



AMERICAN BENEFITS COUNCIL

December 5, 2016

Filed electronically at <http://www.regulations.gov>

Office of Regulations and Interpretations
Employee Benefits Security Administration
Attn: RIN 1210-AB63
Annual Reporting and Disclosure
Room N-5655
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

Re: Comments on Proposed Revision of the Form 5500 Annual Information Return/Reports

Dear Sir or Madam:

The American Benefits Council (the “Council”) is pleased to offer our comments on the proposed changes to the Form 5500 series annual information return/report (“Proposed Revisions”) issued by the Department of Labor (“DOL”), Internal Revenue Service (“IRS”), and Pension Benefit Guaranty Corporation (“PBGC”) (collectively the “Agencies”). Those changes, if adopted, would significantly impact which plans are required to complete the annual information return/report, the way in which such plans must report, and the breadth of information required on each plan’s annual information return/report. Our comments below are offered to inform the Agencies on the ways in which those changes will impact our plan sponsor and service provider members and to recommend changes in the interest of our mission to support employer-sponsored benefit plans. Our comments cover both retirement and health and welfare plans.

The Council is a national nonprofit organization dedicated to protecting and fostering privately sponsored employee benefit plans. The Council’s approximately 400 members are primarily large multistate U.S. employers that provide employee benefits to active and retired workers and their families. The Council’s membership also includes organizations that provide employee benefit services to employers of all sizes. Collectively, the Council’s members either directly sponsor or provide services to

retirement and health plans covering virtually all Americans who participate in employer-sponsored benefit programs. Virtually all of our members file one or more Forms 5500 or assist plan sponsors in preparing and filing them.

The most significant Proposed Revisions would expand the annual reporting requirements to all group health plans regardless of size, collect more information on the operations of health and retirement plans, increase the level of detail reported on each plan's financial information, and expand the information collected with regard to service provider compensation. Although each of those proposed changes are intended to modernize the annual information return/report and to increase the overall transparency of employee benefit plan operations, we are concerned that some of the Proposed Revisions will create significant administrative burdens for employee benefit plan sponsors and service providers, unnecessarily increase the cost of operating employee benefit plans, and reduce the appeal of plan sponsorship. Further, we are concerned that many of the Proposed Revisions would require plan administrators, under penalty of perjury, to answer questions for which they do not have readily available information.

WE RECOMMEND THE AGENCIES WITHDRAW AND REPROPOSE

Based on the concerns already discussed above and further developed below, we urge the Agencies to withdraw their Proposed Revisions and repropose the Form 5500 overhaul. Those steps would allow the Agencies to carefully consider all of the comments they have received, make appropriate changes, and receive feedback on a more appropriate and cost-conscious package. Given the overwhelming number of changes included in the Proposed Revisions and the volume of comments we expect the Agencies to receive, we believe that a withdrawal and reproposal will be necessary in order to address all of the feedback in a meaningful way. Moreover, the Council believes that Proposed Revisions would create implementation costs that are so significant that any incoming administration would want to review all of the public comments submitted and determine which reporting changes should be retained or abandoned in accordance with its own policy preferences.

If the Agencies reject our request for a complete withdrawal and reproposal, we recommend that the Agencies at least delay the effective date of any final Forms revisions beyond the general January 1, 2019 effective date contemplated by the Proposed Revisions. As a general matter, we are concerned that this proposed timetable would not give the parties who are responsible for collecting and reporting all of the newly requested information enough time to thoroughly implement all of the changes. Even on that expedited timetable, we assume that the Agencies would not be able to consider all of the comments and issue final Forms revisions until at least the middle of 2017. In order to be ready to collect information on the 2019 plan year, service providers would need to be ready to collect certain information on the first day of 2019. Given the scope and breadth of the Proposed Revisions, eighteen months does not provide

enough time to implement any final revisions. Accordingly, we encourage the Agencies to delay the implementation of the overall Forms revisions until at least the 2020 plan year.

GENERAL COMMENTS AND RECOMMENDATIONS

Recognizing that the Agencies may not adopt our request for a complete withdrawal and reproposal, we offer the following general comments and recommendations to inform the Agencies' efforts to update the annual information return/report.

Sections 103 and 104 of the Employee Retirement Income Security Act of 1974 ("ERISA") set forth requirements for the annual report (*i.e.*, Form 5500), which must be filed with the DOL on an annual basis. In addition to outlining a number of specific requirements applicable to Forms 5500, the statute grants the Secretary of Labor broad authority in ERISA Section 104(a)(2)(B) to require information or data from a covered plan where such data or information is necessary to carry out the purposes of ERISA Title I. The purposes of ERISA Title I are generally related to protecting participant and beneficiaries' benefits, protecting interstate commerce, requiring disclosure and reporting to participants and beneficiaries of financial and other information related to ERISA plans, establishing standards of conduct, and providing appropriate remedies. Thus, ERISA Section 104(a)(2)(B) allows the Secretary of Labor to gather information that is generally necessary for the protection of benefits or relates to financial or other information related to ERISA plans.

The amount of information sought by the Proposed Revisions extends far beyond the authority permitted under ERISA Section 104(a)(2)(B). Specifically, much of the information proposed to be collected seems intended to further the DOL's audit and enforcement efforts outside of a formal audit or enforcement action. Further, the Proposed Revisions, by adopting a least-common-denominator approach and requiring significantly greater information from all ERISA plans, impose momentous administrative burdens on ERISA plans and their service providers.

To alleviate the above-referenced burdens and provide greater certainty for ERISA plan sponsors and their service providers, the Council urges the Agencies to adopt the following general recommendations:

- Eliminate the proposed requests for information that exceed the scope and purpose of ERISA's annual information reporting requirements.
- Eliminate information requests that will create unnecessary administrative burdens and increase costs without providing meaningful benefits for plan sponsors, participants, or the public. Much of the cost will ultimately be passed

on to the plans and participants for whose benefit these changes are being sought.

- Eliminate duplicative reporting, where possible, to reduce administrative burdens, costs, and confusion.
- Adopt final revisions that are structured and defined in a manner that is consistent with other state and federal regulatory regimes beyond the Agencies' reporting requirements.
- Remove information requests that plan administrators cannot consistently and accurately complete under penalty of perjury.
- Provide clarification on new and existing Form 5500 series elements that are unclear or for which filers would be unable to produce information that is accurate, consistent, and reliable.
- Remove information requests that will drive up the cost of plan sponsorship by unnecessarily increasing litigation risks for plan sponsors and service providers.
- Adopt final revisions that clearly distinguish the operational and reporting responsibilities of plan administrators and service providers.
- Eliminate information requests that are structured in ways that will not accurately reflect plan operations.
- Adopt final revisions to the Form 5500 series that will allow plans and service providers to complete the annual return/report in a manner that is efficient and supports the interest of plan sponsors and participants.

The following comments identify some specific areas in which the Agencies should focus in order to implement these general recommendations. In particular, we have identified areas where changes are necessary to the Proposed Revisions' treatment of group health plan reporting, the reporting of service provider compensation, and the reporting of each plan's financial information. Finally, we conclude our comments by expressing our general recommendation for the Agencies to simplify the annual information return/report, while providing some specific suggestions on how such simplification could be achieved.

COMMENTS REGARDING PROPOSED HEALTH PLAN REPORTING CHANGES

I. Comments Regarding Proposed Schedule J Changes

The new Schedule J set forth in the Proposed Revisions would require plans to report an enormous amount of new information that is not currently collected by plan sponsors, would result in significantly increased costs and administrative burdens, would result in duplicative reporting in many instances, and otherwise exceeds the DOL's authority under ERISA Section 104(a)(2)(B).

A. Eliminate Duplicative Reporting

The proposed Schedule J includes numerous data elements that are already gathered elsewhere on the Form 5500. Specifically, the Schedule J requires filers to report the approximate number of persons covered under the plan at the end of the plan year, though similar information (number of participants in the plan at the end of the plan year and number of persons covered under each insurance policy at the end of the plan or policy year) is currently already reported on the main Form 5500 and the Schedule A. In addition, filers must report on the Schedule J the plan's funding and benefit arrangement, which is currently also reported on the main Form 5500. Information on participant and employer contributions would also need to be reported on the Schedule J despite such reporting already being required for many health and welfare plans on the Schedule H.

To reduce the administrative burden associated with filing the Form 5500, we urge the Agencies to revise the Schedule J to eliminate duplicative reporting requirements. In addition to a reduction of administrative burden, elimination of duplicative reporting would reduce the likelihood of errors resulting from reporting same or similar information in multiple sections of the Form 5500, and would reduce the likelihood of differing interpretations in what information is required to be reported in each section. These changes would also more generally help simplify the reporting, which is by itself an important and sound policy goal – especially in the context of voluntary employer-sponsored benefits.

