ERISA Title I Fundamentals

A Practical Guidance® Practice Note by Alan M. Levine, Morrison Cohen LLP

Alan M. Levine
Morrison Cohen LLP

This practice note describes the principal rules under Title I of the Employee Retirement Income Security Act of 1974 (ERISA), and are applicable to most employer-sponsored retirement, health and welfare, and fringe benefit plans. Among other things, ERISA Title I mandates certain reporting and participant disclosure obligations; sets forth requirements for plan terms, operation, and funding; imposes fiduciary duties on those operating ERISA plans; and establishes the enforcement mechanisms available to remedy ERISA violations and secure beneficial rights under ERISA plans. A thorough knowledge of ERISA concepts is essential for benefits counsel, and in-house attorneys for all types of employers should have a working knowledge of ERISA's basics and the scope of its reach.

ERISA was enacted on September 2, 1974 as a reform statute to remedy abusive practices in the implementation and administration of employee benefit plans, and to help protect the rights of participants and beneficiaries having vested interests in such plans. Title I establishes a wide-ranging legal regime for employee benefit plans voluntarily established and maintained by private sector employers and unions. The other ERISA titles, not covered here, codify rules for qualified pension plans (which are incorporated in the Internal Revenue Code (Title II)); assign responsibilities for administration and enforcement to the Departments of Labor and Treasury (Title III); and establish the Pension Benefit Guaranty Corporation (PBGC) to administer an insurance program for union and non-union defined benefit pension plan benefits (Title IV).

This practice note summarizes the ERISA Title I rules under the following sections, starting with a description of ERISA's scope of coverage and continuing in the order of Parts 1 through 7 of Title I:

- Plans Covered by ERISA and Title I
- Reporting and Disclosure Rules
- Participation, Vesting, Benefit Accrual, and Distributions
- Funding Rules
- Fiduciary Rules
- Administration and Enforcement
- COBRA, HIPAA, and Other Health Plan Legislation

Plans Covered by ERISA and Title I

ERISA's reach is very broad, governing "employee benefit plans" (described below) established or maintained by:

- Any employer engaged in commerce or in any industry or activity affecting commerce
- Any employee organization representing employees engaged in commerce or in any industry or activity affecting commerce
- Both of the foregoing

ERISA § 4(a) (29 U.S.C. § 1003(a)).

Since virtually all employers affect commerce, ERISA's reach is expansive, subject to the below limits.

Definition of Employee Benefit Plan

ERISA defines the term employee benefit plan to include pension plans and welfare plans. ERISA § 3(3) (29 U.S.C. § 1002(3)). The following sections describe the breadth of these categories and list the statutory exceptions to ERISA coverage. For more information on the plans that are subject to ERISA, see ERISA Coverage of Benefit Plans.

Pension Plans and Welfare Plans Encompassed by ERISA

Pension plans. Under ERISA, a pension plan is defined as a plan, fund, or program that provides retirement income to employees, or that results in a deferral of income by employees for periods extending to the termination of covered employment or beyond. ERISA § 3(2) (29 U.S.C. § 1002(2)).

In this practice note, as in ERISA, the term pension plan is used for both defined benefit plans and defined contribution plans, but this distinction is important for the application of many ERISA rules:

- **Defined benefit plans** promise participants a certain benefit at retirement, which can be stated as an exact dollar amount, such as $1,000 per month at retirement. However, it is more commonly determined through a plan formula that considers such factors as salary and service. For example, a pension may pay an annual benefit for life equal to 55%—this percentage is typically determined by an employee's length of service—of the average of the highest three years of earnings while employed. Defined benefit plans also include hybrid plans (e.g., cash balance plans) even though their benefit is expressed as the balance of a participant's account like defined contribution plans.
- **Defined contribution plans** (also called individual account plans), in contrast, provide for benefits based solely upon the contributions made to the participant's account under the plan, adjusted for income, expenses, gains and losses, and forfeitures. The benefit is always equal to the employee's account balance (to the extent vested). Types of defined contribution plans include 401(k) plans, profit-sharing plans, stock bonus plans, employee stock ownership plans (ESOPs), and money purchase plans.

Welfare plans. A welfare plan is defined as a plan, fund, or program established or maintained for the purpose of providing to employees and their beneficiaries with health, welfare, and fringe benefits, specifically:

- Medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services –or–
- Any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. § 186(c)) for its participants or their beneficiaries, through the purchase of insurance or otherwise, other than pensions on retirement or death, and insurance to provide such pensions (these benefits are generally similar (but not exactly) to those described in the first bullet)

ERISA § 3(1) (29 U.S.C. § 1002(1)); 29 C.F.R. § 2510.3-1(a)(3).

These definitions are interpreted broadly to include nearly all types of benefits commonly provided by employers to employees. Nevertheless, the essential elements of a "plan, fund, or program" maintained for the benefit of "employees" (and their beneficiaries) must be present.

Plan, Fund, or Program Requirement

Generally, ERISA case law recognizes the existence of a plan, fund, or program if the facts and circumstances reasonably demonstrate that there are:

- Intended benefits
- Intended beneficiaries
- A source of financing –and–
- A procedure to apply for and collect benefits

See Donovan v. Dillingham, 688 F.2d 1367, 1372 (11th Cir. 1982).

The U.S. Supreme Court has held that an ERISA employee benefit plan must involve an "administrative scheme" to implement the employer's obligations under the arrangement, as distinguished, say, from a mere payroll obligation. Fort Halifax Packing Co v. P. Daniel Coyne, 482 U.S. 1 (1987). Following this holding, federal courts have found several types of simple (usually single lump-sum) severance, window benefit, or golden parachute schemes to be outside of ERISA's purview of employee benefit plans. For further information, see the section entitled "What level of administrative involvement triggers ERISA plan status" in Severance Benefit ERISA Considerations Checklist.

Employee Requirement

In order for an employee benefit plan to be subject to ERISA, the plan must cover employees. For this purpose, partners, sole shareholders, sole proprietors, and their spouses are not considered employees. Generally, a plan that only covers the owner of the business and his or her spouse will not be

considered a plan covered by ERISA. However, if the plan covers one other common law employee, the plan will be an ERISA plan and the owner-employee will have the protections afforded participants under ERISA. ERISA §§ 3(5), 3(6) (29 U.S.C. §§ 1002(5), 1002(6)). Note, however, that even if a plan does not cover any employees (and is not subject to ERISA), it must still satisfy all the applicable requirements of the Internal Revenue Code in order to qualify for employee benefit tax deductions that may be available under the Internal Revenue Code.

Plans Excluded from ERISA Coverage

Certain plans are explicitly excluded from ERISA coverage, or from certain provisions, even if they otherwise meet the statutory definition. ERISA's plan-based exclusions are summarized below; for more information about, see ERISA Coverage of Benefit Plans — Identifying Plans That Are Excluded from ERISA Coverage.

The following plans are completely excluded from ERISA:

- Governmental plans
- Church plans (unless they elect to be covered by ERISA under I.R.C. § 410(d))
- Plans for purposes of complying with workmen's compensation, unemployment compensation, or disability insurance laws
- Plans maintained outside of the United States for the benefit of nonresident aliens –and–
- Unfunded excess benefit plans (described further below)

ERISA § 4(b)(1)–(5) (29 U.S.C. § 1003(b)(1)–(5)).

Excess Benefit Plans

Excess benefit plans (as defined in ERISA § 3(36) (29 U.S.C. § 1002(36)) are nonqualified plans (or portions of plans) that are designed to provide benefits in excess of the I.R.C. § 415 limitations on benefits and contributions that can be provided under qualified retirement plans. Excess benefit plans are exempt from ERISA, provided they are **unfunded**.

To be considered unfunded, the assets of the plan must be subject to the employer's general creditors and not set aside for the exclusive benefit of participants. Thus, a rabbi trust can be used to hold the assets of the excess benefit plan because the assets are still subject to the employer's creditors. For more information on this topic, see Rabbi Trust Drafting and Design.

Similarly, an excess benefit plan is not considered funded merely because an employer purchases life insurance policies to provide funds for the payment of benefits under the plan so long as the plan participants have no actual rights under the policies and the policies are assets of the employer that remain subject to the employer's general creditors.

Plans intended to provide benefits based on compensation in excess of the qualified plan compensation limit under I.R.C. § 401(a)(17) are **not** excess benefit plans eligible for the blanket exemption, but such plans are often designed to qualify for "top hat plan" status, which provides relief from most ERISA requirements, as discussed in the next section.

Partial Exclusion for Funded Excess Benefit Plans

An excess benefit plan that is funded is excluded from certain Title I requirements:

- Excluded provisions: participation and vesting rules (Part 2) and funding rules (Part 3)
- Applicable provisions: reporting and disclosure rules (Part 1), fiduciary rules (Part 4), and administration and enforcement rules (Part 5)

ERISA §§ 201(7), 301(a)(9) (29 U.S.C. § 1051(7), 1081(a)(9)).

Partial Exclusion for Top Hat Plans and Top Hat Welfare Plans

Top hat plans are unfunded plans that are maintained primarily for the purpose of providing deferred compensation (or welfare benefits, for top hat welfare plans) for a select group of key management or highly compensated employees. Top hat plans (and top hat welfare plans) are exempt from Title I's:

- Participation and vesting rules(Part 2)
- Funding rules(Part 3) –and–
- Fiduciary rules(part 4)

ERISA §§ 201(2), 301(a)(3), 401(a)(1) (29 U.S.C. §§ 1051(2), 1081(a)(3), 1101(a)(1)).

In addition, although these plans technically remain subject to Title I reporting and disclosure provisions, a simplified method is available for compliance. 29 C.F.R. §§ 2520.104-23, 2520.104-24. To qualify for the alternative method, top hat plans (but not top hat welfare plans) must file a Top Hat Plan Statement with the DOL.

One of the reasons for the top hat plan exemptions is that the individuals covered by such plans are by definition executives who are in a position to be able to negotiate their compensation and benefit arrangements and are assumed to be savvy enough not to need the same level of protection generally provided under ERISA. Note, however, that both types of top hat plans are subject to ERISA's enforcement provisions.

For more information on top hat plans, see Executive Compensation § 7.03 and Top Hat Plan Statement Filing Rules and Procedures.

Reporting and Disclosure Rules

One of the stated policies behind ERISA is to protect the interests of participants and their beneficiaries in employee benefit plans by, among other things, requiring the disclosure and reporting of financial and other information regarding the operation of plans. ERISA § 2(b) (29 U.S.C. § 1001(b)). Consequently, Part 1 of Title I imposes certain reporting and disclosure rules on employee benefit plans.

