

**Questions and Proposed Answers for the Department of Labor Staff for the
2012 Joint Committee of Employee Benefits Technical Session
Held on May 9, 2012**

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

1. 403(b) Distribution Question

Question: Can a sponsor of a 403(b) plan "force" funds to be distributed from a custodial account when a participant has not made a distribution election in order to fully terminate a 403(b) plan, where such a forced distribution would not violate the terms of the applicable custodial agreement?

Initial Proposed Answer: Yes. It would be permissible for a plan sponsor to automatically distribute a participant's 403(b) plan account held under a custodial agreement upon a 403(b) plan termination without the participant's consent, if the applicable custodial agreement permits the payment.

ERISA Section 203(e)(1), using language also found in Code Section 411(a)(11), generally restricts the ability of a plan to distribute any portion of a participant's accrued benefit over \$5,000 without the participant's consent. However, as an exception to the Code Section 411(a)(11) rules, Treas. Reg. 1.411(a)-11(e)(1) provides that upon termination of a defined contribution plan, if the plan does not offer an annuity option then the plan may generally distribute a participant's accrued benefit without the participant's consent. Notably, Code Section 411 does not apply directly to 403(b) plans, but the rules of Code Section 411 are virtually the same as those found in ERISA 203, which does apply to ERISA covered 403(b) plans. The Code Section 411 regulations are generally applied to interpret the ERISA 203 provisions. Therefore, 403(b) plans that are ERISA plans generally should be subject to exceptions based on the exceptions found in the Code Section 411 regulations (e.g. Treas. Reg. 1.411(a)-11(e)(1)) when applying ERISA Section 203. Accordingly, upon plan termination, where annuities are not available as a distribution option for amounts held under the 403(b) custodial agreement, if the contract permits such payment, a forced lump sum should be permitted without a participant's consent, even if the amounts involved exceed \$5,000.

DOL Answer: The response to this question involves interpretation of section 203(e)(1) of Title I of ERISA and Code Section 411(a)(11) over which interpretive authority rests with the Department of the Treasury.

2. 403(b) Distribution Question

Question: If the answer to Question 1 above is generally "yes," does that answer change if an annuity contract is an alternative funding vehicle under the 403(b) plan?

Initial Proposed Answer: No. The answer to Question 1 should not change, and a lump sum distribution to non-consenting participants should still be able to be forced from a custodial account holding assets of a 403(b) plan that does not itself offer an annuity form of benefit, even if annuities are available as a form of benefit from other funding vehicles (including annuity contracts) under the plan. The analysis of whether an annuity (purchased from a commercial provider) as a form of benefit is available should be made separately for each funding vehicle. Even if the plan has some account balance amounts held under annuity contracts, transfer of the custodial account amounts to one or more of the annuity contracts should not be required. The requirement found in Treas. Reg. 1.411(a)-11(e)(1) for forcing out a lump sum payment, that an annuity form of benefit not be available, if it is deemed to apply, should only be applied to the extent that there are other annuities available as a form of benefit from the custodial account (where the annuity would be purchased from a commercial provider) even if there are other funding vehicles (including annuity contracts) under the plan that might provide an annuity form of benefit.

DOL Answer: The response to this question involves interpretation of section 203(e)(1) of Title I of ERISA and Code Section 411(a)(11) over which interpretive authority rests with the Department of the Treasury.

3. 403(b) Distribution Question

Question: If the answer to Question 1 above is generally "yes," then does the answer change if the plan sponsor also maintains a 401(a) qualified defined contribution plan after it terminates the 403(b) plan? Does the maintenance of a 401(a) defined contribution plan after the 403(b) plan termination ruin the plan sponsor's ability to make distributions to participants upon termination of a 403(b) plan without their consent?