B. Limit Schedule J Reporting to Group Health Plans That Are Not Excepted Benefits

The Proposed Revisions require all group health plans to submit a Schedule J as a part of their Form 5500 filings, with an allowance for limited reporting with respect to small, fully-insured group health plans. The Proposed Revisions further state:

All "group health plans" that meet the definition of 733(a) of the Act . . . would be required to file a Form 5500 and applicable schedules, including the proposed Schedule J, regardless of whether such plans are exempt from certain market

reform requirements under . . . ERISA § 733 (c) (group health plans consisting solely of excepted benefits). Employee welfare benefit plans as defined in ERISA § 3(1) that do not meet the definition of ‘group health plan’ under 733 of the Act (*i.e.*, they do not provide medical care) are not subject to the proposed enhanced reporting requirements applicable to group health plans.

81 Fed. Reg. 47,496, 47,556 (July 21, 2016).

To reduce uncertainty for filers resulting from differing interpretations of which types of coverage are subject to the Schedule J requirement, we strongly urge the Agencies to limit the Schedule J reporting requirement to exclude group health plans that are excepted benefits under ERISA Section 733(c). In addition, we urge the Agencies to provide that Schedule J reporting would not apply to excepted benefits that constitute a part of a larger ERISA plan (*e.g.*, by reason of an umbrella or wrap document), regardless of whether other benefits offered under such plans may be subject to Schedule J reporting.

While it may be clear with respect to certain excepted benefits whether they provide coverage for medical care such that they might constitute group health plans, with respect to many other types of coverage, there is considerable uncertainty as to whether medical coverage is offered to such an extent as to constitute a group health plan. This is due, in part, because existing administrative rules provide limited guidance regarding when a plan becomes a “group health plan” for purposes of ERISA (as well as other federal laws, such as the Internal Revenue Code and the Public Health Service Act).

Whether medical coverage is offered may depend on the facts and circumstances of the specific coverage at issue. This variance based on the specific facts and circumstances of each coverage is likely to result in some filers submitting Schedules J for a certain type of excepted benefit (*e.g.*, hospital or fixed indemnity coverage) and other filers not submitting Schedules J for that same type of excepted benefit. Setting forth a bright-line rule requiring Schedule J reporting only for group health plans that are not excepted benefits would reduce uncertainty and result in consistent reporting by plan sponsors.

Finally, we note that excepted benefits do not generally collect the types of information sought on the Schedule J, and in fact, may not even be subject to certain of the requirements which give rise to the reporting requirement on the Schedule J. For example, the following information, which is proposed to be collected on the Schedule J, would be inapplicable to many excepted benefits: type of group health benefits offered; whether the plan is an high-deductible health plan, flexible spending account or health reimbursement arrangement; stop loss coverage information; and compliance with HIPAA (from which such benefits would be exempt), Mental Health Parity and Addiction Equity Act (MHPAEA), Genetic Information Nondiscrimination Act (GINA), the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer

Rights Act, and the Affordable Care Act (many requirements of which do not apply to excepted benefits). Thus, requiring Schedule J reporting with respect to excepted benefits would significantly increase administrative burdens on plan sponsors that provide such benefits without a corresponding increase in information that would be useful to the Agencies.

C. Eliminate Reporting Regarding Rebates, Reimbursements, and Refunds

The Proposed Revisions require filers to report on the Schedule J as to whether the plan or plan sponsor receives any rebates, reimbursement or other refunds other than those reported on the Schedule A from service providers. The Proposed Revisions also require filers to report the amount and date of each rebate, reimbursement, or refund, as well as the service provider from whom the rebate, reimbursement, or refund was received, as well as how each rebate, reimbursement, or refund was used.

We urge the Agencies to not require rebate, reimbursement, or refund reporting, as such reporting would result in increased administrative burdens and would be inconsistent with prior DOL guidance. All rebate, reimbursement or refund information is currently not compiled and stored by plan sponsors. As such, plan sponsors would need to request this information from all relevant service providers, many of whom may not retain such information and/or account for such information at the plan level.

Additionally, if the DOL intends to require service providers to gather and report this type of information to their ERISA covered plan customers, the DOL should specifically promulgate a regulation under ERISA Section 408(b)(2) – subject to notice and comment and issuance of a final rule – that applies to welfare plan service providers. The public comment and notice process would help ensure that all stakeholders are able to provide input to the DOL regarding relative value and costs/burdens related to such a reporting requirement.

With respect to pharmaceutical rebates in particular, the DOL has previously provided specific reporting relief stating that plans are not required to report pharmaceutical rebate information on the Schedule C. *See* Supplemental Frequently Asked Questions About the 2009 Form 5500, Q27. Requiring such plan-level reporting as part of the Schedule J would appear to nullify the DOL’s prior reporting relief and require group health plans to gather information which the DOL specifically chose not to require in prior guidance. We recommend that the DOL avoid “rulemaking” for purposes of ERISA Section 408(b)(2) via the imposition of revised Form 5500 forms and instructions.

D. Ensure Consistency of Claims and Appeals Reporting with Other Claims and Appeals Rules

The Proposed Revisions require reporting of detailed post-service and pre-service claims and appeals data on the Schedule J; however, the terms related to such reporting are undefined.

We suggest the Agencies incorporate, in the final rule, the definitions used for reporting under Public Health Service Act (“PHSA”) Section 1311(e)(3) through the NAIC’s Market Conduct Annual Statement (“MCAS”) and ensure that such definitions are consistent with the definitions used in the claims and appeals rules under ERISA.

First, we note that ERISA plans and their sponsors generally rely on underlying insurers or their third-party administrators for claims and appeals processing. Given that a single health and welfare plan may offer various different types of benefits, the plan sponsor of a single ERISA health and welfare plan would need to gather information from potentially a myriad of different insurers or third party administrators in order to complete Schedule J reporting, which would *significantly* increase the time and cost associated with completing the Form 5500. Tracking, obtaining, coordinating and applying the information necessary to address this reporting requirement would force employers to substantially increase their benefits staff, expand third party administrator services and otherwise impose a severe financial drain on an employer’s benefit budget as well as creating corollary legal compliance issues, including, for example, the necessity of committing even more resources towards maintaining compliance with HIPAA privacy requirements.

Second, most issuers of insured products – as well as issuers acting as third-party administrators – may already be subject to reporting on the MCAS in their capacity as issuers. As such, many issuers have already programmed or are in the process of programming their systems to gather certain claims and appeals data required to be reported on the MCAS. Using consistent definitions would at least allow for uniform systems processing and reduced administrative burden and cost related to reprogramming databases, as well as facilitate reliance by plan sponsors on their insurance issuers and third-party administrators to perform such reporting.

Third, to the extent the DOL intends to deem reporting on the Schedule J as satisfying the requirements of PHSA Section 2715A, use of consistent definitions would ensure uniform enforcement of such provision (which cross-references PHSA Section 1311(e)(3)).

Lastly, to the extent the DOL intends to use different definitions or expand reporting of claims information by relying on PHSA sections 2715A and 2717¹, the Council is

¹ PHSA Section 2715A provides that group health plans and health insurance issuers offering group or individual health insurance coverage must comply with the transparency reporting requirements of

concerned that doing so may be in violation of the general tri-agency regulatory process required to implement rules under the PHSA. *See* 77 Fed. Reg. 18,310, 18,417 (Mar. 27, 2012). In relevant part, HHS has specifically stated that “HHS intends that the reporting obligations established in this Section and § 155.1040 will be aligned with the transparency reporting standards under Section 2715A of the PHS Act. *HHS, together with the Departments of Labor and the Treasury, will coordinate guidance on the transparency in coverage standards.*” *Id.* (emphasis added).

E. Eliminate or Revise Premium Payment Delinquency Reporting

The Proposed Revisions require plans to report information regarding premium payment delinquencies, including the number of times that payments were delinquent, the number of days of the delinquency, and any resulting lapses in insurance coverage. We urge the Agencies to eliminate this reporting requirement, as this information is difficult to track and reporting of such information would be administratively unfeasible.

Premium delinquencies can arise due to nonpayment or late payment by the plan or by an individual employee. Generally, plans do not maintain an ongoing record of delinquencies by individual employees, and the reporting requirement in the Schedule J seems to require reporting of all delinquencies. Therefore, we request that the final regulations eliminate the reporting requirement with respect to premium payment delinquencies.