These rules include requiring plans to report to various government agencies by filing certain information returns with the Department of Labor (DOL), the Internal Revenue Service (IRS), and, for defined benefit plans, the Pension Benefit Guaranty Corporation. Additionally, plan administrators must disclose certain information to plan participants and beneficiaries. Such disclosure obligations include periodically providing information such as summary plan descriptions (SPDs) and applicable participant notices, as well as making certain plan-related information and documents available upon request.

The main agency filings and disclosure requirements are summarized in the following sections. The DOL has prepared a compilation of the requirements. Reporting and Disclosure Guide for Employee Benefit Plans (Sept. 2017). Plans are also subject to recordkeeping requirements under ERISA § 107 (29 U.S.C. § 1027) and 29 C.F.R. § 2520.107-1.

Agency Reporting Requirements

Annual Return/Report of Employee Benefit Plan (Form 5500)

Title I requires that ERISA plan administrators file with the DOL an annual report (Form 5500 or the short form version Form 5500-SF) for a plan year within 210 days after the close of the year (or as permitted by the Secretary of the Treasury). Form 5500 reporting discloses information about plans' coverage, financial condition, expenses, and operations. ERISA § 104(a)(1) (29 U.S.C. § 1024(a)(1)); 29 C.F.R. § 2520.104a-5(a).

Certain plans are exempt from Form 5500, including a broad exemption for small (fewer than 100 participants), fully insured or unfunded plans. 29 C.F.R. § 2520.104a-1(b), (c); 29 C.F.R. § 2520.104-20.

The DOL makes copies of the Form 5500 annual reports available to the public, including on its website. A summary of the Form 5500 report and schedules can be found in the DOL's Reporting and Disclosure Guide for Employee Benefit Plans (Sept. 2017). Certain other agency reporting obligations have been combined into a uniform set of jointly approved forms known as the Form 5500 series. See, e.g., I.R.C. § 6058(a); ERISA § 4065 (29 U.S.C. § 1365).

All Forms 5500 and all accompanying statements and schedule must be filed electronically, using DOL's ERISA Filing Acceptance System (EFAST2) 29 C.F.R. § 2520.104a-2; DOL, EFAST2 Filing.

Enacted in 2019, the SECURE Act directs the IRS and the DOL to permit a combined Form 5500 filing for an eligible group of plans by January 1, 2022, applicable to returns and reports for plan years beginning after December 31, 2021. To be eligible for combined filing, each plan in the group of plans must:

- Be an individual account plan or defined contribution plan
- Have the same (1) trustee, (2) one or more named fiduciaries, (3) plan administrator, and (4) plan year –and–
- Provide for the same investments or offer the same investment options

Pub. L. No. 116-94, Div. O, § 202.

Other Reporting Requirements

Other Title I, Part 1 reporting requirements include the following:

- **Funding notice filing.** All plans subject to the minimum funding rules and the PBGC insurance program must annually file a notice regarding the plan's funding status and also provide it to participants. 29 C.F.R. § 2520.101-5. See Annual Funding Notice (Single-Employer Defined Benefit Plan) and Annual Funding Notice (Multiemployer Defined Benefit Plan).
- **Report on pension plan termination.** This report is filed with a final summary annual report when the plan is terminated, unless an exception applies. ERISA § 101(c) (29 U.S.C. § 1021(c)).
- **Notice of asset transfer from defined benefit plan to health plan.** This filing is required when a defined benefit plan transfers excess plan assets to fund retiree health benefits or life insurance benefits under I.R.C. § 420. ERISA § 101(e)(2) (29 U.S.C. § 1021(e)(2)).
- **Multiple employer welfare arrangement (MEWA) reporting**. MEWAs providing benefits that consist of medical care (but are not considered group health plans under ERISA) are subject to an annual filing requirement. ERISA § 101(g) (29 U.S.C. § 1021(g)); 29 C.F.R. § 2520.101-2. For more information on MEWAs, see DOL,

Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA).

Participant and Beneficiary Disclosures

This section summarizes the main participant and beneficiary disclosure obligations under Part 1 of ERISA Title I. More information on many of these requirements can be found in the sources cited below and in Disclosure Rules for SPDs, Participant-Directed Plans, Employer Securities, and Blackout Notices.

Summary Plan Description

SPDs are required to inform participants and beneficiaries of their rights and obligations under a plan. They must be written in a manner so that the average plan participant can understand its terms but also sufficiently accurate and comprehensive to reasonably apprise participants and beneficiaries of their rights and obligations under the plan. The regulations also provide that in fulfilling these requirements, the plan administrator must exercise considered judgment and discretion by taking into account factors such as the level of comprehension and education of typical plan participants and the complexity of the terms of the plan. ERISA § 102(a) (29 U.S.C. § 1022); 29 C.F.R. § 2520.102-2(a).

Timing. Plan administrators are required to provide participants (and to any beneficiaries receiving benefits under the plan) an SPD by the later of:

- 90 days from becoming a participant or beginning to receive benefits –or–
- 120 days after the plan becomes subject to the disclosure requirements (generally the first day any employee is credited with service under the plan)

ERISA § 104(b)(1) (29 U.S.C. § 1024(b)(1)); 29 C.F.R. § 2520.104b-2(a).

Contents. The SPD must accurately reflect the terms of the plan as of a date not earlier than 120 days before the SPD is disclosed. 29 C.F.R. § 2520.102-3. Specific information that must be included in the SPD includes, among other things:

- Plan information such as the name and contact information of the employer, administrator, and trustee
- The type of plan and details as to its funding and administration
- Eligibility and participation terms
- How benefits are calculated
- Benefit claim and appeal procedures
- Circumstances that may result in disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, or recovery of plan benefits –and–
- Participants' rights under ERISA

29 C.F.R. § 2520.102-3.

For a complete checklist of required contents, see SPD Content Requirements Chart (Retirement Plans) and SPD Content Requirements Chart (Health and Welfare Plans).

The SPD must not mislead, misinform, or fail to inform participants and beneficiaries. The plan's advantages and disadvantages must be neither exaggerated nor minimized. Descriptions of any exceptions, limitations, or other restrictions regarding plan benefits cannot be minimized, rendered obscure, or otherwise made to appear unimportant (e.g., may not be presented in small type or other less prominent style than is otherwise used to summarize plan terms). 29 C.F.R. § 2520.102-2.

Summary of Material Modifications

When a material change is made to a plan, the plan administrator must inform plan participants and beneficiaries by either updating the SPD or providing a summary of material modifications (SMM). SMMs must:

- Be provided (in the absence of an updated full SPD) whenever there is a change in the information required to be included in the SPD
- Cover all of the changes that are not reflected in the most recently issued SPD
- Be provided within 210 days after the end of the plan year in which the modification is adopted
- Be written in a manner that can be understood by the average plan participant

29 C.F.R. § 2520.104b-3.

ERISA does not define the term material modification, making it difficult for plan administrators to know when an SMM is required. It is clear that any modification to the plan affecting eligibility, participation, vesting, or level of benefits is material. Courts have held that where a participant did not receive proper notice of a material modification to a plan that provision could not be enforced against the participant. E.g., Agro v. Joint Plumbing Industry Bd., 623 F.2d 207, 212 (2d Cir. 1980).

Plan administrators often choose to revise the SPD when a material modification has been made to the plan and distribute the new SPD to all participants and beneficiaries

within the SMM deadline, rather than issuing an SMM. This can be more efficient in that it can reset the clock on the SPD-redistribution requirement described below.

A special rule for group health plans requires the plan administrator to furnish a notice of any material reduction in covered services or benefits within 60 days after the date the change is adopted. An exception to this rule exists if participants regularly receive communications about the plan, including such changes in the terms of the plan, and such communications are provided at least every 90 days. As a practical matter, this rule is largely subsumed by the more stringent requirements for summaries of benefits and coverage noted below in the section entitled "ERISA Disclosures Required Outside of Title I, Part 1." 29 C.F.R. § 2520.104b-3(d).

SPD Updates and Redistribution

ERISA requires plan administrators to furnish SPDs on a periodic basis. The timing depends on whether there have been any amendments to the plan:

- **5-year rule for amended plans.** If a plan is amended, the administrator must provide an updated SPD within 210 days after the end of the fifth plan year following the last date that an SPD for the pre-amended plan would have had to have been furnished.
- **10-year rule for unmodified plans.** If the plan is not amended, the SPD does not have to be redistributed until 210 days after the tenth year after the last date the previous SPD would have had to have been furnished.

ERISA § 104(b)(1) (29 U.S.C. § 1024(b)(1)); 29 C.F.R. § 2520.104b-2(b).

Other Title I, Part 1 Disclosures

Following is a list of other periodic or special-purpose disclosures required under Title I, Part 1, indicating the type of plan for which they are relevant. Most of the notices applicable to defined benefit plans also apply to other types of retirement plans that are subject to the minimum funding standards of ERISA § 302 (29 U.S.C. § 1082), such as money purchase plans.

- **Retirement benefit statements (pension plans).** Participants and beneficiaries are entitled to receive these statements as to their account balance (for individual account plans) or accrued benefit (for defined benefit plans). ERISA § 105(a) (29 U.S.C. § 1025(a)). See also ERISA § 209(a) (29 U.S.C. § 1059(a)).
    - Individual account plan statements are required at least annually, and at least quarterly for plans that allow participants to direct investments in their account (as well as to beneficiaries not having an account upon request, but not more than once per year).
    - In a new rule adopted under the SECURE Act of 2019 (adding new ERISA § 105(a)(2)(B)(iii) (29 U.S.C. § 1025(a)(2)(B)(iii)), individual account plan statements will have to include, at least once during any consecutive 12-month period), a lifetime income disclosure that states how much the monthly payment would be if the participant's account balance or accrued benefit were converted to a lifetime income stream. The disclosure will need to include estimates for a single life annuity scenario and a qualified joint and survivor type annuity arrangement. Employers and plan fiduciaries will not have fiduciary liability if those estimates are provided in accordance with DOL guidance. The rule became effective on September 18, 2021, for statements furnished after that date. Pub. L. No. 116-94, Div. O, § 203. See interim final rules at 85 Fed. Reg. 59,132 (Sept. 18, 2020) (adding 29 C.F.R. § 2520.105-3) and Lifetime Income Benefit Rules for Defined Contribution Plans under the SECURE Act.
    - Defined benefit plan statements must be provided to active participants at least every three years (or upon a participant's or beneficiary's request, but not more than once per year). Alternatively, defined benefit plans may comply by sending an annual notice with information on how to obtain the required information.
- **Notice of deferred vested benefit (pension plans).** Any pension plan that is required to report information to the Social Security Administration on Form 8955-SSA about a plan participant who separates from service with a deferred vested benefit under I.R.C. § 6057(a) must also notify the affected individual. ERISA § 105(c) (29 U.S.C. § 1025(c)).
- **Blackout notice (individual account plans).** Notification to affected participants and beneficiaries is required if a plan intends to limit the ability to request distributions, obtain loans, or direct the investment of accounts for more than three consecutive days, generally at least 30 days before the blackout period begins. ERISA § 101(i) (29 U.S.C. § 1021(i)); 29 C.F.R. § 2520.101-3. See Blackout Notice (Defined Contribution Plan).
- **Diversification right notice (individual account plans with employer stock).** Plans allowing investment in employer stock (including certain ESOPs) must permit participants to diversify their accounts under ERISA §

204(j) (29 U.S.C. § 1054(j)). A notice to inform participants of these rights and the importance of diversification must be furnished no later than 30 days before the participant can exercise the right to diversify. ERISA § 101(m) (29 U.S.C. § 1021(m)). See Employer Stock Diversification Rules for Defined Contribution Plans (IRC § 401(a)(35)).