Initial Proposed Answer: No. The answer to Question 1 should not change, and a distribution to non-consenting participants should still be able to be forced from a 403(b) custodial account even if the employer maintains a 401(a) defined

contribution plan post-termination. The limitation found in the Code Section 411 regulations (Treas. Reg. 1.411(a)-11(e)(1)) prohibiting forced distributions upon a defined contribution plan's termination where another "defined contribution plan" is maintained (and which direct that in that instance rather than a forced distribution, account balances of non-consenting plan participants be transferred to the other defined contribution plan), should only be applied to similar plans (i.e., maintaining another 401(a) plan after terminating a 401(a) plan or maintaining another 403(b) plan after terminating a 403(b) plan). Thus, recognizing that a trust-to-trust transfer is not permitted between a 401(a) plan and a 403(b) plan, or vice versa, the limitation found in the 411 regulations when applied to a 401(a) defined contribution plan should only apply where the employer maintains another 401(a) defined contribution plan, and a similar limitation (based on the 411 regulatory language) should only apply to a 403(b) plan where the employer maintains another 403(b) plan other than the one being terminated.

DOL Answer: The response to this question involves interpretation of section 203(e)(1) of Title I of ERISA and Code Section 411(a)(11) over which interpretive authority rests with the Department of the Treasury.

4. 403(b) Distribution Question

Question: If the answer to Question 3 above is "yes," can a distribution from a 403(b) plan still be made without a participant's consent if it is automatically rolled over to the plan sponsor's 401(a) defined contribution plan?

Initial Proposed Answer: Yes. The concept found under Treasury Regulation 1.411(a)-11(e)(1), when applied to a 403(b) plan termination where the employer maintains a 401(a) defined contribution plan, and accordingly the similar exception under ERISA Section 203(e)(1), should be interpreted to permit a forced distribution to a 403(b) participant if that distribution is automatically rolled over to the employer's 401(a) defined contribution plan. Doing so will satisfy the intent of the Treas. Reg. 1.411(a)-11(e)(1) regulatory rule (to "transfer" those funds to the defined contribution plan, rather than forcing their distribution), while addressing the inability to directly transfer funds from a 403(b) plan to a 401(a) plan. Forced distribution without participant consent coupled with automatic rollover to the employer's 401(a) plan is the best way to satisfy the 1.411(a)-11(e)(1) provision, to the extent it is deemed to apply to a 403(b) plan, and will be necessary to effectuate the required distribution of 403(b) plan custodial account balances upon termination of the 403(b) plan. Such an automatic rollover to the employer's 401(a) plan, rather than an IRA, should be permissible notwithstanding the provisions of Code Section 401(a)(31) that might otherwise contemplate auto rollover to an IRA.

DOL Answer: The response to this question involves interpretation of section 203(e)(1) of Title I of ERISA and Code Section 411(a)(11) over which interpretive authority rests with the Department of the Treasury.

5. Deferred Annuities in Defined Contribution Plans Question

Question: A defined contribution 401(k) plan offers a deferred annuity product allowing participants to invest a portion of their 401(k) balances in an annuity contract investment. The plan is otherwise an individual account plan that complies in form and operation with ERISA Section 404(c). The type of annuity product available is consistent with that described in Revenue Ruling 2012-03. No other annuity distribution options are available under the plan.

Plan participants are permitted to direct the investment of their elective deferral and matching contribution accounts among any of the investment options available under the plan, including a deferred annuity contract that is issued by an insurance company, which has been prudently selected by the plan fiduciaries. Amounts invested for a plan participant in a deferred annuity contract are applied at the time of investment to purchase a contract that provides for payments commencing by the first day of the first month that begins after the later of the date the participant retires or attains age 65 (subject to an exception that provides for an earlier commencement date in the case of any participant who is a 5% owner, as defined in Internal Revenue Code § 416, who retires after age 70½). The amount payable under the deferred annuity contract is fixed on the first day of the first period for which an amount is paid under the contract (the annuity starting date). The terms and conditions surrounding the investment in the deferred annuity investment option are fully disclosed to participants choosing to invest.

If participants are allowed to invest in this deferred annuity investment and, once invested, the funds are not allowed to be transferred out of the annuity investment until the eventual distribution date, does the plan lose its status as an ERISA section 404(c) plan and does the participant's investment decision to invest in the deferred annuity and not be able to exercise control to withdraw the invested amount from the deferred annuity comply with ERISA section 404(c)?