Further, we note that premium delinquencies can arise due to a number of different factors including inadvertent mistakes, staffing issues, or issues with the remitting amounts out of the bank or trust account. Plans do not generally keep an ongoing record of such minor or otherwise *de minimis* delinquencies. Reporting of such information would require plans to reprocess their systems and engage in greater information gathering from their service providers, significantly increasing administrative burden and cost. Accordingly, in the alternative to eliminating the reporting requirement altogether, we request that the rule be modified to except from reporting those delinquencies that are minor or otherwise *de minimis* in nature.

Lastly, the Proposed Revisions are unclear as to whether this reporting requirement would apply with respect to delinquent employer contributions as well as individual contributions. The Council notes that employers may lack full knowledge regarding the

PHSA Section 1311(e)(3), which includes reporting on, *inter alia*, claims payment policies and practices, data on enrollment and disenrollment, periodic financial disclosures, and data on the number of claims that are denied. PHSA Section 2717 imposes quality reporting requirements on group health plans and health insurance issuers offering group or individual health insurance coverage with respect to benefits and provider reimbursement structures that, *inter alia*, improve health outcomes, and implement activities to prevent hospital readmissions, improve patient safety, and implement wellness and health promotion activities.

extent and timing of participant contributions (for example, payments for continuation coverage by individuals on unpaid leave). As such, we request that premium payment delinquency reporting be limited to delinquencies related to employer payments.

F. Clarify Reporting Requirement on Contribution Transmittals to the Plan

The Proposed Regulations would require reporting of failures to transmit to the plan any participant contributions or repayments as of the earliest date on which such contributions could reasonably be segregated from the employer's general assets.

The proposed reporting seems to apply to both funded and unfunded plans equally. However, the Council notes that with respect to unfunded plans, EBSA Technical Release 92-01 provides that an employer may not be required to utilize a trust for purposes of segregating and holding participant contributions. To avoid any confusion, we request the Agencies to limit this reporting requirement to funded group health plans.

G. Eliminate or Revise Compliance Reporting

The Proposed Revisions would require reporting of compliance with applicable federal laws and DOL regulations issued thereunder (*e.g.*, HIPAA, GINA MHPAEA, Newborns' and Mothers' Health Protection Act, Women's Health and Cancer Rights Act, Michelle's Law, and the ACA), as well as the content requirements applicable for summary plan descriptions ("SPDs"), summaries of material modification ("SMMs"), and summaries of benefits and coverage ("SBCs").

We urge the Agencies to eliminate this requirement or revise the requirement to provide for reporting of good faith compliance. If neither of these options is adopted, then the requirement should be changed to refer to compliance based on the signer's knowledge.

The proposed attestation requirement is onerous and could expose plans to penalties of perjury or Form 5500 reporting penalties where the plan reports compliance on the Schedule J, but the DOL or another agency makes a different determination as a result of audit or other enforcement action. In addition, the attestation requirement does not take into account completed or ongoing self-correction efforts and would not provide a complete picture of the plan's ongoing compliance efforts.

H. Concerns Regarding Implementation of *Gobeille v. Liberty Mutual Insurance Co.* Through the Form 5500

In the Proposed Revisions, the DOL has requested comments on "the proposed annual reporting requirements for plans that provide group health benefits, including

the new Schedule J, in light of the Supreme Court's recent decision in *Gobeille v. Liberty Mutual Insurance Co.*, 136 S Ct. 936 (2016)." 81 Fed. Reg. 47,496, 47,534 (July 21, 2016).

While the Council supports the DOL's efforts to facilitate compliance with ERISA and the Code, we believe the establishment of an all payers claims database ("APCD"), would not further that goal. We also believe the DOL lacks the authority to incorporate APCD reporting (either expressly or otherwise) as part of the Form 5500.

First, we emphasize that nowhere in the *Gobeille* decision did the Court suggest that the DOL has existing authority to impose APCD reporting on ERISA plans. In relevant part, the Court states in its decision that "[the Secretary of Labor] *may* be authorized to require ERISA plans to report data *similar* to that which Vermont seeks, *though that question is not presented here.*" *Gobeille*, 136 S. Ct. at 945 (opinion of the court) (emphasis added). Per the Court's language, at best the DOL has authority to require plans to report "similar" – but not "same" – data. And at worst, the DOL "may" not have such authority.

We believe Justice Breyer's concurring opinion provides the most accurate picture of DOL's existing authority. More specifically, in his opinion, he acknowledges that "[ERISA] pre-emption does not necessarily prevent Vermont or other States from obtaining the self-insured, ERISA-based health-plan information that they need," and that "[s]tates wishing to obtain information can ask the Federal Government for appropriate approval. *Gobeille*, 136 S. Ct. at 950 (Breyer, J, concurring) (citations omitted). However, he then goes on to note that while the "Secretary of Labor has authority to establish additional reporting and disclosure requirements for ERISA plans," this authority is supposed to be used to "undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans.'" *Id.* Put differently, Justice Breyer seems to be acknowledging the limits on the DOL and that, while it may have material authority to collect data that will aid states in the regulation of their insurance markets, the DOL lacks full authority to impose APCD reporting on ERISA plans generally.

As noted above, ERISA Section 104(a)(2)(B) allows the Secretary of Labor broad authority to require any information or data from plans. However, such authority is limited to "where he finds such data or information is necessary to carry out the purposes of this subchapter [Title I]" The purposes of Title I generally relate to protection of participant interests in employee benefit plans and reporting and disclosure of financial information and other information with respect to employee benefit plans. The purposes of Title I do not relate to individual member-level data or information on medical providers, which is typically the type of data gathered through an APCD.

Finally, we note that implementation of an all payer claims database would result in significant administrative burdens and costs for employers, as the type of information that would be required for an APCD (*e.g.*, provider information, diagnosis codes, and participant-level claims data) is not currently gathered by plans or reported to plan sponsors due to HIPAA privacy concerns. Proponents of APCDs have not fully contemplated the enormous impact on plan sponsors and the significant HIPAA and state privacy issues that would be triggered by a federal APCD. All of these concerns would need to be more closely evaluated before any federal APCD can be considered.

II. Comments Regarding Elimination of Small Plan Exception for Group Health Plans

The Proposed Revisions require the filing of a Form 5500 by all ERISA-covered plans that provide group health benefits, regardless of size, and regardless of whether funded through a trust, unfunded, or a combination of unfunded/insured. By expanding the annual reporting requirement to all ERISA-covered plans that provide group health benefits, the Proposed Revisions eliminate the current reporting exemption for plans with fewer than 100 participants that are insured, unfunded, or a combination thereof, to the extent that the plans provide group health benefits.

As noted above, the Proposed Revisions define group health plans as those that would meet the requirements of ERISA Section 733(a), regardless of whether they may otherwise constitute excepted benefits under ERISA Section 733(c).

Small plans are generally offered by small employers with limited capital, administrative, and technological resources. Many small employers may not have systems in place to complete Form 5500 reporting each year, and the elimination of the small plan exemption is likely to impose undue burdens on such employers and could have a negative impact on employer-sponsored health care.

To avoid significantly increasing an employer's administrative burdens with respect to Form 5500 filings, we urge the Agencies to retain the small plan exemption in its current form. Alternatively, we request the Agencies to revise the Proposed Rule to provide that the annual reporting requirement only apply to small group health plans that meet the requirements of ERISA Section 733(a), and not plans that provide coverage solely for excepted benefits under ERISA Section 733(c).

COMMENTS REGARDING PROPOSED RETIREMENT PLAN REPORTING CHANGES

I. Comments Regarding Proposed Schedule C Changes

A. Overview of Proposed Schedule C Changes

The Proposed Revisions would make a number of significant changes to the manner in which plans report information regarding service providers on the Form 5500's Schedule C, including changes that are intended to harmonize Schedule C reporting with the DOL's 408b-2 disclosure regulations. As discussed further below, we support the Agencies' efforts to harmonize Schedule C reporting with the DOL's 408b-2 disclosure regulations. However, we also believe that the Proposed Revisions include a number of new elements that are *actually inconsistent* with the 408b-2 disclosure regulations and will create unnecessary challenges for plan sponsors and service providers. In particular, we are concerned about the proposed requirements that would require plans to (1) report the total amount of indirect compensation received by service providers as an actual or estimate dollar amount, (2) report whether a service provider was a fiduciary during the plan year, and (3) report whether any arrangement involved "related party compensation," as that term is defined by the DOL's 408b-2 disclosure regulations. Additionally, we have identified areas where the proposed Schedule C changes and other new information requests regarding service provider compensation will require clarification from the Agencies. We believe that the following list of issues should serve as guide for the Agencies as they work to revise Schedule C.