- **Funding notice (defined benefit plans).** Participants are entitled to receive an annual notice describing the funding status of the plan. ERISA § 101(f) (29 U.S.C. § 1021(f)); 29 C.F.R. § 2520.101-5. See Annual Funding Notice (Single-Employer Defined Benefit Plan) and Annual Funding Notice (Multiemployer Defined Benefit Plan). This notice has replaced the summary of annual report disclosure for defined benefit plans subject to ERISA Title IV. 29 C.F.R. § 2520-104b-10(g)(9).
- **Notice of failure to make required contribution (defined benefit plans).** Unless a waiver is pending, plan administrators must notify participants and beneficiaries if the sponsor failed to make a required minimum funding contribution payment. ERISA § 101(d) (29 U.S.C. § 1021(d)).
- **Notice of funding-based limitations (underfunded defined benefit plans).** Significantly underfunded plans are subject to certain benefit distribution and accrual restrictions and must provide notices to participants when the restrictions are triggered. ERISA § 101(j) (29 U.S.C. § 1021(j)).
- **Notice of asset transfer to health plan (defined benefit plans).** This notice is required when a plan transfers excess plan assets to fund retiree health benefits or life insurance benefits under I.R.C. § 420. ERISA § 101(e)(2) (29 U.S.C. § 1021(e)(2)).
- **Summary of annual report (certain welfare plans).** This is a narrative summary of the annual report filed with the DOL on Form 5500. Most plans other than large funded or insured welfare plans are exempt. ERISA § 104(b)(3) (29 U.S.C. § 1024(b)(3)); 29 C.F.R. § 2520-104b-10.
- **Summary annual report (multiemployer pension plans).** Notice to participating employers and employee organizations regarding financial status and other plan information for multiemployer plans. ERISA § 104(d) (29 U.S.C. § 1024(d)).

Disclosures Required upon Request

In addition to the foregoing, the following plan related documents and information must be made available to participants and beneficiaries upon request:

- Any trust agreement, contract, or other instrument under which the plan is established or operated
- The latest updated SPD
- The latest annual report (with attachments)
- Any terminal report
- Any collective bargaining agreement providing for plan benefits

ERISA § 104(b)(4) (29 U.S.C. § 1024(b)(4)).

The plan administrator may charge a reasonable fee (lesser of actual cost or 25 cents per page) for furnishing additional copies of these documents. 29 C.F.R. § 2520.104b-30(b). These plan documents must be provided (and made available at the plan administrator's principal office) in accordance with the rules under 29 C.F.R. § 2520.104b-1(b), including rules for electronic disclosure.

In addition, participants and beneficiaries covered by a multiemployer plan are, upon request, entitled to receive several specific plan-related documents under the regulations, including actuarial and financial reports and applications for an extension to mandatory employer funding contributions. ERISA § 101(k) (29 U.S.C. § 1021(k)). Multiemployer plans must also, upon request, provide participating employers with information regarding plan funding and potential withdrawal liability. ERISA § 101(l) (29 U.S.C. § 1021(l)).

ERISA Disclosures Required Outside of Title I, Part 1

Several other ERISA disclosure requirements, including the following, are located elsewhere in the act (and thus may apply even to plans that are exempt only from Title I, Part 1):

- **Notice of benefit claim and appeal determinations (all plans)**. ERISA establishes procedures for benefit claim and appeal procedures that include various notice requirements. ERISA § 503 (29 U.S.C. § 1133); 29 C.F.R. § 2560.503-1. For more information, see Claims Procedure ERISA Requirements Checklist (General Rules), Claims Procedure ERISA Requirements Checklist (Disability Benefits), and Claims Procedure ERISA Requirements Checklist (Group Health Plans).
- **Participant fee disclosures (participant-directed individual account plans).** Plan fiduciaries of participant-directed individual account plans are required to provide certain investment-related information to participants and beneficiaries to make them aware of their rights and responsibilities connected with the investment of their retirement plan benefits under ERISA § 404(a)(1) (29 U.S.C. § 1104(a)(1)). To meet the requirements, the plan must furnish a notice no less frequently than annually containing extensive and specific information about the plan's expenses and fees and the available

investment options under the plan (and provide advance notice when the information is materially modified). 29 C.F.R. § 2550.404a-5. For more information, see Section 404a-5 Rules for Participant Disclosures of Plan Fee and Investment Information.

- **Qualified default investment alternative (QDIA) notice (participant-directed individual account plans).** The QDIA notice is required if investments can be made in a participant-directed pension plan without the participant's instruction (e.g., due to a default contribution election upon auto-enrollment where a participant fails to direct the contribution). ERISA § 404(c)(5)(B) (29 U.S.C. § 1104(c)(5)(B)); 29 C.F.R. § 2550.404c-5.
- **Qualified automatic contribution arrangement (QACA) notice (defined contribution plans with default contribution feature).** Defined contribution plans that automatically enroll eligible employees with a default contribution election are required to furnish a notice regarding the arrangement and the ability to opt out. ERISA § 514(e)(3) (29 U.S.C. § 1144(e)(3)); 29 C.F.R. § 2550.404c-5.
- **Notice of significant reduction in benefit accrual (defined benefit plans).** Advance notice is required before any plan amendment can become effective if the new plan terms provide for a significant reduction in the rate of a participant's future benefit accrual. ERISA § 204(h)(1) (29 U.S.C. § 1054(h)(1)); 26 C.F.R. § 54.4980F-1.
- **Separation from service benefit statement (pension plans).** Pension plans are required to provide a benefit statement upon a participant's termination of service or after a one-year break in service (or upon request up to once per year). ERISA § 209(a) (29 U.S.C. § 1059(a)).
- **COBRA notices (group health plans).** ERISA's COBRA provisions require certain notices concerning the right to continue coverage under group health plans. ERISA § 606(a) (29 U.S.C. § 1166(a)); 29 C.F.R. § 2590.606-4. For more information, see COBRA Compliance and Enforcement.
- **Qualified domestic relations order (QDRO) and qualified medical child support order (QMCSO) notices.** Affected participants and alternate payees must be notified when the plan receives a domestic relations order request to grant an interest on the participant's benefit to an alternate payee and upon authorizing it as a QDRO, and health plans must inform participants and affected children when the plan receives a QMSCO requiring coverage of a non-custodial child of the participant. ERISA § 206(d)(3)(G) (29 U.S.C. § 1056(d)(3)(G)); ERISA § 609(a)(5)(A) (29 U.S.C. § 1169(a)(5)(A)).
- **Notice of HIPAA special enrollment rights (group health plans).** This notification informs participants of certain enrollment rights under ERISA's HIPAA rules (e.g., after a loss of other coverage or of marriage, birth of a child, adoption, or placement for adoption and in connection with Medicaid and state child health plans). ERISA § 701(f) (29 U.S.C. § 1181(f)); 29 C.F.R. § 2590.701-6(c).
- **Notices under the Women's Health and Cancer Rights Act, Newborns' and Mothers' Health Protection Act, Mental Health Parity Act.** Participants and eligible employees must be notified of certain rights under these laws. ERISA § 713(b) (29 U.S.C. § 1185b(b)); 29 C.F.R. §§ 2590.711(d), 2590.712(d).
- **Summary of benefits and coverage and other ACA disclosures (group health plans).** Group health plans are subject to several disclosure obligations under the Patient Protection and Affordable Care Act (ACA) amendments to ERISA. One of the rules require group health plans to distribute a summary of benefits and coverage (SBC) before the period of coverage begins (and a description of any material modifications before the relevant changes go into effect). ERISA § 715 (29 U.S.C. § 1185d; 29 C.F.R. § 2590.715-2715. For details on the SBC rules, see ACA Summary of Benefits and Coverage Requirements Checklist.

Participation, Vesting, Benefit Accrual, and Distributions

Part 2 of Title I covers ERISA pension plans, setting forth minimum participation and vesting requirements as well as benefit accrual and distribution rules. Both ERISA and the Internal Revenue Code contain corresponding provisions relating to the topics in Parts 2 and 3 of ERISA. These rules are intended to be interpreted and enforced in a consistent manner. ERISA § 3002(c) (29 U.S.C. § 1202(c)).

Plans Exempt from Title I, Part 2

The following types of plans are exempt from the participation and vesting provisions and the benefit accrual and distribution requirements of Part 2:

- Welfare benefit plans
- Top hat plans
- Plans of fraternal beneficiary societies, orders, or associations that do not receive contributions from employers of the participants
- Plans of voluntary employees' beneficiary associations (VEBAs) that do not receive contributions from employers of the participants

- Plans established and maintained by unions or other labor organizations that do not provide for employer contributions
- Plans providing payments to or on behalf of a retired or deceased partner under I.R.C. § 736 (non-active partner plans)
- IRAs treated as pension plans under ERISA because of employer involvement and deemed IRAs under I.R.C. § 408(q) (IRA-based plans)
- Excess benefit plans
- Non-ERISA plans (e.g., governmental and non-electing church plans)

ERISA § 201 (29 U.S.C. § 1051).

Participation Rules

ERISA § 202 (29 U.S.C. § 1052) (and the corresponding rules under I.R.C. § 410) provides for minimum participation standards to prohibit employers from imposing lengthy service requirements or advanced age-based criteria before becoming eligible to accrue benefits under a pension plan. 29 C.F.R. §§ 2530.202-1, 2530.202-2.

Length of service requirement. The minimum participation standards generally prohibit a plan from requiring an employee to complete more than one year of service as a service requirement to participate in the plan. There is an exception for plans that provide for 100% vesting in the participants' benefit upon joining the plan. For those plans, the minimum length of service can be two years. ERISA § 202(a) (29 U.S.C. § 1052(a)).

Age-based requirements. Likewise, a plan generally can only exclude employees who are under a certain age from participation up to age 21, subject to an exception for plans maintained by tax-exempt educational institutions that provide for 100% vesting upon admission to the plan, for which the threshold is age 26. Additionally, a plan may not exclude employees who have attained a specific age, such as age 65, from participating in the plan. ERISA § 202(a) (29 U.S.C. § 1052(a)).

