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ERISA Compliance FAQs: Fiduciary Responsibilities

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for employee benefit plans maintained by private-sector employers. ERISA includes requirements for both retirement plans (for example, 401(k) plans) and welfare benefit plans (for example, group health plans). ERISA has been amended many times over the years, expanding the protections available to welfare benefit plan participants and beneficiaries.

ERISA includes standards of conduct for those who manage an employee benefit plan and its assets, who are called "fiduciaries." This Legislative Brief includes a set of frequently asked questions (FAQs) to help employers understand the basic fiduciary responsibilities applicable to group health plans under ERISA.

WHO IS A FIDUCIARY?

The key to determining whether individuals or entities are fiduciaries is whether they are exercising discretion or control over the plan.

Many of the actions involved in operating an employee benefit plan make the person or entity performing them a fiduciary. Using discretion in administering and managing a plan or controlling the plan's assets makes that person a fiduciary to the extent of the person's discretion or control.

Thus, fiduciary status is based on the functions performed for the plan, not just a person's title.

Group health plans can be structured in a variety of ways. The structure of the plan will affect who has fiduciary responsibilities. Most employers sponsoring self-funded group health plans exercise some discretionary authority and therefore are fiduciaries. If the employer sponsors a fully-insured plan, fiduciary status depends on whether the employer exercises discretion over the plan.

A plan must have at least one fiduciary (a person or entity) named in the written plan, or through a process described in the plan, as having control over the plan's operation. The named fiduciary can be identified by office or by name. For some plans, it may be an administrative committee or a company's board of directors.

A plan's fiduciaries will ordinarily include:

- Plan administrators, trustees and investment managers;
- Individuals exercising discretion in the administration of the plan; and
- Members of a plan's administrative committee (if applicable) and those who select committee officials.

WHO IS NOT A FIDUCIARY?

Attorneys, accountants and actuaries generally are not fiduciaries when acting solely in their professional capacities. Similarly, a third-party administrator (TPA), recordkeeper or utilization reviewer who performs solely ministerial tasks is not a fiduciary; however, that may change if the entity exercises discretion in making decisions regarding a participant's eligibility for benefits.

Also, a number of decisions are not fiduciary actions, but, rather, are business decisions made by the employer. For example, the decisions to establish a plan, determine the benefit package, include certain features in a plan, amend a plan and terminate a plan are **employer business decisions not governed by ERISA**. When making these decisions, an employer is acting on behalf of its business, not the plan, and, therefore, is not a fiduciary. However, when an employer (or someone hired by the employer) takes steps to implement these decisions, that entity is acting on behalf of the plan and, in carrying out these actions, may be a fiduciary.

WHAT DOES IT MEAN TO BE A FIDUCIARY?

Fiduciaries have important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries.

ERISA requires fiduciaries to discharge their duties with respect to employee benefit plans:

- Solely in the interest of plan participants and their beneficiaries;
- For the exclusive purpose of providing plan benefits, or for defraying reasonable expenses of plan administration;
- With the care, skill, prudence and diligence that a prudent person in similar circumstances would use;
- By diversifying the plan's investments to minimize the risk of large losses; and
- In accordance with the plan's documents (unless inconsistent with ERISA).

The duty to **act prudently** is one of a fiduciary's central responsibilities under ERISA. It requires expertise in a variety of areas. Lacking that expertise, a fiduciary will want to hire someone with that professional knowledge to carry out those functions. Prudence focuses on the process for making fiduciary decisions. Therefore, it is wise to document decisions and the basis for those decisions. For instance, in hiring any plan service provider, a fiduciary may want to survey a number of potential providers, asking for the same information and providing the same requirements. By doing so, a fiduciary can document the process and make a meaningful comparison and selection.

Following the **terms of the plan document** is also an important responsibility. The plan document serves as the foundation for plan operations. Employers will want to be familiar with their plan document, especially when it is drawn up by a third-party service provider, and periodically review the document to make sure it remains current. For example, if a plan official named in the document changes, the plan document must be updated to reflect that change.

In addition, a fiduciary should be aware of others who serve as fiduciaries to the same plan, since all fiduciaries have potential liability for the actions of their co-fiduciaries. For example, if a fiduciary knowingly participates in another fiduciary's breach of responsibility, conceals the breach or does not act to correct it, that fiduciary is liable as well.