B. Proposed Revisions Intended to Harmonize Schedule C Reporting with the DOL's 408b-2 Disclosure Regulations

Support for Harmonization: The Council appreciates and supports the Agencies' efforts to harmonize Schedule C reporting with the DOL's 408b-2 disclosure requirements. In particular, the Council supports (1) the elimination of the concept of eligible indirect compensation, and (2) limiting the reporting of indirect compensation to covered service providers. The Schedule C reporting rules and the DOL's 408b-2 disclosure regulations, as presently promulgated, require plan administrators and service providers to design and implement compliance and reporting strategies based on two different sets of rules. Any harmonization between the Schedule C and 408b-2 disclosure regimes reduces the costs and administrative burdens associated with sponsoring an employee benefit plan. Accordingly, where harmonization is possible, we encourage the Agencies to provide one set of standards that can be coordinated and implemented in a less costly and more efficient manner.

Suggestion: One of our members has expressed concerns with how the Proposed Revisions would create two different dollar amount thresholds for reporting service providers on the Schedule C – \$5,000 for service providers only receiving direct compensation and \$1,000 for service providers receiving direct *and indirect compensation*.

In an effort to help synchronize the Form 5500 reporting rules with the DOL's 408b-2 disclosure regulations, that member advocates for the adoption of a single consistent dollar amount threshold regardless of whether a service provider exclusively receives direct compensation, and even if the threshold is the lower amount of \$1,000. In any case, the dollar amount threshold for Schedule C reporting purposes should be consistent regardless of whether such compensation is direct or indirect. It should either consistently be \$1,000 or \$5,000.

Clarification Requested For Welfare Benefit Plans: As part of the Agencies' harmonization efforts, the Proposed Revisions indicate that plans will only be required to report indirect compensation paid to "covered service providers," as such term is defined in Labor Reg. § 2550.408b-2(c)(1). Under those regulations incorporated by the Proposed Revisions, a "covered service provider" only includes certain service providers that enter into a contract or arrangement with a "covered plan." The term "covered plan" under Labor Reg. § 2550.408b-2(c)(1)(ii) does not include an "employee welfare benefit plan," as defined under ERISA Section 3(1). Consequently, we understand the Proposed Revisions to mean that "employee welfare benefit plans," as defined under ERISA Section 3(1), are not required to report any indirect compensation paid to service providers. We request the Agencies to issue guidance expressly stating that the final Forms revisions will not require employee welfare benefit plans to report indirect compensation paid to any service provider.

C. Eliminate Proposed Revision Requiring Plans to Report the Total Amount of Indirect Compensation Received By Service Providers as an Actual or Estimate Dollar Amount

The Proposed Revisions would require plans to report the total amount of indirect compensation received by a covered service provider during the plan year as a dollar amount and indicate that any reasonable method of allocation to generate plan level estimates would be permitted, provided the method is disclosed to the plan administrator. We recommend the Agencies remove this new requirement because it is inconsistent with the DOL's 408b-2 regulations, provides limited utility for plan sponsors evaluating service provider compensation, and creates new costs that would not justify its marginal benefits.

Inconsistent with 408b-2: Reporting the total amount of indirect compensation as an actual or estimate dollar amount runs contrary to the Agencies' efforts to harmonize Schedule C reporting with the DOL's 408b-2 disclosure regulations. The 408b-2 disclosure regulations do not require plans to report, or service providers to calculate, the total amount of indirect compensation paid to a service provider as an actual or estimate dollar amount. To the contrary, the 408b-2 regulations permit the disclosure or reporting of indirect compensation as a formula or percentage of assets, rather than an actual or estimate dollar amount. This was a deliberate and carefully considered choice that the DOL made during the notice and comment process for the 408b-2 regulations

and it would not be appropriate to upend that regulatory outcome. The current Schedule C and 408b-2 disclosure regulations represent a compromise between the needs of the Agencies, plan and participant advocates, and the financial services industry. As described above, part of that compromise reflects the cost-saving benefits and increased efficiencies for plan sponsors created when the Agencies' disclosure and reporting rules are harmonized. The proposed dollar amount requirement would disrupt that compromise, which has worked well to inform plan sponsors on the amounts of compensation received by service providers.

The Dollar Amount Would Not Be Useful for Plan Sponsors: In the absence of any further guidance instructing service providers on how to calculate, value, and allocate indirect compensation among the plans they serve, an estimate amount of indirect compensation reported on the Schedule C will lack uniformity and will not provide a reliable reference point for plan sponsors attempting to compare service provider compensation. Further, this variation is problematic for plan sponsors and service providers who could become the target of frivolous litigation created by the misplaced reliance of plaintiffs' attorneys on those unreliable figures.

For example, even the more straightforward forms of indirect compensation – like asset-based revenue received with respect to mutual funds and other investments – would be highly sensitive to the value of the investment on the day or days in which the asset based compensation is assessed. Estimates regarding those kinds of indirect compensation could be the product of significant differences in service providers' methodologies for calculating indirect compensation estimates. Moreover, the estimate amount of indirect compensation received by a service provider would also presumably include estimate values for soft dollar compensation, non-monetary compensation, and float revenue. Producing plan-level estimates for those forms of compensation would require significant judgment calls by each service provider and costly systems that do not justify this reporting. This is why, for example, the DOL's guidance on float compensation does not require specific estimates of dollar amounts. Instead, that guidance focuses on how float income is earned.¹

In fact, we think that if the Agencies decide to overturn years of careful consideration on how service providers should disclose, and plan administrators should review, indirect compensation, a much more robust process to evaluate the myriad forms of indirect compensation must be undertaken. And the Agencies need to provide guidance on soft dollars, revenue sharing, non-monetary compensation, float, and every other form of indirect compensation. It is blatantly insufficient to simply tell plan administrators in the Forms' instructions to ask their service providers to "make up a reasonable methodology and tell us what it is." Because service providers will differ, plan administrators, and the public, will receive inconsistent and unreliable figures that would provide a poor comparison measure.

¹ See Field Assistance Bulletin 2002-3 (Nov. 5, 2002).

Accordingly, we ask the Agencies to eliminate the Proposed Revisions that would require reporting of an actual or estimate amount of indirect compensation. Unless reliable figures can be generated to capture the total indirect compensation received by a service provider, formulas and descriptions of compensation are a more accurate and appropriate way of allowing plan fiduciaries to compare compensation being paid to service providers.

Costs Outweigh Benefits: The current reporting of indirect compensation as a formula is beneficial to plan sponsors and service providers because it provides plans with all the information they need to evaluate service provider compensation while avoiding unnecessary administrative burdens and costs. By reporting indirect compensation as a formula, plans and service providers avoid the unnecessary costs that would be incurred if they were required to calculate an actual or estimate dollar amount for each plan. Simply put, the costs associated with calculating a rough estimate of indirect compensation are not justified by the marginal benefits that those estimates may provide to plan sponsors beyond what is currently disclosed through easily comparable formulas and percentages. Finally, there is no evidence the DOL's regulatory impact analysis made any attempt to determine the costs associated with all of the systems changes needed to capture and report this information.

D. Eliminate New Information Requests Regarding "Related Party Compensation"

The Proposal would add a new question asking whether the arrangement with each covered service provider required to be reported on Schedule C involved any related party compensation. If "yes," the filer would be required to indicate the services for which the compensation was paid, the names of the payor(s) and recipient(s) of such compensation, status as an affiliate or subcontractor (indicated by checkbox), and the amount of the compensation.

We recommend that the lines seeking detailed information on "related party compensation" be removed. First of all, as the 408b-2 regulations make clear, this information is typically *duplicative* of direct or indirect compensation already disclosed.² It does not reveal information on the total costs that a plan pays (directly or indirectly) for services. While it may be helpful for a responsible plan fiduciary to understand the relationships among affiliates and subcontractors of the primary service provider, this is not useful for Schedule C, which should provide information about the direct and indirect expenses paid by the plan.

² The 408b-2 regulation specifically requires disclosure of related party compensation "regardless of whether such compensation also is disclosed pursuant to paragraph (c)(1)(iv)(C)(1) or (2), (c)(1)(iv)(E), or (c)(1)(iv)(F) of this section." Labor Reg. § 2550.408b-2(c)(1)(iv)(C)(3).

In addition, the “related party compensation” provision in the 408b-2 regulations is the mostly poorly understood and inconsistently applied part of the 408b-2 disclosure. The examples given in the regulation for payments made “on a transaction basis” or “charged directly against the covered plan’s investment and reflected in the net value of the investment” are either conflicting or incomplete. In our experience, service providers have done their best to understand what is and is not considered “related party compensation,” and generally over-disclose out of an abundance of caution. Given this, we think that this disclosure is not appropriate for Schedule C. At most, the Schedule C should simply include a question as to whether the arrangement with each covered service provider required to be reported on Schedule C involved any related party compensation.