Initial Proposed Answer: Assuming that there has been full disclosure of the terms and conditions of the deferred annuity investment (including a clear explanation of the investment restrictions), a participant's decision to invest in a deferred annuity product should be consistent with ERISA section 404(c) even though the participant may not exercise control to withdraw funds from the deferred annuity investment prior to an actual distribution. The preamble to the section 404(c) regulations specifically states that a plan will not lose its status as an ERISA section 404(c) plan merely because the plan offers a non-core

investment option that fails to meet the requirements of ERISA section 404(c) and regulations thereunder, in addition to at least three core investment options that comply. The preamble includes an example of a plan that offers an illiquid real estate limited partnership investment in addition to three core section 404(c) investment alternatives that allow for free transferability at least once within any three-month interval. 57 Fed. Reg. 56906 (Oct. 13, 1992). In addition, regulation section 2550.404c-1(b)(2)(ii)(C) provides that a participant or beneficiary must have the ability to give reasonable investment instructions for all investment options available under the plan with a frequency appropriate in light of the market volatility of the investment option. One reason for limiting the frequency of investment diversification within a deferred annuity investment is that a restriction on the withdrawal of funds facilitates the ability to maximize the internal rate of return. Therefore, if the type of deferred annuity (which has been prudently selected by the plan fiduciaries) includes investment restrictions designed to be appropriate in light of market volatility for the option in question, a participant's decision to invest in the investment should be compliant with ERISA section 404(c).

DOL Answer: The Department has current initiatives related to arrangements designed to encourage and provide for a lifetime stream of income for plan participants. Issues related to arrangements designed to provide for a lifetime stream of income, including in-plan annuities and the application of section 404(c) have been raised in this context. Staff believes that the resolution of these issues should be accomplished as we go forward with these initiatives.

6. Deferred Annuities in Defined Contribution Plans Question

Question: Assume the same situation that is described in the opening two paragraphs of Question 5. If a participant has the right to invest in the deferred annuity investment, does that right have to be granted to an alternate payee under a qualified domestic relations order?

Initial Proposed Answer: Alternate payees do not necessarily have to have the same investment options as participants in a defined contribution plan. Although alternate payees are beneficiaries under ERISA and the plan investment options made available to alternate payees need to comply with ERISA section 404(c) if the plan intends to be protected by ERISA section 404(c) with respect to alternate payees, that does not mean that alternate payees must be provided with the same investment options as participants. Moreover, the fact that the deferred annuity investment ultimately provides for distribution options that are not otherwise provided for in the plan should not change this result. According to the DOL summary of QDRO rules, "The plan administrator must act in accordance with the provisions of the QDRO as if it were a part of the plan. In particular, if, under a plan, a participant has the right to elect the form in which

benefits will be paid, and the QDRO gives the alternate payee that right, the plan administrator must permit the alternate payee to exercise that right under the circumstances and in accordance with the terms that would apply to the participant, as if the alternate payee were the participant." Nevertheless, the deferred annuity investment option is more of an investment option under the plan than a distribution option and a plan should be able to restrict the availability of the deferred annuity investment to participants only.

DOL Answer: The Department has not addressed this question in any prior guidance and does not believe this to be the appropriate forum in which to answer this question.

7. Employee Assistance Plans Question

Question: An employer provides its employees with access to the following types of employee assistance program which is paid for in full by the employer. Eligible employees are allowed to call an EAP counselor for no more than three times during a calendar year. During those calls, the trained counselor (who could be a licensed physician if the need arises) will provide basic diagnoses and treatment suggestions for certain medical-related issues, such as basic counseling for psychological issues or diagnoses and prescription renewal in case the employee's personal physician is not available. However, the employee is not allowed to call the EAP counselor more than three times during a year. The EAP will also provide referrals for further treatment beyond the three permitted calls.

Is this program a welfare benefit plan that constitutes a group health plan for ERISA purposes (which would be subject to the COBRA continuation coverage requirements as well as reporting and disclosure requirements)?