Measuring Service

For purposes of applying the length of service-based participation rules discussed above, and the vesting and benefit accrual rules discussed below, an employer must determine employees' hours of service to determine whether the employee has earned a year of service in accordance with the regulations. An hour of service generally includes:

- Each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during a computation period
- Each hour for which an employee is paid, or entitled to payment, by the employer for periods during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence (subject to certain limitations) – and–
- Each hour for which back pay, irrespective of mitigation of damages, has been either awarded or agreed to by the employer

29 C.F.R. § 2530.200b-2(a).

See 29 C.F.R. § 2530.210(b) for application of controlled group rules to determine the relevant employers when crediting service for the ERISA and I.R.C. minimum participation, vesting, and accrual rules.

Alternative Methods for Calculating Service

Instead of counting actual hours of service, a plan may determine an employee's service by using equivalencies that credit a certain number of hours for the period if at least one hour of service was rendered during the computation period. 29 C.F.R. § 2530.200b-3. These equivalencies generally favor the employee and credit more hours than counting actual hours.

Additionally, rather than counting actual or equivalent hours the plan can credit service by referring to the total period of time that the employee is employed under the elapsed time method pursuant to IRS regulations. 26 C.F.R. § 1.410(a)-7.

Vesting Rules

ERISA § 203 (29 U.S.C. § 1052) (and the corresponding rules under I.R.C. § 411(a)) provides for minimum vesting standards for plans covered by Part 2 of Title I. A benefit is considered vested if it cannot be forfeited. Thus, if a participant is 100% vested in his or her benefit, the participant cannot lose the benefit for any reason, including termination of employment with the employer. Whereas a participant who is only 50% vested at the time of a termination of employment may be required to forfeit one-half of the benefit due to the separation from service.

Employee contributions are always 100% vested under ERISA § 203(a)(1) (29 U.S.C. § 1052(a)(1). For benefits deriving from employer contributions, ERISA imposes minimum vesting standards. Thus, employer-provided

benefits earned under the plan cannot vest at a slower rate measured as of any year than the statutory minimum. Plans can always provide for faster vesting. The minimum vesting rules apply differently for the two different types of vesting schedules:

- **Cliff vesting.** A cliff vesting schedule provides for 100% vesting, all at once, after completion of the required period of service; there is no partial vesting. For example, under five-year cliff vesting, a participant is not at all vested until he or she has completed five years of service and would forfeit any benefit subject to vesting under the plan if he or she terminates employment prior to the five-year period.
- **Graded vesting.** Under graded vesting, a participant earns a percentage of the benefit for each year of service. For example, under a five-year graded vesting schedule, the participant may vest 20% for each year of service until fully vested after five years. Graded vesting schedules do not need to start after one year of service or provide for an equal vesting percentage each year, so long as the minimum schedule is satisfied.

The Title I minimum vesting schedules are:

- **Defined benefit plans**:
  - Five-year cliff vesting –or–
  - Graded vesting of 20% per year beginning at three years of service and becoming fully vested after seven years
- **Defined contribution plans**:
  - Three-year cliff vesting –or–
  - Graded vesting of 20% per year beginning at two years of service and becoming fully vested after six years

ERISA § 203(a)(2) (29 U.S.C. § 1052(a)(2)); 29 C.F.R. § 2530.203-1.

Special rules apply for plan amendments that change the vesting schedule to protect participants in the plan as of the date of the amendment against adverse effects from the change. Participants having at least three years of service must have the option to retain the original vesting schedule. ERISA § 203(c) (29 U.S.C. § 1052(c)); 29 C.F.R. § 2530.203-2(c). See also I.R.C. § 411(a)(10).

Accelerated Vesting

In addition to the minimum vesting schedules, covered plans must fully vest participants in certain circumstances. For example, a participant must be fully vested in his or her accrued benefit upon reaching normal retirement age under the plan, and all participants must become fully vested upon the employer's termination of the plan. Participants who are affected by a so-called partial termination of the plan must also become fully vested. ERISA § 203(a) (29 U.S.C. § 1052(a)). See also I.R.C. §411(d)(3).

Break-in-Service Rules

When counting service, if a participant incurs a "one-year break in service," then service prior to the break can be ignored for vesting purposes unless and until the participant completes a year of service after the break. A one-year break in service is a year in which the employee is not credited with at least 500 hours of service. 29 C.F.R. § 2530.200b-4.

Under the so-called rule of parity, for vesting purposes, a plan need not credit years of service performed prior to a multiple-year break in service upon reemployment to the extent the participant was unvested at the time of the break in service and the number of consecutive one-year breaks in service equals or exceeds the greater of:

- Five years of service –or–
- The total number of years of service prior to the break

ERISA § 203(b)(3)(D) (29 U.S.C. § 1053(b)(3)(D)); 26 C.F.R. § 1.411(a)-6(c)(1)(iii).

To the extent such a participant was vested in his or her benefit, pre-break service is always reinstated for vesting purposes (and for purposes of determining accrued benefit in a defined benefit plan). 26 C.F.R. § 1.411(a)-6(c)(1)(ii). However, if a participant receives a cash-out of a defined benefit plan benefit at a time when he or she is less than 100% vested, the plan can require the participant to repay the prior distribution plus interest upon reemployment in order to have his benefit service reinstated. ERISA § 204(e) (29 § 1054(e)); 26 C.F.R. § 1.411(a)-7(d).

For more information on the break-in-service rules, see Employee Benefits Law § 5.03[7].

Benefit Accrual Requirements

ERISA § 204 (29 U.S.C. § 1054) (and the corresponding rules under I.R.C. § 411(b)) sets forth minimum benefit accrual rules for defined benefit plans that are primarily intended to prevent excessive back-loading of benefit accruals. Briefly, such plans must provide for a rate of benefit accrual rate that satisfies one of the three following rules:

- **3% rule.** The plan's accrued benefit equals at least the benefit determined as 3% of the normal retirement benefit to which he or she would be entitled if he or she entered the plan at the earliest possible age and served

continuously until the plan's normal retirement age (or 65, if earlier), multiplied by the number of years of participation in the plan (up to 33 1/3 years).

- **133 1/3% rule.** The plan's accrued benefit equals the normal retirement benefit and, for any plan year X, the benefit accrual rate in any later plan year Y does not exceed 133 1/3% of the benefit accrual rate for plan year X or any subsequent plan year before plan year Y. Essentially, the benefit accrual rate must be within a particular zone in order to satisfy this test.
- **Fractional rule.** The plan's accrued benefit at any time equals at least the "fractional rule benefit," multiplied by a fraction whose numerator is the number of years of participation and whose denominator is the total number of years of participation assuming the participant separated from service at the plan's normal retirement age. The fractional rule benefit is the annual benefit commencing at normal retirement age assuming the participant continued to earn the same rate of compensation upon which the normal retirement benefit is computed through normal retirement age.

ERISA § 204(b) (29 U.S.C. § 1054(b)); 26 C.F.R. § 1.411(b)-1.

Benefit Reduction

Plans are prohibited from eliminating a participant's accrued plan benefit, including elimination or reduction of an early retirement benefit or retirement-type subsidy or an optional form of benefit available under the plan. ERISA § 204(g) (29 U.S.C. § 1054(g)). These provisions correspond to the anti-cutback rules of I.R.C. § 411(d)(6).

Plan sponsors may adopt amendments to reduce benefit accrual prospectively, or eliminate benefits for future participants, in accordance with the restrictions and, for defined benefit plans and other plans subject to the minimum funding standards, advance notice requirements under ERISA §§ 204(g), (h) (29 U.S.C. § 1054(g), (h)); I.R.C. § 4980F; 26 C.F.R. § 54.4980F-1.

Benefit Distribution Requirements

Title I also includes rules for benefit distributions, including:

- Requirement for defined benefit plans (along with other plans subject to the minimum funding standards and non-exempt defined contribution plans) to provide for:
  - A default benefit in the form of a joint and survivor annuity (with the spouse as beneficiary for married participants) and a pre-retirement survivor annuity benefits for married participants in case of their death while having a vested interest in the plan prior to retirement (ERISA § 205(a) (29 U.S.C. § 1055(a)))
  - A qualified optional survivor annuity alternative form of benefit (ERISA § 205(c)(1)(A) (29 U.S.C. § 1055(c)(1)(A)))
  - Participant notices explaining the available benefit distribution options (ERISA § 205(c)(3) (29 U.S.C. § 1055(c)(3)))
- Spousal consent rights for all pension plans to permit married participants to designate a non-spouse beneficiary (or, for applicable plans, a form of benefit other than the default joint and survivor annuity or a qualified optional survivor annuity) (ERISA §§ 205(b)(1)(C)(i), (c)(2) (29 U.S.C. § 1055(b)(1)(C)(i), (c)(2)))
- Timing requirements for payment of benefits (ERISA § 206(a) (29 U.S.C. § 1056(a))), which require a default commencement date for the payment of benefits that is no later than the 60th day after the end of the plan year in which the latest of the following events occurs:
  - The participant attains age 65
  - The participant's 10th anniversary of participation in the plan
  - The participant terminates service with the employer

Anti-Alienation of Benefits

ERISA § 206(d) (29 U.S.C. § 1056(d)) generally prohibits the assignment or alienation of pension benefits, with a few exceptions, including for QDROs.

Funding Rules

Part 3 of Title I (and corresponding rules under I.R.C. §§ 412 and 430-433) covers minimum funding requirements. The funding rules are designed to ensure that employers make sufficient periodic contributions to applicable pension plans to ensure their financial health and ability to provide the benefits promised under the plan and pay for administrative costs.

Coverage. Part 3 generally only covers ERISA pension plans to which employers contribute. It also excludes:

- Individual account plans (other than money purchase plans)
- Insured plans (whose benefits are provided through an insurance contract)
- Top hat plans
- Non-active partner plans
- Excess benefit plans
- IRA-based plans
- Non-ERISA plans (e.g., governmental and non-electing church plans)

ERISA § 301 (29 U.S.C. § 1081).

Since pension plan liabilities extend many years into the future, determining whether a plan is adequately funded requires converting the stream of pension payment liabilities due in the future into the amount that would be needed to pay off those liabilities if the plan were terminated today. This is the present value of the plan's liabilities, sometimes called the termination liability. If the plan's current assets are sufficient to pay the present value of the currently accrued liabilities, the plan is considered fully funded. If the assets are less than those liabilities, the plan is underfunded.