E. Eliminate Proposed Checkbox Requiring Plans to Indicate Whether a Service Provider Was a Fiduciary During the Plan Year

The Proposed Revisions would require plans responsible for completing the Schedule C to check a box indicating whether the service provider was a fiduciary within the meaning of Section 3(21) of ERISA during the plan year. This includes named fiduciaries and functional fiduciaries, which become a fiduciary based on their exercise of control over plan assets, their discretionary authority over the administration or management of the plan, or their provision of investment advice for a fee.

This new Schedule C checkbox should either be removed or modified from the Proposed Revisions. A service provider’s status as a functional fiduciary is a fact and circumstances test for which reasonable differences of opinion will exist. For example, a service provider’s status as a functional fiduciary under the DOL’s recently finalized conflicts of interest rule could depend on whether the service provider delivers to the plan any “communication that, based on its content, context, and presentation, would reasonably be viewed as a suggestion that the [plan] engage in or refrain from taking a particular course of action.” The contours of that highly technical standard require significant judgment calls for which differences of opinion will exist, even among legal experts who have built careers advising client’s on ERISA’s fiduciary standards. It would be unfair to ask plan administrators who have incomplete information to make this determination and attest to that determination under penalty of perjury. Further, those determinations will not be consistent among plan administrators and will result in unreliable reporting on the Form 5500.

Moreover, we are also concerned that this new checkbox unfairly increases litigation and enforcement risks for plan sponsors and service providers who may, based on the information reported on the Form 5500, appear to be engaging in prohibited transactions for which no exemption exists. This is a distinct possibility in the event that a plan administrator incorrectly identifies a service provider as a fiduciary. Because the prohibited transaction rules carry significant liabilities and often hinge on whether a service provider enters into a fiduciary relationship with a plan or its participants, this

new checkbox would raise significant red flags, which would at the very least require a response from any service provider incorrectly identified as a fiduciary. This response would be necessary and create costs for service providers regardless of whether they are actually a fiduciary. These costs would ultimately be passed on to plans and participants and make plan sponsorship less appealing. As indicated above, we are concerned that the indeterminate fiduciary standard creates reasonable difference of opinions, even among experts in the retirement industry. Given the significant consequences associated with becoming a fiduciary, especially as they relate to the prohibited transaction rules, it is inappropriate to leave the question of identifying whether a service provider is a fiduciary in the hands of each plan administrator, who may or may not have a thorough understanding of what constitutes fiduciary activity. Accordingly, we encourage the Agencies to remove this question from its Proposed Revisions, or at least limit its application to service providers who have affirmatively stated on their 408b-2 disclosure that they *expect* to provide services as a fiduciary.

Finally, we want to point out that this new reporting element, as proposed, would not allow plans to clearly identify which specific services the entity being reported is assuming fiduciary status for. This failure to represent the nuance of a service provider's fiduciary status is particularly problematic for health plan service providers who may provide a wide range of services to the plan, while only assuming fiduciary status with respect to claims administration. If this element is ultimately retained, the Agencies must provide some mechanism to allow plans to identify when a service provider is a limited fiduciary.

F. Provide Clarification For Bundled Service Provider Reporting

The Proposed Revisions would require plans to complete a separate Schedule C for each service provider that must be reported. We are requesting clarification under the Proposed Revisions on whether compensation paid to a bundled service provider – typically understood by plan sponsors as a unified solution – must be reported on separate Schedule Cs when a bundled service provider is made up of several affiliated corporate entities. For example, one bundled retirement plan service provider could consist of an entity providing recordkeeping and claims administration services, another affiliated entity providing brokerage services, another affiliated entity providing custodial and trustee services, and another affiliated entity providing investment advisory and management services. We think it is unnecessary to report each individual corporate entity on a separate Schedule C and encourage the Agencies to allow reporting of each affiliated service provider on a single consolidated Schedule C.

G. Provide Clarification on New Elements Collecting Information on Employer-Paid Administrative Expenses

The Proposed Revisions would add a new compliance question asking whether the employer sponsoring the plan paid administrative expenses that were not reported as service provider compensation on Schedule C or a plan administrative expense on Schedule H. The Agencies should clarify whether this question requires the reporting of all plan sponsor-paid administrative expenses, even if the amounts would not be appropriately charged to the plan. For example, certain employer-paid services, such as design assistance, may not be properly payable out of plan assets. Would those amounts trigger this newly proposed information request?

II. Comments Regarding Proposed Schedule H Changes

A. Overview of Proposed Schedule H Changes

The Proposed Revisions make a number of changes to the Schedule H by requiring more granular reporting on the Schedule H balance sheets, altering the way investments through direct filing entities (“DFEs”) are reported, adding new compliance questions, and requiring trustees to sign the Schedule H. At a general level, we are concerned that many of these changes will increase administrative burdens and costs that will ultimately be passed on to the plans and participants for whose benefit the changes are being sought. In an effort to limit those administrative burdens and costs, we encourage the Agencies to eliminate proposed information requests that would produce few marginal benefits to plans and participants and eliminate information requests that cannot be consistently or reliably answered by plan administrators under penalty of perjury. Also, we encourage the Agencies to provide clarification on certain other new elements for which the Proposed Revisions raise significant questions. Our comments below identify the key areas that must be addressed in order to implement these recommendations.

B. New Schedule H Breakouts

Granular Reporting Creates Significant Costs: Under the Proposed Revisions, the Schedule H balance sheet would collect significantly more detail on each plan’s assets, liabilities, income, and expenses by requiring each plan to break out the Schedule H balance sheet into more granular categories. While the Council believes the Form 5500 series could be improved by updating the current Schedule H breakouts, the level of detail required under the Proposed Revisions goes too far. Many of the proposed breakout categories will increase plan administration costs without providing any appreciable benefits for plans, participants, regulators, and other stakeholders. For example, one of our members has expressed specific concerns regarding the new administrative expense breakouts in Schedule H, Part II, Line 2i(10), which would require plans to break out trustee fees/expenses, including expenses for “travel, seminars, and meetings.” This is just one example of the overly detailed and difficult to track breakout categories being added by the Proposed Revisions. Accordingly, we encourage the Agencies to carefully consider which breakouts are actually useful for the

annual information return/report's purpose and to eliminate any breakouts that are unnecessary.

Schedule H Breakouts Inconsistent with FASB: The Council is also concerned that the new Schedule H breakouts are inconsistent with the investment categories prescribed by the Financial Accounting Standards Board ("FASB"). With the issuance of Accounting Standards Update 2015-12, FASB changed its reporting requirements so that employee benefit plans only have to report their investment holdings by their general type, not by other hard-to-measure information such as the nature of the investments and their risks. In order to satisfy the Form 5500 requirements, as opposed to FASB's standards, plan sponsors and service providers would need to expend significant resources to report the same assets according to two different reporting standards – once under FASB's standards and again under the Agencies' revised reporting requirements. This bifurcation in reporting standards is inefficient, costly, and must be carefully considered. In addition, the financial statements are attached to the Form 5500. This could cause confusion for a reader who is examining the same assets broken out differently under two different standards.

Specific Concerns. Beyond those high-level issues, we also want to identify some of our specific concerns regarding the proposed Schedule H revisions below:

- **Redundant Master Trust Reporting:** Under the Proposed Revisions, any plan investing through a master trust would be required to report detailed information about the master trust's underlying investments on the plan's expanded Schedule H, Line 4i Schedules of Assets. This requirement is duplicative because the Proposed Revisions would also require master trusts to report detailed investment information on their own filings' Line 4i Schedules of Assets. In order to eliminate this duplication, we ask the Agencies to remove the proposed requirement for plans participating in a master trust to break out the master trust's underlying portfolios on each plan's Line 4i Schedules of Assets.
- **Brokerage Accounts:** The Proposed Revisions would require more granular information to be reported with regard to participant directed brokerage accounts. Although we appreciate the Proposed Revisions making it clear that participant brokerage accounts should be reported on their own Schedule H line item (except for certain asset classes), we do not think that plans should be required to provide detailed reporting on the underlying investments of a brokerage window on the Schedule H balance sheet or Line 4i Schedules of Assets.

We also think it is particularly inappropriate to require detailed information on brokerage accounts while the DOL has a regulatory project pending on this topic. This is reminiscent of the last Schedule C reporting revisions, when the DOL moved forward with back-end reporting before determining what information actually should be required to be disclosed and considered by plan administrators under the 408b-2

regulation. Therefore, we encourage the Agencies to remove requirements contained in the Proposed Revisions that would make plans report detailed information on investments selected through a brokerage window on the Line 4i Schedules of Assets. If and when the DOL moves forward with a regulatory project on brokerage windows, then the Agencies can consider what information is appropriate for reporting at the end of the year.