Initial Proposed Answer: Yes. The EAP program is a group health plan for ERISA purposes, which subjects the EAP to COBRA requirements as well as reporting and disclosure requirements. The fact that the EAP is limited to a three-call restriction does not impact the analysis. The answer depends on what types of services were provided, not the quantity of the services.

A group health plan is a welfare benefit plan under ERISA section 3(1) that provides medical care to employees and their dependents. A welfare benefit plan under ERISA Section 3(1) includes a plan that provides, in relevant part, "medical, surgical, or hospital care benefits, or benefits in the event of sickness...".

The DOL has issued three separate Advisory Opinions addressing whether an EAP is an ERISA welfare benefit plan. See Advisory Opinion 91-26A (July 9,

1991); Advisory Opinion 88-04A (Mar. 11, 1988), and Advisory Opinion 83-35A (June 27, 1983). In these opinions, the DOL identifies at least two key elements that determine whether an EAP is a welfare benefit plan under ERISA. First, the employer must bear some portion of the cost of the program. Second, the program must provide medical or sickness benefits, not merely referrals to others outside the program who would provide the services. The advisory opinions provide that medical or sickness benefits include, for example, treatment for drug and alcohol abuse and treatment for mental health benefits, such as stress, anxiety, depression and similar health and medical programs. Nothing in the applicable statutory provisions or advisory opinions suggests that imposing a limit on the number of visits changes the basic analysis of when a program constitutes an employee welfare benefit plan (and a group health plan).

DOL Answer: The JCEB and DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

8. Employee Pay-All Exception Question

Question: An employer offers employees a voluntary dental plan. The employer makes no contributions toward the premiums for the plan and receives no consideration in cash, or otherwise, in connection with the plan. The employer allows employees to pay their contributions toward the premiums on a pre-tax basis through a cafeteria plan that complies with the requirements of Code section 125. For purposes of this question, it is assumed that the arrangement otherwise complies with DOL Regulation section 2510.3-1(j), which provides a safe harbor from ERISA coverage for plans in which: (1) No contributions are made by an employer or employee organization; (2) Participation in the program is completely voluntary for employees or members; (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

Does the fact that employee contributions toward premiums are paid through a cafeteria plan mean that the arrangement cannot comply with the safe harbor for voluntary employee-pay all plans in DOL Regulation section 2510.3-1(j)?

Initial Proposed Answer: Assuming the arrangement otherwise complies with the safe harbor regulation, the fact that employee voluntary payroll deductions are taken on a pre-tax basis should not on its own cause the program to cease to be an employee-pay-all program for ERISA purposes.

DOL Answer: The JCEB and DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

9. Employee Pay All Exception Question

Question: Assume the same situation that is described in the opening paragraph of Question 8. Assuming that the use of a cafeteria plan to pay the premiums does not, on its own, mean that the safe harbor does not apply, is the answer different if the employer includes the pre-tax contribution as part of a cafeteria plan that provides a payment procedure for plans that are otherwise employee welfare benefit plans subject to all of ERISA's requirements?

Initial Proposed Answer: Assuming the arrangement otherwise complies with the safe harbor regulation, the fact that employee voluntary payroll deductions are taken on a pre-tax basis should not on its own cause the program to cease to be an employee-pay-all program for ERISA purposes.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

10. Grandfathered Status Question

Question: May health plans eliminate coverage for non-network, non-emergency medical services, (i.e., switch to an Exclusive Provider Network), keep the same coinsurance percentages for in-network coverage, and maintain grandfathered status?

Initial Proposed Answer: Yes. A plan will not cease to be a grandfathered plan if it eliminates coverage for non-network, non-emergency services because the coverage of medical services is still available to the plan's participants at the same pre-PPACA copayment percentage as before the plan's change. The elimination of coverage of the services of non-network providers, as long as

those services are still available from network providers, is not listed in 29 CFR § 2590.715-1251(g) as a situation that causes loss of grandfathered status.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

11. Grandfathered Status Question

Question: May health plans change their participant cost-sharing percentage for non-network providers only beyond the threshold in the Interim Final Rules [29 CFR § 2590.715-1251(g)(ii), Increase in Cost-Sharing Requirement] if they keep the pre-PPACA coinsurance percentage for in-network providers, without relinquishing grandfathered status? For example, could a plan that now covers dental benefits at 80% both in and out-of-network be amended to provide that in-network coverage remains at 80% but out-of-network coverage is reduced to 60%, without losing grandfathered status?