ERISA's funding rules:

- Establish minimum funding standards under which plan sponsors (and participating employers to multiemployer plans) must make periodic contributions toward the funding of the plan (ERISA §§ 302–304 (29 U.S.C. §§ 1082–1084))
- Establish asset valuation rules and actuarial assumptions (interest rates and mortality tables) that must be used for calculating the present value of future liabilities to determine funding targets, plan costs, and the amount of the amortized installment payments for underfunded plans (ERISA §§ 303(c)(2), (g), (h), 304(c) (29 U.S.C. §§ 1083(c)(2), (g), (h), 1084(c)))
- Allow the Secretary of the Treasury to grant temporary waivers of all or a portion of such contributions for a plan year in cases of business hardship (ERISA § 302(c) (29 U.S.C. § 1082(c)) –and–
- Set forth special rules for significantly underfunded plans (ERISA §§ 303(i), 305 (29 U.S.C. §§ 1083(i), 1085))

These rules were overhauled by the Pension Protection Act of 2006 (PPA) (Pub. L. No. 109-280). The PPA sought to improve the funding status of defined benefit plans by, among other things, raising the funding target from 90% to 100% and accelerating the amortization periods over which underfunded plans must be brought up to fully funded status.

As briefly described in the following sections, the rules differ for plans maintained by a single employer (including a controlled group of entities treated as a single employer under ERISA § 302(d)(3) (29 U.S.C. § 1082(d)(3)) and multiemployer plans (under which more than one employer contributes under a collective bargaining agreements with a labor union). ERISA Part 3 provisions are intended to be interpreted and enforced in a consistent manner with the corresponding Internal Revenue Code provisions. ERISA § 3002(c) (29 U.S.C. § 1202(c)).

Single-Employer Plan Funding Rules

The PPA's 100% funding goal requires single-employer plans either to be fully funded or to make payments over an amortization period of no more than seven years to achieve full funding, although the Pension Relief Act of 2010 (Pub. L. No. 111-192) permitted sponsors to elect longer amortization periods for eligible plan years. ERISA § 303(c) (29 U.S.C. § 1083(c)).

The amount the plan must contribute each year is called the minimum required contribution, which consists of:

- The plan's target normal cost (i.e., the anticipated amount of benefit liabilities and plan expenses anticipated to accrue for the year, less employee contributions), reduced by any excess in the value of the plan assets over the funding target –and–
- For underfunded plans, the amortized installment of the existing unfunded liability, if any, consisting of:
    - A shortfall amortization charge, representing the shortfall in funding for a plan year (ERISA §§ 303(c) (29 U.S.C. §§ 1083(c)) –and–
    - If applicable, a waiver amortization charge, referring to any portion of a minimum funding contribution that was waived for a previous plan year. ERISA § 303(e) (29 U.S.C. § 1083(e)).

ERISA § 303(a) (29 U.S.C. § 1083(a)).

The minimum required contribution may also be reduced by the amount of any prefunding in excess of amounts owed for the previous year and carryover balances credited to the sponsor under the pre-PPA rules, provided the plan is at least 80% funded for the plan year (calculated using the FTAP ratio described in the next section). ERISA § 303(f)(2) (29 U.S.C. § 1083(f)(2)).

Failure to make a required minimum contribution in full for a plan year results in an obligation to pay the following year's contribution in quarterly installments. Plan sponsors that make untimely payments are subject to interest penalties, and a substantial underpayment (generally in excess of $1 million) can result in the imposition of a lien on the assets of all of the members of the sponsor's controlled group. ERISA §§ 303(j), (k) (29 U.S.C. §§ 1083(j), (k)).

At Risk Plans and Funding-Based Limitations

Single-employer plans considered to be in "at risk" status are subject to special rules, including the imposition of more conservative actuarial assumptions and loading factors for calculating funding targets and the normal cost of the plan.

The determination is based on the plan's funding target attainment percentage (FTAP), which is the ratio of the value of the plan's assets over the funding target (i.e., the present value of the plan's total accrued benefit liabilities). ERISA § 303(d)(2) (29 U.S.C. § 1083(d)(2)).

If the FTAP is less than 80% (disregarding the at-risk special assumptions) and the FTAP for the preceding year is less than 70% (using the at-risk special assumptions), the plan is considered to be at risk. ERISA § 303(i)(4) (29 U.S.C. § 1083(i)(4)). In addition to being subject to the special actuarial assumptions, at risk plans are restricted from reducing their minimum required contribution by prefunded amounts.

Small plans are exempt from these at risk rules (but not the funding-based limitations described below). For this purpose, a small plan means there are 500 or fewer participants for the plan year who are employed by a single employer in all defined benefit plans maintained by the employer's controlled group. ERISA § 303(i)(6) (29 U.S.C. § 1083(i)(6)).

Funding-Based Limitations

Single-employer plans whose adjusted FTAP, or AFTAP (as defined in ERISA § 206(g)(9)(B) (29 U.S.C. § 1056(g)(9)(B))) is less than applicable thresholds are subject to additional restrictions:

- Limitations on paying lump sum distributions for AFTAPs between 60% and 80%
- Restrictions on paying shutdown benefits for AFTAPs less than 60%
- Prohibition on amending the plan to increase benefits for AFTAPs less than 80%
- Ceasing of additional benefit accruals for AFTAPs less than 60%

ERISA § 206(g) (29 U.S.C. § 1056(g)).

If these rules are triggered, the plan administrator must provide participants with a notice to inform them of the applicable restrictions. ERISA § 101(j) (29 U.S.C. § 1021(j)).

Plan language to incorporate these rules is available at Benefit Limitation Clause (Defined Benefit Plan) (IRC § 436).

Multiemployer Plan Funding Rules

Multiemployer plan funding rules retain the concept of a funding standard account from the pre-PPA rules (no longer applicable for single-employer plans). This is a notional account that tallies up "charges" and "credits" for a plan:

- Charges for a plan year generally include the normal costs of the plan for the plan year (based on anticipated benefit accruals and plan expenses for the year) and amortized installments relating to any unfunded past service liabilities, net experience loss, loss due to actuarial assumption changes, and waived funding deficiencies for prior plan years.
- Credits for a plan year generally include contributions made to the plan, the amount of any waived funding deficiency for the plan year, and amortized installments relating to any net decrease in past service liabilities, net experience gain, or net grain due to changes in actuarial assumptions.

ERISA § 304(b) (29 U.S.C. § 1084(b)).

To the extent the charges exceed the credits as of the end of a plan year, there is an accumulated funding deficiency, and a contribution will be required for the plan year.

Special rules apply for employers that are no longer required to contribute to the plan (e.g., because of a change in workforce or collective bargaining agreement). Such employers must pay for its share of accrued but unfunded benefits under the withdrawal liability rules. ERISA § 304(b)(7) (29 U.S.C. § 1084(b)(7)).

PPA Multiemployer Plan Funding Improvement Provisions

Due to the poor funding status of many multiemployer plans, the PPA enacted special procedures for identifying significantly underfunded plans and improving their funding status. These rules require plan trustees to increase contributions, decrease liabilities, or both. ERISA § 305 (29 U.S.C. § 1085).

Similar to the at-risk status test for single-employer plans, multiemployer funding status for this purpose is based on the value of the plan's assets compared to the present value of its accrued benefit liabilities as of the beginning of each plan year. ERISA § 305(i)(2), (29 U.S.C. § 1085(i)(2)). The plan actuary must make annual certifications as to the funding status:

- **Endangered status** applies to plans that are over 65%, but less than 80%, funded (or if they have or are projected to have an accumulated funding deficiency over the next six years). These plans must adopt a funding improvement plan designed to decrease the funding shortfall by 33% in 10 years and eliminate any accumulated funding deficiency, as described in ERISA § 305(c) (29 U.S.C. §§ 1085(c)).

- **Critical status** applies to plan that are 65% funded or less (or fails certain accumulated funding deficiency-based tests). Critical status plans must adopt a rehabilitation plan designed to bring the funding status up to at least 80% within 10 years and eliminate any accumulated funding deficiency, as described in ERISA §§ 305(e) (29 U.S.C. §§ 1085(e)).

ERISA § 305(a), (b)(3), (29 U.S.C. § 1085(a), (b)(3)).

In addition, both endangered and critical status plans are subject to restrictions as to reductions in employer contributions, plan amendments that increase liabilities, and (for critical status plans) restrictions on lump sum distributions, among other things. ERISA § 305(d), (f), (29 U.S.C. § 1085(d), (f)).

Fiduciary Rules

Part 4 of ERISA Title I contains rules regarding the establishment and administration of plans, including importantly ERISA's fiduciary standards.

Coverage. The only ERISA employee benefit plans that are excluded from coverage under Part 4 are top hat plans and non-active partner plans. ERISA § 401(a) (29 U.S.C. § 1101(a)).

Part 4 generally provides that:

- Every plan must name at least one named fiduciary
- Those operating the plan are subject to fiduciary duties
- Fiduciaries are prohibited from permitting the plan to enter into certain transactions
- All plans must be established in writing
- Plan assets generally must be held in trust

These and related rules are briefly described below. For additional information, see ERISA Fiduciary Duties.

Named Fiduciary Requirement

Every ERISA employee benefit plan must provide for one or more named fiduciaries to inform participants as to who is responsible for the overall operation and administration of the plan. The named fiduciary may be actually named in the plan document or the plan may describe the procedure for designation of the named fiduciary. If the plan document contains a procedure for allocating fiduciary duties among several named fiduciaries, and duties are allocated in accordance with the procedure, a named fiduciary is not generally liable for the acts or omissions of another named fiduciary except as provided under the co-fiduciary liability provisions of ERISA, described below. ERISA § 402(a) (29 U.S.C. § 1102(a)); 29 C.F.R. § 2509.75-8 Q&A FR-13.

ERISA Fiduciaries

An ERISA fiduciary is any person that:

- Exercises any discretionary authority or discretionary control with respect to the management of the plan or exercises any authority with respect to the management or disposition of plan assets
- Renders investment advice for a fee or other compensation with respect to any plan asset or has any authority or responsibility to do so –or–
- Has any discretionary authority or discretionary responsibility in the administration of the plan

ERISA § 3(21)(A) (29 U.S.C. § 1002(21)(A)).

This definition encompasses plan administrators, trustees, investment advisors, investment managers, other third-parties performing fiduciary services for the plan, and may include the plan sponsor.

In 2016, the DOL issued final rules expanding the definition of fiduciary for those who render investment advice for a fee, but that guidance was vacated upon legal challenge. Chamber of Commerce of the United States v. United States Department of Labor, 885 F.3d 360 (5th Cir. 2018); see also Unwinding the Department of Labor's Fiduciary Rule. However, on June 29, 2020, the DOL announced new guidance on the investment advice fiduciary rule. The agency issued a technical amendment formally removing the 2016 regulations, withdrawing its accompanying new prohibited transaction exemptions, and restoring the prohibited transaction exemptions it had amended to their earlier form. 85 Fed. Reg. 40,589 (July 7, 2020). In addition, it proposed a new prohibited transaction class exemption (PTE 2020-02) allowing registered investment advisers, broker-dealers, insurance companies, and banks to receive compensation for providing fiduciary investment advice, as well as to engage in principal transactions involving the purchase and sale of their (and their affiliates') proprietary investment products, so long as certain conditions are met. 85 Fed. Reg. 40,834 (July 7, 2020). PTE 2020-02 extends certain principles of the impartial conduct standards from the 2016 rules' best interest contract exemption as reflected in FAB 2018-02. The new exemption was finalized in 85 Fed. Reg. 82,798 (Dec. 18, 2020) and became effective on February 16, 2021. See also DOL, New Fiduciary Advice Exemption: PTE 2020-02 Improving Investment Advice for Workers & Retirees Frequently Asked Questions (Apr. 13, 2021). For more information on fiduciaries generally, see ERISA Fiduciary Duties — Types of ERISA Plan Fiduciaries.