- **Hard-to-Value Assets:** Under the Proposed Revisions, plans would be required to indicate on the Line 4i Schedules of Assets whether any of the plan’s investments are hard-to-value assets. For this purpose, the preamble to the Proposed Revisions indicates that common collective trusts (“CCTs”) and pooled separate accounts (“PSAs”) would need to be identified as “hard-to-value” assets if the CCT or PSA is primarily invested in hard-to-value assets itself. This is true regardless of whether the CCT or PSA is valued annually. This “hard-to-value” label for CCTs and PSAs that are valued annually mischaracterizes those investments and is unfair when compared to the treatment of registered mutual funds that may also be invested primarily in hard-to-value assets without being labeled as hard-to-value assets. CCTs and PSAs are regulated by state banking and insurance agencies, can be accurately valued, and typically provide the same daily net asset value provided by mutual funds. Accordingly, we are requesting for the Agencies to remove the requirement to identify CCTs and PSAs as hard-to-value assets on the Line 4i Schedules of Assets when they are independently valued at least annually.

C. Eliminate Proposed Collection of the 404a-5 Participant-Level Fee Disclosure Chart

The Proposed Revisions would require plans subject to the DOL’s participant-level fee disclosure rules, also known as the 404a-5 disclosure rules, to attach the investment option comparison chart or charts that were used to satisfy the disclosure requirement in 29 CFR 2550.404a-5(d)(2) for the plan year. This new requirement would provide almost no marginal benefit for the intended audience of those disclosures – retirement plan participants – while increasing administrative burdens and costs, making plan sponsorship less appealing, and potentially creating confusion for plan participants. Accordingly, we encourage the Agencies to eliminate this new requirement. In the alternative, if the Agencies retain this new element, they must provide clarification on the issues identified below.

The purpose of the 404a-5 comparison chart is to provide participants who have the ability to direct their own retirement plan investments with “information critical to making informed decisions about the management of their accounts, particularly information on investment choices, including attendant fees and expenses.”³ The DOL’s

³ 75 Fed. Reg. 64,910, 64,910 (Oct. 20, 2010).

current 404a-5 rules fulfill this purpose by requiring plan administrators to furnish certain investment related information to participants on an annual basis, including the 404a-5 comparison chart. The Proposed Revisions' repurposing of the DOL's 404a-5 comparison chart on the Form 5500 series would not provide participants with any greater access to the information contained in the chart, while increasing administrative costs and making retirement plan sponsorship less appealing for employers concerned about litigation risks.

This proposed requirement could also create confusion in two particular instances. First, this requirement could create confusion for plan participants in the event that they attempt to reference the 404a-5 comparison chart available through EFAST after changes to the plan's investment options have occurred. Second, this requirement could create confusion for plan participants because sometimes information that addresses what is covered in the total operating expense ratio of a fund is contained in another section of the fee disclosure or in other documents provided to the participant. The expense ratio does not tell the whole story. For these reasons, we encourage the Agencies to eliminate the proposed requirement for plan administrators to attach the 404a-5 comparison chart.

Inconsistent with Statutory Mandate: We are very concerned that requiring the 404a-5 comparison chart to be included in the Form 5500 is not consistent with ERISA. Title I of ERISA provides for the filing of the plan's summary plan description (which the Agencies no longer require), but no other documents provided to participants. Had Congress believed that the annual return/report might include attaching documents provided to participants, it would not have provided separately for filing of the summary plan description. And the 404a-5 disclosure is not even a disclosure required by Congress. The DOL created the detailed 404a-5 disclosure based on the requirement in Section 404(a) of ERISA that a fiduciary of a participant-directed plan must act prudently, which entails providing information *to participants* to make informed decisions. In addition, since plan sponsors will be understandably more concerned about litigation risks from plaintiffs' attorneys perusing the charts to find litigation targets, the DOL should remove this requirement from the final rule.

Clarification Requested: If the Agencies do not follow our recommendation and the 404a-5 comparison chart must be attached to the plan's annual return/report, we request the Agencies to provide further clarification on the attachment itself. For example, there are often multiple versions of the 404a-5 comparison chart that exist during a given plan year. These different versions are created to reflect changes in the plan's investment menu and to reflect changes in the fees of existing investment options. We request clarification that only the 404a-5 comparison chart existing for the plan at the end of the plan year needs to be attached in order to fulfill the new requirement.

D. New Elements Requesting Information on Uncashed Checks and Missing Participants

The Proposed Revisions would add a new information request to the Form 5500-SF and Schedule H asking whether there were any uncashed checks owed to participants or beneficiaries as of the end of the plan year. If there are uncashed checks, filers would be required to provide the number of uncashed checks, the total value of uncashed checks, the procedures followed by the plan to verify a participant's or beneficiary's address before checks are mailed, and the procedures followed by the plan to monitor uncashed checks, including steps to verify addresses and locate "missing" or "lost" participants. Like the 404a-5 comparison chart discussed in the preceding section, we are concerned that the new elements requesting information on uncashed checks and missing participants will increase the administrative burdens and costs created by Form 5500 reporting without providing justifiable benefits for participants and the public.

Specifically, we are concerned that the new questions regarding uncashed checks and missing participants will not collect any meaningful information that would help solve the problems created by uncashed checks and missing participants. The Agencies, plans sponsors, and service providers already are keenly aware that uncashed checks prevent many retirement savers from tapping into sources of retirement income owed to them. Nevertheless, the preamble to the Proposed Revisions indicates that the Agencies are proposing these new reporting elements in order "to get better information about the magnitude of the problem." But this has it backwards. The DOL has provided guidance on missing participants in terminated plans, but not on missing participants in ongoing plans, despite repeated requests from the community to do so. Plan sponsors have done the best they can in the absence of guidance, but it is inappropriate to require reporting before the DOL provides guidance. For example, plan sponsors and service providers would benefit from more guidance on when uncashed checks are considered to be "plan assets," as well as circumstances, if any, under which they cease to be considered plan assets. Providing such guidance would not only help plan administrators complete the Form 5500 more accurately, it would also help to more clearly define how those assets can be used and whether the sponsor remains a fiduciary with respect to such assets. Rather than requesting information that would require plans and service providers to develop new and costly information systems intended to generate statistics on uncashed checks and missing participants, we believe that the Agencies should issue guidance making it clear how such assets should be treated by plan sponsors and service providers, which would then pave the way for resolution.

"Uncashed Check" Definition: If the Agencies ultimately do not eliminate these new requirements, they must provide clarification on the definition of "uncashed checks" for purposes of Form 5500 reporting. In particular, guidance must be provided on the following issues:

- **Returned Checks:** Checks owed to missing participants are often returned to the plan or its service provider as “undeliverable.” The proposed instructions define an uncashed check as a check that is “no longer negotiable or is subject to limited payability.” However, before those checks expire, they continue to be negotiable and are not subject to limited payability. Further, we are not even sure what it means that a check has “limited” payability. Should those checks be reported as uncashed checks, even though they do not meet the instruction’s definition of an uncashed check?
- **Forfeitures:** Some plans provide that uncashed checks will be forfeited after a certain period of time and subsequently returned to a participant’s account if the missing participant returns to claim his or her interest. Would those forfeited amounts need to be reported?

E. Eliminate Question Asking Whether the Plan Terminated Any Service Provider Due to a Material Failure to Meet the Terms of the Service Arrangement or Failure to Comply With ERISA

The Proposed Revisions would add a new question asking whether the plan terminated any service provider other than an accountant or enrolled actuary for a material failure to meet the terms of the service arrangement or a failure to comply with Title I of ERISA, including the failure to provide required disclosures under 29 CFR 2550.408b-2. We encourage the Agencies to eliminate this new information request because it is unlikely to yield consistent or reliable information. And, if this proposed element is not removed, significant clarification is necessary.

“Material Failure” Standard: The proposed Form 5500-SF, proposed Schedule H, and proposed instructions do not provide any clarification on what is meant by “material failure.” This standard is nebulous and is unlikely to yield information that would be consistent or reliable for reference by plans, participants, and policy makers who may seek to rely upon such information when making decisions or creating policy. Form 5500 preparers are not equipped to make this judgment call on behalf of the plans they serve. Plan administrators would be required to complete this new question by answering whether the plan terminated any service provider for a “material failure” – an indefinite term that would require each plan administrator to make a judgment call for which reasonable differences of opinion would exist. Ultimately, we believe that this uncertainty will lead to an inaccurate reporting of “material failures” (most likely over-reporting) and generate information that is as unreliable as it is misleading. If the Agencies retain this new question when the Proposed Revisions become final, significant clarification must be provided on what is meant by “material failure.”