Initial Proposed Answer: Yes. A plan will not cease to be a grandfathered plan as long as it provides the same benefits at the same pre-PPACA cost-sharing percentage for in-network services. Q&A 3 in Part VI of the FAQs indicates that with respect to wellness benefits, a plan complies with the 100% coverage of wellness benefits if it covers preventive colonoscopies without a copayment at an in-network ambulatory surgery center, even if it imposes a \$250 copayment on colonoscopies performed at an in-network hospital. By analogy, as long as plan benefits at pre-PPACA coinsurance percentages are available for services rendered by some providers, the plan does not necessarily have to provide them at that same level for all providers in order to maintain grandfathered status.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

12. Designated Investment Alternative Question

Question: The DOL has issued final regulations that require periodic disclosures of certain plan-related and investment-related information to participants and beneficiaries in participant-directed individual account plans. Is a managed account a designated investment alternative (“DIA”) that should be disclosed as an investment option (i.e., as part of the investment charts)?

Initial Proposed Answer: A managed account is more appropriately subject to exemption from the DIA disclosure rules (i.e., as part of the investment charts) similar to the exemption of brokerage windows. Even though a particular professionally-managed pooled fund is offered by a participant-directed individual account plan as an investment option, the managed account is more like a broker window with respect to the availability of information required to be disclosed in the investment chart. Therefore, the managed account should be exempt as a DIA. An alternative approach is to treat managed accounts as DIAs but to develop special disclosure rules that are specifically tailored to managed accounts, much like the special rules for qualifying employer securities and annuity options.

DOL Answer: It is not clear from the question what is meant by the term managed account. Some of the questions and answers in the Field Assistance Bulletin issued on May 7, 2012 (FAB 2012-02, superseded by FAB 2012-02R), may be relevant to this question. See FAB Questions and Answers 4, 27 and 28.

13. Late Employee Contributions Question

Question: Plan sponsor discovers that certain employee deferrals for a pay period were deposited to the plan's trust a few days late. Sponsor plans to self-correct the error instead of filing through VFCP, and to file a Form 5330 and pay the associated excise taxes. May the plan sponsor use the DOL's online calculator to determine the amount of interest owed of the late contributions?

Initial Proposed Answer: Yes, the plan sponsor may use the DOL's online calculator for this purpose.

DOL Answer: EBSA's online calculator was developed in connection with its Voluntary Fiduciary Correction Program. Although the VFCP Program does include a covered transaction for the correction of delinquent employee contributions, the VFCP Program as currently structured does not recognize self-correction of delinquent employee deferrals nor was the calculator meant to be utilized in connection with the self-correction of delinquent employee deferrals. Some members of the public have been urging EBSA to explore the concept of a self-correction component similar to the one included in the IRS's EPCRS. EBSA is currently looking into the challenges associated with expanding the VFCP Program to include a self-correction component for delinquent employee deferrals. However, at the present time under these facts, the plan sponsor making this self-correction would not necessarily be protected from an EBSA enforcement action or civil monetary penalties under ERISA section 502(l), and would not receive an EBSA "no-action" letter for correction of the fiduciary breach.

14. Audit Initiative Question

Question: Can you comment on the audit initiative being handled out of the Boston EBSA office, under which selected employers are being comprehensively audited to determine their compliance with the laws contained in Section 7 of ERISA, including HIPAA, the Newborns' and Mothers' Health Protection Act, the WHCRA, GINA, and PPACA? What compliance issues have been identified in these audits? What corrective actions or sanctions have been required for such issues? What plans does the Department have for expanding the program to other parts of the country?

