is uncertain about whether an Code section 403(b) retirement plan that it makes available is or isn't an ERISA-governed plan. The employer follows the guidance suggested by FAB 2007-2 together with its expert lawyer's advice to have the least involvement that still allows the employer the lowest level of "reasonable cause" needed to report W-2 wages under an assumption that elective contributions are Code section 403(b) contributions. Because of the uncertainty, the employer would like to file a protective Form 5500 without conceding that a plan exists. May an employer do so?

Proposed

Answer 22: A clear statement that a person submits a filing only to the extent that the subject of it was an ERISA-governed plan and only to the extent that the filer is such a plan's administrator does not, by itself, cause something that otherwise was not a plan to become a plan or cause a filer that otherwise is not a plan administrator to become one.

DoL

Answer 22: The DoL's "safe harbor" regulation at 29 C.F.R. section 2510.3-2(f) states that a program for the purchase of annuity contracts or custodial accounts in accordance with provisions set forth in section 403(b) of the Code and funded solely through salary reduction agreements or agreements to forego an increase in salary are not "established or maintained" by an employer under ERISA section 3(2), and, therefore, are not employee

pension benefit plans subject to Title I, provided that certain factors are present. As noted in Field Assistance Bulletin 2007-02, the question of whether any particular employer has established or maintained a section 403(b) plan covered under Title I of ERISA must be analyzed on a case-by-case basis applying the criteria set forth in 29 C.F.R. section 2510.3-2(f) and ERISA section 3(2).

Although Staff agrees that filing a Form 5500 Annual Return/Report does not itself cause a Code section 403(b) plan to be a “pension plan” within the meaning of ERISA section 3(2) and covered under Title I, Staff does not believe that in a case-by-case analysis the filing of a Form 5500 would be consistent with a claim that the employer did not establish an ERISA-covered plan. Staff cautions that they would not recommend such a practice as a way for an employer to hedge a Title I coverage bet. Rather, employers with serious questions regarding whether a Code section 403(b) plan is covered under Title I of ERISA should seek legal advice from a qualified benefits consultant or seek an advisory opinion from the DoL on the coverage question. *See, e.g.*, Advisory Opinion 94-30A and Advisory Opinion 83-23A.