WHAT ARE THE POSSIBLE CONSEQUENCES OF A FIDUCIARY BREACH?

A person who is an ERISA fiduciary can be liable for a breach of fiduciary duty. Fiduciaries who do not follow the basic standards of conduct may be personally liable to restore any losses to the plan, or to restore any profits made through improper use of the plan's assets resulting from their actions. A fiduciary's liability for a breach may also include a **20 percent penalty** assessed by the Department of Labor (DOL), removal from his or her fiduciary position and, in extreme cases, criminal penalties.

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WHAT STEPS CAN FIDUCIARIES TAKE TO LIMIT THEIR LIABILITY?

Fiduciaries can limit their liability in certain situations. One way fiduciaries can demonstrate that they have carried out their responsibilities properly is by **documenting the processes** used to carry out their fiduciary responsibilities.

A fiduciary can also hire a service provider or providers to handle fiduciary functions, setting up the agreement so that the person or entity then assumes liability for those functions selected. If an employer contracts with a plan administrator to manage the plan, the employer is responsible for the selection of the service provider, but is not liable for the individual decisions of that provider. However, an employer is required to monitor the service provider periodically to ensure that it is handling the plan's administration prudently.

As an additional protection for plans, every person, including a fiduciary, who handles plan funds or other plan property generally must be covered by a **fidelity bond**. A fidelity bond is a type of insurance that protects the plan against loss by reason of acts of fraud or dishonesty on the part of individuals covered by the bond. Many individuals dealing with group health plans that pay benefits from the general assets of an employer or union (unfunded) or group health plans that are insured (benefits are paid through the purchase of a group health insurance contract from a licensed insurer) may be eligible for **exemptions** from the fidelity bonding requirements.

In addition, the DOL maintains a voluntary correction program for fiduciary breaches. The Voluntary Fiduciary Correction Program (VFCP) allows plan officials who have identified certain violations of ERISA to take corrective action to remedy the breaches and voluntarily report the violations to the DOL, without becoming the subject of an enforcement action.

HOW DO THE FIDUCIARY DUTY RULES AFFECT THE PLAN OPERATION?

Employee Contributions

If a plan provides for salary reductions from employees' paychecks for contribution to the plan or participants make payments directly, such as the payment of COBRA premiums, the employer must deposit the contributions in a plan trust in a timely manner.

ERISA requires that participant contributions be deposited in the plan as soon as it is reasonably possible to segregate them from the company's assets, but no later than 90 days from the date on which the participant contributions are withheld or received by the employer. If employers can reasonably make the deposits sooner, they need to do so. For plans with fewer than 100 participants, salary reduction contributions deposited with the plan no later than the seventh business day following withholding by the employer will be considered contributed in compliance with the law.

> ***Important Exceptions to ERISA's Trust Requirement:***
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> For participant contributions to **cafeteria plans** (also referred to as Section 125 plans), the DOL will not assert a violation solely because of a failure to hold participant contributions in trust.
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> Other contributory health plan arrangements may obtain the same trust relief if the participant contributions are used to pay **insurance premiums within 90 days of receipt**.

Hiring Service Providers

Hiring a service provider in and of itself is a fiduciary function. When considering prospective service providers, an employer should provide each of them with complete and identical information about the plan and the desired services so that the employer can make a meaningful comparison.

Some actions fiduciaries need to consider when selecting a service provider include:

- Getting information from more than one provider;
- Comparing providers based on same information (for example, services offered, experience and costs);
- Obtaining information about the provider itself, including financial condition and experience with group health plans of similar size and complexity;
- Evaluating information about the quality of the firm's services, including the following (as applicable):
    - The identity, experience and qualifications of professionals who will be handling the plan or providing medical services;
    - Any recent litigation or enforcement action that has been taken against the provider and the provider's experience or performance record;
    - Ease of access to medical providers and information about the operations of the health care provider;
    - The procedures for timely consideration and resolution of patient questions and complaints;
    - The procedures for the confidentiality of patient records; and
    - Enrollee satisfaction statistics.
- Ensuring that any required licenses, ratings or accreditations are up to date (for example, insurers, brokers, TPAs, health care service providers).