Initial Proposed Answer: The Boston Office health plan audit initiative is designed to test the level of compliance among employers with Title 1, part 7 of ERISA and to determine where additional guidance to the employer community may be helpful in ensuring compliance. The employers subjected to this audit initiative will not be subjected to significant penalties as long as they have attempted in good faith to comply with the applicable requirements.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

15. Medicare Question

Question: Can a plan include financial incentives, such as reduced cost-shares and Medicare premium payment, for beneficiaries who have end stage renal disease ("ESRD") to apply for Medicare coverage?

Initial Proposed Answer: No. Financial incentives for beneficiaries who have ESRD to apply for Medicare coverage would be a differentiation of benefits in violation of the Medicare secondary payor rules ("MSP").

ESRD is one of only two medical conditions which qualify individuals for Medicare coverage, and there are four conditions to Medicare coverage for individuals with ESRD. An individual is "eligible to enroll under" Medicare Part B due to ESRD if that individual is (1) "fully or currently insured," (2) has been diagnosed with ESRD, and (3) has filed an application for Medicare benefits. 42 U.S.C. § 426-1(a). If these three conditions are met, then (4) once the individual begins a "regular course of dialysis," Medicare coverage begins the third month after the month in dialysis commenced. 42 U.S.C. § 426-1(b)(1)(a).

Once Medicare coverage for such an individual commences, existing plan coverage is required to be primary to Medicare for a 30 month “coordination period” which begins on the date the individual becomes eligible for Medicare Part B. 42 U.S.C. § 1395y(b)(1)(C). Medicare benefits may therefore not be payable as primary benefits with respect to such an individual until 33 months from the month in which the individual has met all four conditions to coverage.

The MSP provides that a group health plan “may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner[.]” 42 U.S.C. § 1395y(b)(1)(C)(ii). Non-exclusive examples of prohibited differentiation are provided in the MSP regulations, including -

- Terminating coverage of individuals with ESRD when there is no basis for such termination unrelated to ESRD;
- Benefit limitations such as less comprehensive coverage, reduced or excluded benefits, higher deductibles or copayments, a longer waiting period, lower annual or lifetime benefit limits, or more restrictive preexisting condition limitations, on individuals who have ESRD which do not apply to individual who do not.
- Charging individuals with ESRD higher premiums.
- Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD.
- Failure to cover routine maintenance dialysis or kidney transplants for members who have ESRD, when the plan covers other dialysis services and organ transplants.

42 C.F.R. § 411.161(b).

The inclusion of financial incentives for beneficiaries who have been diagnosed with ESRD clearly “differentiates in the benefits” provided to individuals who have ESRD, by establishing additional benefits (the incentives) which are only available if the individual has ESRD. Such a requirement is therefore contrary to the plain statutory language of the MSP. It is also inconsistent with the non-exclusive examples of prohibited benefits practices provided in the regulations.

This is the case even if the plan’s dialysis benefit reimbursement levels are set at rates higher than Medicare rates prior to the end of the coordination period. In such a case it might be argued that the MSP is nonetheless not violated by the benefit differentiation because the inclusion of incentives for Medicare enrollment requirement would not affect Medicare financially. Courts have held that

Congress enacted the MSP in order to “reduce federal spending and to protect the financial well being of the Medicare program.” *United States v. Travelers Insurance Co.*, 815 F. Supp. 521, 522 (D. Conn. 1992). The purpose of the MSP was therefore to require Medicare beneficiaries to exhaust all available private insurance coverage before resorting to Medicare. See *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996). For this reason, “where the fiscal integrity of the Medicare program [is] not jeopardized, the MSP statute ha[s] no application[.]” *Harris Corporation v. Humana Health Insurance Co.*, 253 F.3d 598 (11th Cir. 2001) at 604.

This argument necessarily assumes that financial incentives for a Medicare enrollment requirement could not increase the fiscal burden on Medicare over that of a plan which does not include such a requirement. However, the law does not require an individual who is “fully or currently insured,” has been diagnosed with ESRD and has commenced a regular course of dialysis to apply for Medicare, even if application is the only remaining condition to eligibility.

Some individuals who have ESRD choose to defer enrollment or choose not to enroll in Medicare at all. Under a plan with incentives for a Medicare enrollment requirement, however, such individuals will be provided with a motivation to enroll which would not otherwise exist. Medicare enrollment incentives therefore increase the risk that beneficiaries who might otherwise defer enrollment or not enroll in Medicare will instead apply as soon as possible.