Note that fiduciary status based on discretionary authority or discretionary control only makes such person a fiduciary with respect to those aspects of the plan for which he or she

has such authority and control. For example, an investment manager that has discretion over the investment of the plan's assets is only a fiduciary for those decisions. The investment manager would not be a fiduciary with respect to a plan administrator's decision that a particular participant was not entitled to a benefit.

Unless the plan provides otherwise, the trustees of a plan funded by plan assets held in trust are the fiduciaries having exclusive control and authority over plan assets. However, the plan can provide for a directed trustee arrangement, in which case such authority is held by the fiduciary directing the trustee. Alternatively, the plan can provide that the authority to manage, acquire, or dispose of plan assets can be delegated to one or more investment managers. ERISA investment managers must be registered under the Investment Adviser's Act of 1940, a bank, or an insurance company qualified to manage plan assets under the laws of more than one state. When an investment manager is appointed and manages plan assets, the trustee is relieved from the fiduciary duty regarding such investment activity. ERISA § 403(a) (29 U.S.C. § 1103(a)).

Fiduciary Duties

ERISA requires that a plan fiduciary observe the following standards when acting on behalf of the plan or handling plan assets:

- **Duty of loyalty (exclusive benefit rule).** Fiduciaries must act solely in the interest of the plan's participants and beneficiaries and with the exclusive purpose of providing benefits to participants and beneficiaries or defraying the reasonable expenses of administering the plan. The duty of loyalty requires a fiduciary who may have a conflict of interest to ignore the conflicting interest and only consider the interests of the plan participants and beneficiaries, or take alternative action, such as retaining an independent fiduciary to deal with the relevant matter.
- **Duty of prudence.** Fiduciaries are required to act with the care, skill, prudence, and diligence, under the circumstances then prevailing, that a prudent person, acting in like capacity and familiar with such matters, would use in similar circumstances. If a fiduciary lacks the requisite skills or experience to fulfill this standard, it must seek advice from others or delegate the task to a competent fiduciary (if it has delegation authority). This duty is not static; fiduciaries also have the duty to monitor plan-related activities to ensure the ongoing prudence of, for example, the plan's investment policy or specific investments and the performance of duties delegated to others.
- **Duty to diversify.** Fiduciaries responsible for the investment of plan assets must diversify the investments of the plan to minimize the risk of large losses, unless it is clearly not prudent to do so under the particular circumstances. There is an exception to this duty (and a more limited exception from the duty of prudence) for defined contribution plans designed to invest in qualifying employer securities or qualifying employer real property. However, continued investment in qualifying employer securities when clearly not prudent to do so can violate the duty of prudence.
- **Duty to follow plan documents.** Fiduciaries are obliged to follow the terms of the documents and instruments governing the plan unless to do so would violate the provisions of ERISA. Note that this requirement can extend beyond merely the plan and trust document to include other ancillary documents effecting the plan, such as investment management agreements and collective bargaining agreements.

ERISA § 404(a) (29 U.S.C. § 1104(a)).

Since fiduciary decision-making usually involves inherently subjective questions, courts tend to focus on the procedure the fiduciary used to reach its conclusions, rather than the substance of the decision. Thus, when deliberating important plan matters fiduciaries should:

- Engage in a formal, objective process and use reasonable criteria to determine what actions should be taken
- Properly document the process –and–
- Record the criteria used in weighing the particular decision

Participant-Directed Plan Safe Harbors

An exception from fiduciary liability relating to plan investments is available where plan participants are made responsible for directing the investments of their plan account and certain requirements are met (including providing for a broad range of investment options and satisfying disclosure rules). For these plans, the participant is not considered to be the fiduciary when exercising such control over his or her account. And no person who is otherwise a plan fiduciary can be held liable for any loss or any breach that is the direct or necessary result of that participant's or beneficiary's exercise of control. ERISA § 404(c) (29 U.S.C. § 1104(c)); 29 C.F.R. § 2550.404c-1(b).

Additionally, where the plan permits the participants to exercise control over the investment of their account, it can also provide that if the participant does not exercise control by making an investment election, the account will be

invested in a qualified default investment alternative (QDIA). No fiduciary will be liable for any loss resulting from such investment provided the QDIA requirements are met. ERISA § 404(c)(5) (29 U.S.C. § 1104); 29 C.F.R. § 2550.404c-5.

For more information on these topics, see ERISA § 404(c) and QDIA Safe Harbors.

Prohibited Transactions

Fiduciaries are prohibited from permitting the plan to enter into certain transactions that are deemed to be so risky or unethical that they are strictly prohibited. Engaging in such a prohibited transaction is a per se violation of the ERISA fiduciary rules. Additionally, I.R.C. § 4975 has similar parallel provisions that impose excise taxes for engaging in prohibited transactions. The prohibited transactions can be classified as:

- Transactions with a party in interest
- Self-dealing transactions
- Transactions involving employer securities or employer real property in excess of specified limits

Each of these are described briefly in the following sections. For more information on prohibited transactions and exemptions, see Employee Benefits Law § 12.08[2].

Party-in-Interest Prohibited Transactions

A fiduciary is prohibited from permitting an ERISA plan from entering into any transaction with a party in interest that is a:

- Sale, exchange, or leasing of property between the plan and a party in interest
- Lending of money or other extension of credit between the plan and a party in interest
- Furnishing of goods, services, or facilities between the plan and a party in interest –or–
- Transfer of plan assets to a party in interest or use of plan assets by or for a party in interest

ERISA § 406(a) (29 U.S.C. § 1106(a)).

Under ERISA, the term "party in interest" includes numerous persons and entities having a relationship with the plan, such as any plan fiduciary, plan service providers, employers of plan participants (and related entities) and their employees, and persons related or having an interest in the foregoing. ERISA § 3(14) (29 U.S.C. § 1002(14)). For more information, see Prohibited Transaction and Parties in Interest Checklist (ERISA Rules).

Self-Dealing Prohibited Transactions

ERISA also prohibits a fiduciary from entering into transactions for personal gain or that would otherwise cause the fiduciary not to act exclusively in the best interests of the plan participants and beneficiaries. The self-dealing prohibited transactions prohibit a fiduciary from:

- Dealing with plan assets in the fiduciary's own interest
- Acting in a transaction involving the plan in behalf of a party whose interests are adverse to the plan or its participants and beneficiaries –or–
- Receiving compensation for his personal account from any party dealing with the plan in connection with a transaction involving plan assets

ERISA § 406(b) (29 U.S.C. § 1106(b)).

Prohibited Transactions Involving Employer Securities or Real Property

ERISA prohibits a plan from acquiring or holding employer securities or employer real property, unless certain criteria are met, and imposes an aggregate limit on qualifying employer securities and qualifying employer real property of 10% of the total fair market value of the plan, subject to an exception for certain individual account plans and ESOPs. ERISA § 407 (29 U.S.C. § 1107).

Exemptions from Prohibited Transactions

Due to the breadth of the prohibited transaction rules, ERISA provides for certain statutory exemptions for common arrangements that would otherwise frequently violate the rules. ERISA § 408(b) (29 U.S.C. § 1108(b))

Examples include the reasonable services exemption and the service provider exemption under ERISA §§ 408(b)(2) and (17) (29 U.S.C. §§ 1108(b)(2) and (17)). Additionally, ERISA permits the Secretary of Labor to granting administrative exemptions for particular transactions (or types of transaction) if the exemption is administratively feasible, in the interest of the plan and its participants and beneficiaries, and protective of the rights of participants and beneficiaries. ERISA § 408(a) (29 U.S.C. § 1108(a)).

There are two kinds of administrative exemptions: class exemptions and individual exemptions. Class exemptions apply to any transaction that meets the defined class that is exempt. Examples include the qualified professional asset manager (QPAM) exemption (see QPAM Exemption Requirements) and the in-house asset manager (INHAM) exemption. Unlike class exemptions, individual exemptions only apply to the specific parties and the particular transaction described in the application for exemption.

Fiduciary Liability

ERISA fiduciaries are personally liable for any loss to the plan arising from a breach of their fiduciary duty. ERISA also

imposes joint and several liability among multiple fiduciaries who are responsible for a breach and, in some cases, on a non-breaching co-fiduciary for the breach of another co-fiduciary (see next section). In addition, a fiduciary is liable for the acts of any agents it hires. ERISA § 409(a) (29 U.S.C. § 1109(a)).

Co-Fiduciary Liability

A fiduciary can be held liable for a breach by another fiduciary under the co-fiduciary liability rule if the first fiduciary:

- Knowingly participates in or attempts to conceal the co-fiduciary's breach
- Enables the co-fiduciary to commit the breach through the neglect of the first fiduciary's own duties under ERISA –or–
- Knows of a breach by a co-fiduciary, but fails to make reasonable efforts to remedy it

ERISA § 405(a) (29 U.S.C. § 1105(a)).

Managing Fiduciary Liability

Although ERISA prohibits so-called exculpatory clauses that seek to shield fiduciaries from the duties imposed on them under the statute (ERISA § 410 (29 U.S.C. § 1110), plan sponsors, employee organizations, or individual fiduciaries may purchase insurance to cover a fiduciary's liability for potential breaches of ERISA fiduciary duties. ERISA § 410(b) (29 U.S.C. § 1110(b)).

The DOL has interpreted ERISA's prohibition on exculpatory provisions to mean that a plan cannot indemnify a fiduciary of the plan for a breach of fiduciary duty. However, third parties are permitted to indemnify fiduciaries for breaches of fiduciary duty. Such third parties can be employer plan sponsors, affiliates of employers, employee organizations, and certain other fiduciaries that are service providers of a plan (where the potential breach may be committed by employees of such service providers). 29 C.F.R. § 2509.75-4.

In addition, with limited exceptions, ERISA requires that every fiduciary be bonded to protect the plan against fraud and dishonesty by such individuals. The required bond amount is 10% of the money handled for the plan during the previous plan year by the covered fiduciary(ies), with a minimum of $1,000 and a maximum of $500,000 per plan (or $1,000,000 if the plan holds employer securities). Exceptions apply for plans that pay benefits from the general assets of the sponsor and for certain types of fiduciaries (e.g., broker-dealers, financial institutions, and insurance companies). (ERISA § 412(a) (29 U.S.C. § 1112(a); 29 C.F.R. §§ 2580.412-23 to -32.