Inadequate Notice: We are also concerned that the new compliance question asking plan administrators whether they terminated any service providers other than an accountant or enrolled actuary for a material failure to meet the terms of a service

arrangement or failure to comply with Title I of ERISA does not afford service providers that would be reported under those questions with the same benefit of notice provided to parties reported through the current compliance question asking about the termination of accountants and enrolled actuaries. The instructions to the proposed Schedule H say that any plan administrator reporting the termination of an accountant or enrolled actuary must provide such accountant or enrolled actuary with a copy of an explanation of the termination along with a copy of a standard notice included in the instructions. Not only does that notice alert a terminated accountant or enrolled actuary that they have been reported, but it also provides them with an explanation for their termination and notice of their right to submit comments to the DOL concerning any aspects of that explanation. If terminated service providers other than accountants or enrolled actuaries must be reported on the annual return/report, they must be afforded similar notice rights as terminated accountants and enrolled actuaries.

F. Provide Clarification on Trustee Signature Requirement

Under the Proposed Revisions, the plan's trustee or custodian would be required to sign the Form 5500-SF or Schedule H. The Proposed Revisions indicate that "[t]he signature is intended to satisfy the requirements under Code Section 6033(a) for an annual information return from every Code Section 401(a) organization exempt from tax under Code Section 501(a)." The Proposed Revisions only provide limited guidance on which trustees must provide a signature and on the scope of the attestation signified by the trustee's signature. Accordingly, if the trustee signature requirement is ultimately retained, we request clarification on (1) which trustees are required to sign the Form 5500-SF or Schedule H; and (2) the scope of the attestation signified by the trustee's signature.

Which trustees are required to sign the Form 5500-SF or Schedule H? The instructions to the Form 5500-SF and Schedule H indicate that the plan's trustee or custodian is required to sign the Form 5500-SF or Schedule H, and if there is more than one trustee, the trustee authorized by the others may sign. The instructions do not provide further details on which trustees are required to sign or which trustees are required to provide authorization to another trustee to sign on their behalf. Council members are specifically interested in getting clarification on the following issues:

- Where a plan has multiple service providers that serve as trustees (which is common), we think it would be rare for these trustees to have an "agreement" authorizing one to sign on behalf of the others. We are not sure trust law would permit such an authorization.
- Many plans have employees associated with the plan sponsor named as trustee, but also employ a directed trustee. Is a directed trustee required to sign?

- Some trustees are passive custodians not involved in the day-to-day plan operations of the plan. Are they required to sign?
- In the case of a 403(b) plan with multiple trustees, is each trustee required to sign or authorize another trustee to sign on their behalf?
- If a plan administrator is also the plan's trustee, must it sign as both plan administrator and trustee?
- In the event that a plan is fully funded by an insurance arrangement in lieu of a master trust, it would not have either a trustee or custodian. Any final Forms and instructions should clarify that the trustee signature requirement is applicable only where a trustee or custodian is retained by the plan.

What is the scope of the trustee's attestation? The trustee signature block on the Form 5500-SF closely follows a representation declaring that "[u]nder penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete." The trustee signature block on the Schedule H is not preceded by a similar attestation. We assume that the Agencies do not expect trustees and custodians to represent that all information contained in the return/report is "true, correct, and complete." Many plan trustees would not be in any position to make that representation based on the information to which they have access. Accordingly, we seek clarification on the scope of the attestation signified by the proposed trustee signature requirement.

The former Schedule P, Annual Return of Fiduciary of Employee Benefit Trust (discontinued after 2005), was also used to satisfy Code Section 6033(a). It required the trustee to declare, under penalty of perjury, that the trustee had examined the Schedule P and to the best of the trustee's knowledge and belief, the information reported on Schedule P was true, correct, and complete. Schedule P covered a limited set of information exclusively regarding the trust itself. Accordingly, the attestation on the Schedule P did not encompass any representations regarding information beyond the trust itself. As explained above, it would not be reasonable for the trustee to make such a representation and clarification is necessary to reaffirm that the plan administrator is responsible for verifying that all information reported on the Form 5500 series, not the plan's trustee. If the trustee signature element is retained, the Agencies should make clear that the trustee's attestation only relates to a limited set of information regarding the trust itself.

III. Simplify the Annual Information Return/Report

A. The Council Supports Revisions that Would Simplify the Information Return/Report

As discussed above, the Council generally encourages the Agencies to implement changes that would streamline and simplify the preparation and filing of the annual information return/report. Consistent with this recommendation, the Proposed Revisions would make certain changes that would create some simplification and we applaud the Agencies for proposing those changes. For example, the following Proposed Revisions would all help simplify the annual reporting requirements: (1) the proposed elimination of the requirement for plans to file a Schedule D; (2) a new threshold measurement broadening which defined contribution retirement plans are eligible to file the Form 5500-SF; (3) simplified reporting of CCTs and PSAs on a plan's Schedule H balance sheet (regardless of whether a CCT or PSA files as a DFE); and (4) the above-discussed changes intended to harmonize Schedule C reporting with DOL's 408b-2 disclosure regulations. The Council supports each of those changes and encourages the Agencies to make more changes that would reduce administrative burdens and lower the costs associated with preparing and filing the annual information return/report.

B. Eliminate Proposed Revisions that Increase Administrative Complexity and Costs

On the other hand, the Proposed Revisions would also make a number of changes that would increase administrative complexity and ultimately increase costs that would be passed on to plans and participants. When considering these administrative burdens and costs, we want to remind the Agencies that, for many sponsors, the Form 5500 is prepared by recordkeepers, who produce the Forms and Schedules systematically for their clients. In fact, larger recordkeepers often produce the Form 5500 for thousands of clients and any new information requests being added to the Form 5500 series require those entities to redesign and implement new information systems, which can be labor intensive, complex, and costly. Such efforts would not only require coordination among plan sponsors, Form 5500 preparers, and other service providers, it would also require significant programming. For some of the newly proposed elements, these new information systems would need to be operational on the first day of the reporting period.

The Council understands that many of the Proposed Revision's information requests are being added for research and enforcement purposes. And we recognize that the Form 5500 series is intended to serve both of those purposes. However, after reviewing the Agencies' Proposed Revisions, we are concerned that the Agencies have failed to strike an appropriate balance when weighing the Agencies' research and enforcement needs against the need for reporting rules that minimize regulatory burdens and costs.

This imbalance starkly departs from previous Forms revisions and must be reevaluated before finalizing any of the Forms or Schedules.

In an effort to simplify the Form 5500 reporting process and to reduce the administrative burdens and costs previously discussed, we encourage the Agencies to adopt the following recommendations.

Eliminate Certain Reporting Elements Requesting Statistical Information: The Proposed Revisions include a number of new elements seeking to collect statistical information on defined contribution plan operations even though much of this newly requested information is not currently tracked by plans and recordkeepers because it does not otherwise aid the plan in meeting its compliance obligations. For example, the Proposed Revisions would add new information requests seeking to collect the following information: (1) the number of participants passively defaulted into the plan's qualified default investment alternative ("QDIA"); (2) the number of participants making catch-up contributions; and (3) the number of participants maximizing the employer match. Any efforts to collect such information would require a costly redesign of the information systems supporting each plan's Form 5500 preparation and filing. For the reasons discussed above, we encourage the Agencies to eliminate each of these new reporting requirements or, at the very least, to simplify reporting on those plan features by only asking plans to report whether the plan offers a QDIA, catch-up contributions, or an employer match in the form of a simple "yes/no" question.

Also, if the proposed reporting elements regarding QDIAs and employer matching contributions are not eliminated, the Agencies must provide clarification on a number of issues. Our members have specifically raised the following issues requiring further guidance:

- **Schedule R, Part VII, Line 24(b):** The proposed reporting element seeking to collect information on the number of participants who have been defaulted into the plan's QDIA instructs filers to enter the number of participants that "have not made any investment decisions and remain in the plan's default investment accounts." The instructions indicate that this should include the "number of participants that remain in the plan's default investment account(s) and have not directed any assets into other plan investments." This instruction requires further clarification. For example, would this figure be calculated on the last day of the plan year? And would this figure include participants who have only moved some of their investments out of the default fund? Finally, what would happen if a participant moved out of the default investment but returned to the default investment by the end of the plan year?
- **Schedule R, Part VII, Line 23:** As discussed above, the Proposed Revisions include new elements that would require plans to report detailed information

about the plan's matching contributions. However, the proposed Forms seemingly fail to take into account that a plan may have more than one matching formula. This is not an uncommon plan design, especially for plans with different employee groups, like collectively bargained groups. If this question is retained in any final Forms revisions, it must accommodate plans with multiple matching contribution formulas. Specifically, we suggest providing a category that simply indicates that the plan has multiple matching contribution formulas, rather than asking for specific details about those formulas.