An employer should document its selection (and monitoring) process, and, when using an internal administrative committee, should educate committee members on their roles and responsibilities.

Evaluating Fees

Fees are just one of several factors fiduciaries need to consider in deciding on service providers. When the fees for services are paid out of plan assets, fiduciaries will want to understand the fees and expenses charged and the services provided.

> While ERISA does not specify a permissible level of fees, the law does require that fees charged to a plan be "**reasonable**." After careful evaluation during the initial selection, the plan's fees and expenses should be monitored to determine whether they continue to be reasonable.

In comparing estimates from prospective service providers, employers should ask which services are covered for the estimated fees and which are not. Some providers offer a number of services for one fee, sometimes referred to as a "bundled" services arrangement. Others charge separately for individual services. Employers should compare all services to be provided with the total cost for each provider and consider whether the estimate includes services the employer did not specify or want. Remember, all services have costs.

Some service providers may receive additional fees from third parties, such as insurance brokers. Employers should ask prospective providers whether they get any compensation from third parties, such as finder's fees, commissions or revenue sharing.

Plan expenses may be paid by the employer, the plan or both. In any case, the plan document should specify how fees are paid, and the fiduciary must ensure that those fees and expenses are reasonable, necessary for the operation of the plan, and not excessive for the services provided.

Monitoring Service Providers

An employer should establish and follow a formal review process at reasonable intervals to decide if it wants to continue using the current service providers or look for replacements.

When monitoring service providers, employers should:

- Review the service providers' performance;
- Read any reports they provide;
- Check actual fees charged;
- Ask about policies and practices (such as a TPA's claims processing systems);
- Ensure that plan records are properly maintained; and
- Follow up on participant complaints.

Maintaining the Plan's Benefits Claims Procedure

Under ERISA, group health plans must establish and maintain reasonable claims procedures that allow participants and beneficiaries to apply for and receive the plan's promised benefits. Fiduciaries must maintain the plan's procedures. DOL regulations provide minimum standards for benefit claims determinations for ERISA plans (including insured and self-funded plans). While many plans hire benefits professionals or insurance companies to process claims, it is important for an employer to understand the requirements before selecting a service provider who can comply with the standards.

A claim for benefits is a request for a plan benefit made in accordance with the plan's procedures by a claimant (participant or beneficiary) or a claimant's authorized representative. Questions concerning plan benefits, coverage and eligibility questions, and casual inquiries are generally not considered claims for benefits.

The key issues to become familiar with are the timeframes for deciding claims, the contents for the notices of benefit denials and the standards for appeals of benefit denials. More information on the benefit claims procedures for group health plans is available on the DOL's webpage for health plan compliance assistance.

ARE THERE SOME TRANSACTIONS THAT ARE PROHIBITED?

Certain transactions are prohibited under ERISA to prevent dealings with parties who may be in a position to exercise improper influence over the plan. In addition, fiduciaries are prohibited from engaging in self-dealing and must avoid conflicts of interest that could harm the plan.

Prohibited parties (called parties-in-interest) include the employer, the union, plan fiduciaries, service providers and statutorily defined owners, officers and relatives of parties-in-interest. Some of the prohibited transactions are:

- A sale, exchange or lease between the plan and party-in-interest;
- Lending money or other extension of credit between the plan and party-in-interest; and
- Furnishing goods, services or facilities between the plan and party-in-interest.

Other prohibitions relate solely to fiduciaries who use the plan's assets in their own interest or who act on both sides of a transaction involving a plan. Fiduciaries cannot receive money or any other consideration for their personal account from any party doing business with the plan related to that business.

ERISA includes a number of exemptions that provide protections for the plan in conducting necessary transactions that would otherwise be prohibited. The DOL has authority to grant additional exemptions. ERISA includes exemptions for many dealings that are essential to the ongoing operations of the plan. **One of these exemptions allows the plan to hire a service provider as long as the services are necessary to operate the plan and the contract or arrangement under which the services are provided and the compensation paid for those services is reasonable**.

The exemptions issued by the DOL can involve transactions available to a class of plans or to one specific plan. Both class and individual exemptions are available on the DOL's webpage for technical guidance for employee benefit plans. More information on applying for an exemption is available in the DOL's Exemption Procedures under Federal Pension Law. This publication and the procedures also apply to group health plans.

Source: Department of Labor