Written Plan and Trust Requirements

ERISA requires every plan covered by Title I Part 4 to be established in writing and operated in accordance with the written terms. ERISA § 402(a) (29 U.S.C. § 1102(a)). Generally, the plan document must (as applicable):

- Provide procedures for establishing and implementing a funding policy and method consistent with the plan's objectives and ERISA
- Describe any procedure for allocating responsibilities for the operation and administration of the plan, including the allocation of duties among named fiduciaries and the designation of other fiduciaries and their duties
- Provide procedures for amending the plan and identifying who has authority to amend the plan –and–
- Specify the basis for contributing to the plan and distributing benefits from the plan

ERISA § 402(b) (29 U.S.C. § 1102(b)).

In addition, unless otherwise excepted (as discussed below), all assets of an employee benefit plan must be held in a trust for the exclusive purposes of providing benefits to participants and beneficiaries or defraying plan expenses. ERISA § 403(a) (29 U.S.C. § 1103(a)). The DOL has issued rules that define when amounts participants contribute to a plan (including via payroll withholding) constitute plan assets and the time by which they must be segregated from the employer's general assets. 29 C.F.R. § 2510.3-102.

Plan assets may not inure to the benefit of the employer, subject to certain exceptions in the case of a termination of the plan and timely corrections of employer contributions made due to a mistake of fact. ERISA § 403(c) (29 U.S.C. § 1103(c)).

Exception to Trust Requirement

There are some exceptions to the rule requiring employee benefit plan assets must be held in trust:

- **Insured plans.** Plan assets consisting of insurance policies, or the assets of—or plan assets held by—an issuer of such policies are exempt from the trust requirement. Thus, for example, sponsors of fully insured health plans need not maintain a trust for the plan. ERISA § 403(b)(1), (2) (29 U.S.C. § 1103(b)(1), (2)).
- **Certain contributory welfare plans.** The DOL has adopted a non-enforcement policy for the trust requirement for cafeteria plans and other contributory welfare plans in which participant contributions are applied only to the payment of premiums. DOL Technical Release No. 92-01.

- **Certain custodial account arrangements.** The trust requirement does not apply for plans whose assets are held in qualified custodial accounts, such as funding arrangements for self-employed persons qualified under I.R.C. § 401(f), SIMPLE IRAs and simplified employee pension arrangements qualified under I.R.C. § 408(h), and 403(b) plans employing accounts qualified under I.R.C. § 403(b)(7). ERISA § 403(b)(3), (5) (29 U.S.C. § 1103(b)(3), (5).
- **DOL exemption.** The DOL has authority to exempt from the trust requirement plans that are not subject to any of ERISA Part 2 (participation and vesting requirements), Part 3 (funding rules), or Title IV (PBGC provisions). ERISA § 403(b)(4) (29 U.S.C. § 1103(b)(4)).

Administration and Enforcement

Part 5 of ERISA addresses the administration and enforcement of the statute.

Administrative Authority

The DOL is charged with broad regulatory, investigatory, and enforcement authority under ERISA, in conjunction with other agencies at its discretion (e.g., with the Department of Treasury in various areas affecting pension plans). ERISA §§ 504–506 (29 U.S.C §§ 1134–1136).

Benefit Claim and Appeal Procedures

ERISA requires every employee benefit plan to provide for adequate written notice if a claim for benefits is denied and a reasonable opportunity for a full and fair review of such denial. ERISA § 503 (29 U.S.C. § 1133). DOL regulations set out procedures that will comply with this requirement under 29 C.F.R. § 2560.503-1. Certain details vary based on the type of plan. Full descriptions of these requirements can be found in Claims Procedure ERISA Requirements Checklist (General Rules), Claims Procedure ERISA Requirements Checklist (Disability Benefits), and Claims Procedure ERISA Requirements Checklist (Group Health Plans) (addressing requirements under both HIPAA and the ACA).

Most plans require participants and beneficiaries to exhaust the internal appeal process (and external review requirement where applicable) before bringing an action in federal court. However, a plan's failure to implement adequate and reasonable procedures, or to adhere to them, may result in the internal process being deemed to be exhausted. E.g., Bilyeu v. Morgan Stanley Long Term Disability Plan, 683 F.3d 1083, 1089 (9th Cir. 2012).

ERISA Preemption of State Law

ERISA § 514(a) (29 U.S.C. § 1144(a)) expressly provides that, unless otherwise excepted, ERISA supersedes all state laws that "relate to" employee benefit plans covered by Title I. This is known as ERISA preemption, briefly discussed below. For more information, see ERISA Preemption.

The purpose of ERISA preemption is to provide for the nationally uniform administration of employee benefit plans and ensure that the regulation of ERISA employee benefit plans is exclusively a federal concern. It is interpreted broadly, extending beyond the specific subject matters covered by its provisions to the entirety of employee benefit plan legislation. E.g., Shaw v. Delta Airlines, 463 U.S. 85 (1983).

Savings Clause Exception

An important exception to ERISA preemption applies to state laws regulating insurance, banking, and securities. ERISA § 514(b)(2)(A) (29 U.S.C § 1144(b)(2)(A)) (known as the savings clause). In this regard, the Supreme Court has held that a law is considered to regulate insurance (so as to be covered by the savings clause) only if it:

- Is directed specifically at entities engaged in insurance – and–
- Substantially affects the risk pooling arrangement between the insurer and insured.

Kentucky Ass'n of Health Plans v. Miller, 538 U.S. 329, 341–42 (2003).

As a result of the savings clause, fully insured group health plans are subject to state insurance laws regulating the insurers providing the underlying contracts or policies, at least to the extent they do not conflict with ERISA. Some state insurance laws have stricter requirements or more consumer protections than provided for under ERISA.

Deemer Clause Clarification for Self-Funded Plans

The savings clause does not generally apply to self-funded benefit plans due to a special carve-out provision in ERISA known as the deemer clause. Specifically, the deemer clause provides that no employee benefit plan (other than a plan primarily intended to provide a death benefit) may be deemed to be an insurance company, bank, or investment company, or engaged in such businesses, for the purpose of state laws purporting to regulate such businesses. Thus, ERISA preemption precludes state law regulations of self-funded employee benefits (with a potential exception for life insurance benefits). ERISA § 514(b)(2)(B) (29 U.S.C § 1144(b)(2)(B))

For more information on ERISA preemption, see Employee Benefits Guide § 2.01 and Moore's Federal Practice - Civil § 107.75[3].

ERISA Enforcement Provisions

ERISA contains both civil and criminal sanctions for violations of the statute and private rights of action by participants and beneficiaries to enforce their rights under ERISA.

Civil Suits

ERISA authorizes private rights of action against persons violating the statute in certain circumstances under ERISA § 502 (29 U.S.C § 1132). This statutory enforcement scheme constrains the relief and measure of damages that may be sought for an ERISA claim. The causes of action contemplated are limited primarily to the following:

- **Enforce plan terms.** Participants and beneficiaries can seek to:
    - Receive plan benefits that are due, enforce their rights under a plan, or clarify their rights to future benefits under the terms of a plan (ERISA § 502(a)(1)(B) (29 U.S.C § 1132(a)(1)(B))) –or–
    - Obtain relief under certain enumerated civil penalties for a plan's failure to furnish certain required information (ERISA § 502(a)(1)(A) (29 U.S.C § 1132(a)(1)(A)))
- **Recover plan assets from fiduciary for breach.** Participants, beneficiaries, plan fiduciaries, or the DOL can bring an action against a fiduciary to compensate the plan for losses arising from the fiduciary's breach (or profits the fiduciary obtained from the breach) and for equitable relief to enforce an ERISA fiduciary obligation under section 409 of ERISA. ERISA § 502(a)(2) (29 U.S.C § 1132(a)(2)).
- **End violations and seek equitable relief.** Participants, beneficiaries, or fiduciaries (and, in some cases, the DOL) can seek to enjoin any act or practice that violates ERISA or an ERISA plan and obtain appropriate equitable relief to redress such a violation or to otherwise enforce any provision of ERISA or an ERISA plan. ERISA § 502(a)(3), (5) (29 U.S.C § 1132(a)(3), (5)).
- **Redress interference with exercise of ERISA rights.** Participants or beneficiaries who suffer a dismissal from employment or other adverse employment actions to discourage, prevent, or retaliate against them from asserting rights under an ERISA plan can seek equitable remedies available to them under ERISA § 502(a)(3), such as an injunction ordering reinstatement. ERISA § 510 (29 U.S.C § 1140).
- **Impose civil penalties.** The DOL may seek civil penalties for any of the causes of action it can enforce above, as well as against fiduciaries in certain other situations described below. ERISA § 502(a)(6) (29 U.S.C § 1132(a)(6)).

Procedural Matters

Federal courts have exclusive jurisdiction over ERISA claims, and an ERISA plan itself may sue (under rare circumstances) or be sued in an action brought under the statute. ERISA § 502(d), (e) (29 U.S.C § 1132(d), (e)). Commonly, plan sponsors, administrators, and fiduciaries are also named defendants.

Since remedies are generally limited to equitable relief, there is no right to a jury trial for ERISA claims. Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry, 494 U.S. 558, 564 (1990). Courts may grant reasonable attorney's fees and costs to either party (which is mandatory in successful actions against multiemployer plan participating employers to collect delinquent contributions). ERISA § 502(g) (29 U.S.C § 1132(g)). However, courts have interpreted the ERISA enforcement provisions to preclude "extra-contractual" damages, such as for emotional distress or punitive damages. E.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 54 (1987).

ERISA actions are time limited. Subject to an extension in the case of fraud or concealment, ERISA suits against fiduciaries must be filed within the earlier of:

- Six years after the last action constituting the breach (or the last day a fiduciary could have cured a breach in the case of an omission) –or–
- Three years after the earliest date the suing party had actual knowledge of the breach (or on which the party could have reasonably accessed a DOL-filed report containing the necessary information)

ERISA § 413 (29 U.S.C. § 1113).

Although there is no statutory rule for non-fiduciary actions, courts hold that the applicable time period is the one used under applicable state law for the same, or most similar, type of suit (often this will be the state's limitation for contract claims). E.g., Hinton v. Pacific Enters., 5 F.3d 391, 394 (9th Cir. 1993).

Enforcement and Special Civil Penalties Against Fiduciaries and Parties in Interest

ERISA fiduciaries are subject to personal liability to make the plan whole for breaches of a fiduciary duty. In addition, courts may impose other appropriate equitable or remedial relief. Equitable remedies could include injunctions to prevent

fiduciaries from engaging in further prohibited behavior or even to prevent a person from acting as an ERISA fiduciary in the future in cases of egregious breaches. ERISA §§ 409(a), 502(a)(2) (29 U.S.C. §§ 1109(a), 502(a)(2)).