Eliminate Burdensome Open Text Fields. The Council is also concerned about the proliferation of open text fields throughout the various Forms and Schedules. These open text fields will be difficult and costly to complete, while generating information that provides limited reliability and consistency. Examples of these burdensome open text fields include the following:

- **Schedule H, Part IV, Line 4z:** The new reporting elements regarding “uncashed checks” would require plans to describe (1) the procedures followed by the plan to verify a participant's or beneficiary's address before a check was mailed, and (2) the procedures followed by the plan to address uncashed checks, including steps to locate “lost participants.” Like other open text fields included in the Proposed Revisions, these information requests would not uniformly or consistently report information regarding plan operations because each plan would be at liberty to complete the reporting element using any language they deem to be appropriate. We encourage the Agencies to remove this open text field, and others like it, because they would create significant reporting costs without yielding uniform and consistent reporting information. At the very least, this proposed reporting element should be turned into a “yes/no” question asking the plan whether it has procedures to verify addresses and to locate lost participants.
- **Form 5500, Part II, Line 9a(9):** In another new reporting element, the Agencies are requesting information about the types of “features” the plan offers, e.g., whether the plan offers automatic enrollment, financial education, financial advice, or “other” features. Without providing any guidance on what “other” features may be appropriate for reporting under this new element, the instructions direct filers who select the “other” option to “enter a short description [of the feature] in the space provided.” We recommend the Agencies eliminate this “other” category because it is extremely broad and unclear about what types of other features a plan should report and how details on such features should be reported.

Eliminate Certain Reporting Elements Regarding Controlled Groups. The Proposed Form 5500, Part 1(A) would require filers to identify whether the plan covers members

of a controlled group and to provide basic identifying and contribution information regarding those arrangements. In particular, if the filer indicates that the return is for a controlled group plan, the filer would be required to provide a “good faith estimate of each employer’s percentage of the total contributions (including employer and participant contributions) made by all employers during the year.” One of our members has expressed concerns that this information request may be particularly difficult for a company to complete depending on intercompany chargebacks or other structures in place for allocating costs and contributions within the controlled group of companies. This requirement could be overly burdensome for a company to determine and it is unclear what benefit is provided by adding this information to the Form 5500 filing. Accordingly, we encourage the Agencies to remove this information request.

C. IRS-Only and ERISA Compliance Questions

In addition to the administrative difficulties and costs already discussed above, we also want to express the Council’s specific concerns regarding two other categories of information for which the Agencies are soliciting comments: (1) the IRS-only compliance questions; and (2) other miscellaneous ERISA and Code compliance questions being added through the Proposed Revisions.

IRS-Only Compliance Questions: IRS added IRS-only compliance questions to the 2015 and 2016 Form 5500 series, but subsequently directed filers not to answer the new questions for the 2015 and 2016 plan years. Similar to other new information requests included in the Agencies’ broader Proposed Revisions, we are concerned that some of those new IRS-only compliance questions would create significant administrative burdens and costs, which do not justify their collection. Further, if those new information requests are retained, IRS will need to provide clarification. The Council previously voiced its concerns over these new questions when it submitted comments to IRS on May 31, 2016. Nevertheless, we feel it is important to reiterate some of those comments as part of this rulemaking project, especially in light of the fact that IRS only instructed filers not to answer the new questions on the 2016 Form 5500 series after the Council submitted its initial comments.

- **Request for Delay:** We request IRS *not* require filers to answer the IRS-only compliance questions already appearing on the Form 5500 series until after the Agencies have finalized their broader Forms revisions and EFAST3 is rolled out. This delay would allow service providers to coordinate their programming for the IRS-only compliance questions with the programming necessary to accommodate the Agencies’ broader Forms revisions and EFAST3. As discussed further below, significant changes to the Form 5500, like those included in the IRS-only compliance questions, require significant time and effort to implement. Any appropriate implementation timeline would have to allow

interested stakeholders at least two years to implement all of the changes from the time that the final Forms are released.⁴

- **Request for Clarification:** Some of the IRS-only compliance questions also include ambiguities for which clarification is necessary. IRS must be responsive to the community's requests for clarification and revise the new questions and/or instructions accordingly. For example, under the Proposed Revisions, Schedule H, Line 2e(1)(c) and Form 5500-SF, Line 23b would ask whether the plan made "distributions to employees who have attained age 62 and who were not separated from service *when the distributions were made for a defined benefit plan or a money purchase pension plan.*" As we expressed in our previous comments, it is unclear whether this reporting element would apply to a defined contribution plan with a frozen Money Purchase Pension Plan account. Also, it is unclear whether the question can be left blank without an invalidation error in the EFAST2 system. Finally, IRS should also clarify whether the question was intended to ask about an employee "who has *not* attained age 62," since in-service distributions beginning at age 62 are now permitted if the plan allows it. The instructions in the Proposed Revisions for Form 5500-SF, Line 23b suggest that employees who have *not* attained age 62 should be reported because it notes that "[a]ny distribution . . . made prior to age 59½ would be subject to an additional 10% tax under Code Section 72(t)." However, if this is the case, express confirmation in the instructions would greatly assist plans and service providers complete this question.
- **Preparer Name:** The Council's service provider members (as well as individual plan sponsor employees who prepare the form) remain concerned that new questions asking for the Form 5500 preparer's contact information call into question previous guidance indicating that Form 5500 preparer activities do not make the preparer a "tax return preparer" (e.g., Notice 2008-13, Notice 2011-6 and June Service website updates). These members are also concerned the change will subject Form 5500 preparers to additional liability and, in the case of service providers, allow others to obtain their client lists. The Council urges IRS to continue to make this new information request optional or propose the change through the regulatory process instead of making changes in a Forms revision. If the purpose of this new information request is to identify someone IRS can speak with, the Service should rely on existing methods per-

⁴ We also want to note that the current status of the IRS-only compliance questions is somewhat unclear. IRS published a proposal regarding the IRS-only compliance questions in the Federal Register on March 31, 2016, indicating that the new questions would appear on the 2016 Form 5500 series. Despite including the proposed IRS-only compliance questions on publicly released draft forms, IRS has not issued final compliance questions in the Federal Register and guidance appearing on the IRS website instructs filers not to answer these questions on the 2016 Form 5500 series. In the absence of clear guidance, these facts raise significant uncertainty about whether the new IRS-only compliance questions have been finalized and how IRS intends to proceed with these new information requests.

mitting the plan sponsor to authorize someone to speak on their behalf to IRS, like the Form 2848.

- **Determination Letter Dates:** Under the Proposed Revisions, Schedule R, Lines 11a and 11b, and Form 5500-SF, Lines 22a and 22b would require filers to provide the date of the last favorable IRS opinion letter or advisory letter, if the plan is a master and prototype plan or volume submitter plan; or the date of the last favorable determination letter if the plan is an individually designed plan. It would be helpful for IRS to explain why the Form 5500 requires the date of the last determination letter for individually designed plans since the IRS is terminating the determination letter program. Also, for master and prototype plans, Council members need clarification on whether the date of the letter and the serial number is as of the “beginning date” or “ending date” of the plan year. Clarification is also needed if a plan has utilized more than one preapproved plan in the same year.

Miscellaneous Code and ERISA Compliance Questions: The Proposed Revisions add a series of new information requests seeking to collect information regarding defined contribution plan operations and to collect information that would identify various ERISA and Code compliance issues. The defined contribution plan operation questions focus on plan participation and contribution rates, default investments, missing participants, and terminated plans. The ERISA and Code compliance questions would collect information regarding a wide range of issues, but include a series of questions seeking information on compensation paid and received among affiliated service provider. Similar to other issues discussed above, we are concerned that these questions require information that the underlying regulation does not require to be collected. The Form 5500 is not the place for substantive regulation; it should be based on existing regulatory requirements. As the Agencies continue to develop changes to the Form 5500 series in this area, we urge them to avoid questions that create duplication across the various Forms and Schedules and to avoid information requests that will increase administrative burdens and costs without providing useful information to plans and participants.


* * * * *

In addition to the comments offered above, the Council would be happy to provide additional information or answer any questions the Agencies may have regarding potential changes to the Form 5500 reporting process. If additional input would be useful, please contact the undersigned at 202-289-6700.

Sincerely,



Jan Jacobson
Senior Counsel, Retirement Policy
jjacobson@abcstaff.org



Kathryn Wilber
Senior Counsel, Health Policy
kwilber@abcstaff.org