For any given plan, then, adoption of Medicare enrollment incentives increases the risk of an increased financial burden on Medicare, compared to a plan without such a requirement. If Medicare enrollment incentives are widely adopted by plans, the probability of a shift of financial burdens to Medicare increases to near certainty.

Further, Medicare enrollment incentives would increase the probability of termination of primary plan coverage of any beneficiary entitled to plan continuation coverage benefits under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). The COBRA amendments to ERISA require plan sponsors to extend temporary continuation insurance benefits to individuals who lose coverage due to specified qualifying events. See 29 U.S.C. § 1161(a). “Qualifying events” include the “termination (other than by reason of such employee's gross misconduct), or reduction of hours, of the covered employee's employment.” 29 U.S.C. § 1163(2). Once a beneficiary qualifies for and has elected continuation coverage, such coverage extends for eighteen or thirty-six months depending on the qualifying event. See 29 U.S.C. § 1167(3)(A).

However, COBRA also permits a plan to terminate continuation coverage earlier than the full coverage term, on “[t]he date on which the qualified beneficiary first becomes, after the date of the election . . . entitled to [Medicare].” 29 U.S.C.

§ 1162(2)(D)(ii). *Accord* 26 C.F.R. § 54.4980B-7 Q&A – 3. See *Blue Cross & Blue Shield of Texas, Inc. v. Shalala*, 995 F.2d 70 (5th Cir. 1993).

Under this provision:

- If a beneficiary becomes entitled to Medicare benefits *before* electing COBRA, the beneficiary's *COBRA coverage would be extended* to a 36-month period from the date of Medicare entitlement. See 29 U.S.C. § 1162(2)(A)(vii). In order to ensure extended continuation coverage, then, a beneficiary must apply for Medicare and the three month period to eligibility must have elapsed.
- If a beneficiary becomes entitled to Medicare benefits *after* electing COBRA, the plan has the discretion to *terminate the COBRA coverage* as of Medicare entitlement.

Whether or not a plan can terminate COBRA coverage therefore depends on whether a COBRA qualifying event occurs and the beneficiary elects COBRA after applying and becoming eligible for Medicare, in which case COBRA continues and is extended, or before the beneficiary applies and becomes eligible for Medicare, in which case the plan could terminate COBRA coverage. Medicare enrollment incentives would allow the manipulation of the COBRA election and Medicare application processes to procure the latter result, and increase the probability of the latter result even without manipulation.

The key issue is the timing of COBRA election. ESRD is a debilitating condition and typically requires the patient to dialyze at least two or three times a week, for some four hours per session. When the beneficiary is the employee, there is therefore a material risk the beneficiary's employment will be terminated or employment hours reduced upon commencement of dialysis. Since the beneficiary will also by this point have been diagnosed with ESRD, three out of four conditions for Medicare eligibility will be met at the same time that a COBRA qualifying event occurs.

When a qualifying event occurs the employer must notify the plan administrator within 30 days of notice of the event. The administrator then must provide the employee with a COBRA election form within 14 days of notice of the event, and the employee has 60 days to elect COBRA coverage. The maximum period from qualifying event is therefore 104 days, while the minimum period could in principle be as short as 61 days (if the employer and administrator coordinated with each other to provide the election form in an exit interview, for example). The COBRA election period could therefore be made shorter than the 90-plus days required between Medicare application and Medicare coverage.

If a plan includes Medicare enrollment incentives, it would therefore be possible to manipulate Medicare enrollment and COBRA election to ensure that COBRA

would be elected before the date of effective Medicare coverage. The plan could then terminate coverage altogether as of the latter date. The same result could follow without deliberate manipulation whenever a beneficiary elected COBRA before the Medicare effective date.