In the case of a prohibited transaction with a party in interest, the DOL may assess a penalty on the party in interest of up to 5% of the amount involved in the transaction for each year in which the violation continues (or up to 100% if the transaction is not corrected within 90 days after notice from the DOL). ERISA § 502(i) (29 U.S.C. § 1132(i)).

The DOL may also impose a civil penalty on a fiduciary (or a non-fiduciary person knowingly participating in a fiduciary breach) of up to 20% of the amount a plan recovers from the breaching fiduciary (or other person), whether by settlement or court order. This assessment may be reduced by other prohibited transaction-related civil penalties the fiduciary is required to pay, including a civil penalty or excise tax imposed on the fiduciary as a party in interest subject to the penalty noted in the preceding paragraph or under I.R.C. § 4975(a), (b). ERISA § 502(l) (29 U.S.C. § 1132(l)).

Enumerated Civil Penalties

ERISA § 502(c) (29 U.S.C. § 1132(c)) lists civil penalties assessable against a plan administrator for failure to comply with certain administrative duties, such as reporting and disclosure obligations. These are now adjusted annually for inflation pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. Depending on the type of violation, the civil penalty may include assessment of daily fines payable to the DOL or, subject to a court's discretion, imposition of liability to pay amounts similar to such fines to aggrieved participants and beneficiaries of the plan and such other relief a court deems proper. For example, plan administrators may be assessed civil penalties (as of 2021) for failure to provide, as required:

- Annual Form 5500 reports (up to $2,259 per day)
- Annual MEWA reports (up to $1,644 per day)
- Plan reports or benefits statements to certain former employees ($31 per employee)
- Automatic contribution arrangement information, benefit limitation notices for underfunded plans, requested multiemployer plan financial information or estimate of withdrawal liability (up to $1,788 per day)
- Summaries of benefit coverage notices (up to $1,190 per person)
- Plan documents to the DOL upon request ($161, not to exceed $1,613 per request)
- Special enrollment rights information (up to $120 per day per person)
- Blackout period notices, missed minimum funding contribution payments, (up to $143 per day)

ERISA § 502(c) (29 U.S.C § 1132(c)); see 29 C.F.R. § 2575.1-2575.3.

Other civil penalties apply for other non-compliance, such as a failure to maintain retirement plan records, to comply with Genetic Information Nondiscrimination Act requirements, to certify the funded status of a multiemployer plan, or remediate such a plan in endangered or critical status, among others. Id.

Further, ERISA authorizes a court to award to an aggrieved participant or beneficiary a civil penalty up to $110 per day (not adjusted for inflation) against an employer that fails to provide notices regarding COBRA rights, pension plan statements, defined benefit plan funding notices, and other information the administrator must provide upon request in a timely manner (e.g., plan documents and SPDs). ERISA § 502(c)(1) (29 U.S.C § 1132(c)(1)); 29 C.F.R. § 2575.502c-1.

Criminal Provisions

Although rarely invoked, the criminal provisions of Part 5 provide for the following penalties:

- **Willful violations of the reporting and disclosure rules of Part I:** Fine up to $100,000 or imprisonment up to 10 years, or both (or $500,000 for entities). ERISA § 501(a) (29 U.S.C § 1131(a)).
- **Willful coercive interference with a participant's ERISA rights:** Fine up to $100,000 or imprisonment up to 10 years, or both for that actual or attempted restraint, coercion, or intimidation of an individual to interfere with or prevent the exercise of any right under an employee benefit plan or ERISA via fraud, force, violence, or the threat of force or violence. ERISA § 511 (29 U.S.C § 1141).
- **Making false statements or false representations in the marketing or sale of multiple employer welfare arrangement (MEWA).** ERISA § 519 Fine as provided under the United States Criminal Code (U.S.C. Title 18) or imprisonment up to 10 years, or both. ERISA § 501(b) (29 U.S.C § 1131(b)).

COBRA, HIPAA, and Other Health Plan Legislation

New Parts 6 and 7 were added to ERISA, respectively, to codify (1) group health plan continuation coverage rules enacted under the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA) (Pub. L. No. 99-272) (COBRA), and (2) certain provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191) (HIPAA) relating to portability, non-discrimination based on health status, and guaranteed renewability in certain plans. In addition, various other legislative provisions relating to health plan coverage have been added to ERISA Parts 6 and 7, including the incorporation of ACA provisions.

COBRA Continuation Coverage

COBRA added a new Part 6 to Title I, dealing with mandated continuation coverage of health benefits under certain circumstances known as qualifying events. Briefly, these provisions require employer sponsors of group health plans (having at least 20 employees) to provide "qualified beneficiaries" with an election to continue coverage under the plan for a period of time in the case of loss of coverage due to a "qualifying event," such as a loss of employment or loss of eligibility under a plan. Qualified beneficiaries include any employee, spouse, or dependent child who loses coverage as a result of the qualifying event. ERISA § 601 (29 U.S.C. § 1161).

The plan must generally provide continuation coverage, if elected for 18 months or 36 months, depending on the qualifying event. The health plan may charge a premium to COBRA participants, which generally cannot exceed 102% of the plan's group rate. ERISA §§ 602, 604 (29 U.S.C. §§ 1162, 1164).

Parallel tax provisions appear in the I.R.C., which imposes an excise tax of up to $100 per day on health plans that violate the COBRA rules. I.R.C. § 4980B. There is no direct penalty under ERISA for COBRA violations, but participants can bring an action to enjoin non-compliant practices and restore benefits under ERISA's general enforcement provisions.

For further discussion, see COBRA Compliance and Enforcement.

HIPAA

HIPAA generally addresses requirements for group health plan portability, access, and health status-related non-discrimination. The requirements of Part 7 generally apply to group health plans and "health insurance issuers" that offer group health insurance coverage. HIPAA reaches beyond ERISA and ERISA plans through amendments to the Public Health Service Act and the Internal Revenue Code (to cover, for example, non-ERISA governmental and church plans). Some HIPAA rights were expanded in subsequent federal legislation, including under the Genetic Information Nondiscrimination Act and the ACA.

In general, HIPAA:

- Limits the ability of health plans to exclude a participant or beneficiary from coverage due to a pre-existing condition for a period in excess of 12 months, and prohibits (1) pre-existing condition-based exclusions for conditions relating to pregnancy, and (2) exclusions of newborns and adopted children who had "creditable coverage" within 30 days after birth or adoption and have not had a coverage gap of more than 64 days. ERISA § 701 (29 U.S.C § 1181).
- Prevents group health plans and health insurance issuers from (1) basing coverage eligibility on health-related factors, such as medical history or disability, and (2) charging a higher premium or contribution based on these health-related factors than applies to other similarly situated participants. ERISA § 702 (29 U.S.C § 1182).
- Prevents health plans covering multiple employers from denying a participating employer coverage under the plan, except for certain reasons, such as an employer's failure to pay plan contributions. ERISA § 703 (29 U.S.C § 1183).

The general ERISA enforcement provisions, discussed above, also applies to these requirements, but special preemption rules apply. ERISA § 731 (29 U.S.C. § 1191).

For basic information on HIPAA, see Health Care Benefits Law § 16.02. For how the ACA modified HIPAA, see ACA Preexisting Condition, Benefit Limit, Rescission, Patient Protection, and Clinical Trial Rules.

For further information on HIPAA's privacy rule, security rule, and other HIPAA "administrative simplification" provisions pertaining to the handling of health information, see HIPAA Privacy, Security, Breach Notification, and Other Administrative Simplification Rules.

Other Health Plan Legislation ERISA Amendments

The Omnibus Budget Reconciliation Act of 1993 (Pub. L. No. 103-66) added several provisions to Part 6 of ERISA, generally requiring employer-sponsored group health plans to:

- Recognize qualified medical child support orders (ERISA § 609(a) (29 U.S.C. § 1169(a))
- Adopt coordinating provisions with the Social Security Act that establish private health plans as the primary insurer of Medicaid-eligible persons (ERISA § 609(b) (29 U.S.C. § 1169(b))
- Provide certain coverage rights for the adopted children of participants and beneficiaries (ERISA § 609(c) (29 U.S.C. § 1169(c))

- Not reduce coverage for pediatric vaccines (ERISA § 609(d) (29 U.S.C. § 1169(d))

Several other important health care-related statutes have been incorporated into Part 7 of ERISA, including the incorporation of ACA requirements into ERISA. These are summarized below:

- **Length of maternity stay.** The Newborns' and Mothers' Health Protection Act of 1996 (Pub. L. No. 104-204) establishes minimum hospital stay requirements for mothers following the birth of a child, among other things. ERISA § 711 (29 U.S.C § 1185).
- **Mental health coverage.** The Mental Health Parity Act of 1996 [Pub. L. No. 104-204] regulates the level of mental health benefits made available for plans that cover mental health conditions, including substance abuse. ERISA § 712 (29 U.S.C § 1185a).
- **Reconstructive surgery following mastectomies.** The Women's Health and Cancer Rights Act of 1998 (Pub. L. No. 105-277) requires group health plans providing mastectomy coverage to cover prosthetic devices and reconstructive surgery. ERISA § 713 (29 U.S.C § 1185b).
- **Dependent college student coverage.** Michelle's law (Pub. L. No. 110-381) prohibits group health plans from discontinuing coverage of dependent college students who take a medically necessary leave of absence from attending college. ERISA § 714 (29 U.S.C § 1185b).
- **Affordable Care Act market reforms.** Section 715 of ERISA incorporates the ACA market reforms into ERISA. ERISA § 715 (29 U.S.C § 1185(d)). For more information, see Health Care Reform: Law and Practice § 3.01 and the ACA practice notes in the Group Health Plans and Affordable Care Act subtask of the Health and Welfare Plans task in Practical Guidance's Employee Benefits & Executive Compensation practice area.

Alan Levine, Partner, Morrison Cohen LLP

Alan is a partner at Morrison Cohen in its New York office and is also Co-Chair of Morrison Cohen's Compensation, Benefits & Employment Department. He is one of Morrison Cohen's primary transactional lawyers for compensation and benefits matters, and also regularly advises employers on incentive compensation design. In addition, Alan counsels executives and management teams on their employment and equity arrangements, often in change of control situations. Alan also advises clients on issues relating to restrictive covenants, including non-competes and non-solicits. Alan also has considerable experience in designing and implementing short- and long-term incentive compensation plans and non-qualified deferred compensation arrangements under Internal Revenue Code Section 409A for a wide variety of businesses in every stage of the business life cycle.

Alan has also represented executives at all levels and management teams in many industries, including technology, health care, pharmaceutical, and biotechnology, in connection with their employment agreements, separation agreements, and restrictive covenant agreements.