While it is to be hoped few if any plans would take advantage of this loophole, it does follow logically if Medicare enrollment incentives are permitted. A plan with Medicare enrollment incentives may therefore be able to procure the ability to terminate **all** coverage for employee beneficiaries who have ESRD. In such an event, the plan would be able to shift not only dialysis but all medical coverage from the plan to Medicare. And if Medicare enrollment incentives are widely adopted, again, the probability of a shift of financial burdens to Medicare increases to near certainty.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

16. Medicare Question

Question: Can a plan pay the Medicare Part B premiums for a beneficiary who is eligible for Medicare benefits because s/he has ESRD?

Initial Proposed Answer: No. The payment of Medicare Part B premiums for a beneficiary who is diagnosed with ESRD would be “taking into account” the beneficiary’s Medicare eligibility and ESRD diagnosis and a differentiation of benefits in violation of the MSP. It would also violate the antikickback law (“AKL”).

There are four conditions to Medicare coverage for individuals with ESRD. An individual is “eligible to enroll under” Medicare Part B due to ESRD if that individual is (1) “fully or currently insured,” (2) has been diagnosed with ESRD, and (3) has filed an application for Medicare benefits. 42 U.S.C. § 426-1(a). Once these three conditions are met, (4) once the individual begins a “regular course of dialysis,” Medicare coverage begins the third month after the month in dialysis commenced. 42 U.S.C. § 426-1(b)(1)(a).

Once Medicare coverage for such an individual commences, existing plan coverage is required to be primary to Medicare for a 30 month “coordination period” which begins on the date the individual becomes eligible for Medicare Part B. 42 U.S.C. § 1395y(b)(1)(C). Medicare benefits may therefore not be payable as primary benefits with respect to such an individual until 33 months from the month in which the individual has met all four conditions to coverage.

The MSP provides that a group health plan “may not take into account that an individual is entitled to or eligible for [Medicare] benefits” and “may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner[.]” 42 U.S.C.

§ 1395y(b)(1)(C)(i), (ii). Non-exclusive examples of prohibited differentiation are provided in the MSP regulations, including -

- Terminating coverage of individuals with ESRD when there is no basis for such termination unrelated to ESRD.
- Benefit limitations such as less comprehensive coverage, reduced or excluded benefits, higher deductibles or copayments, a longer waiting period, lower annual or lifetime benefit limits, or more restrictive preexisting condition limitations, on individuals who have ESRD which do not apply to individual who do not.
- Charging individuals with ESRD higher premiums.
- Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD.
- Failure to cover routine maintenance dialysis or kidney transplants for members who have ESRD, when the plan covers other dialysis services and organ transplants.

42 C.F.R. § 411.161(b).

A Medicare premium payment benefit clearly “takes into account” that a beneficiary is eligible for Medicare – the benefit can only be payable if the beneficiary has Medicare coverage. Likewise, a Medicare premium payment benefit available based on the beneficiary having ESRD clearly “differentiates in the benefits” provided to such individuals by providing a benefit which is available only to those individuals. Such a requirement is therefore contrary to the plain statutory language of the MSP.

It may be argued that a Medicare premium payment benefit nonetheless does not violate the MSP because it would not affect Medicare financially. Courts have held that Congress enacted the MSP in order to “reduce federal spending and to protect the financial well being of the Medicare program.” *United States v. Travelers Insurance Co.*, 815 F. Supp. 521, 522 (D. Conn. 1992). The purpose of the MSP was therefore to require Medicare beneficiaries to exhaust all available private insurance coverage before resorting to Medicare. See *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996). For this reason, "where the fiscal integrity of the Medicare program [is]

not jeopardized, the MSP statute ha[s] no application[.]” *Harris Corporation v. Humana Health Insurance Co.*, 253 F.3d 598 (11th Cir. 2001) at 604.

This argument necessarily assumes that a Medicare premium payment benefit would not increase the fiscal burden on Medicare over that of a plan which does not include such a benefit. However, the effect of Medicare premium payment is to provide an incentive for beneficiaries who have ESRD to apply for Medicare. The law does not require an individual who is “fully or currently insured,” has been diagnosed with ESRD and has commenced a regular course of dialysis to apply for Medicare, even though application is the only remaining condition to eligibility.

The increased risk to Medicare is presented because Medicare enrollment would permit a plan to terminate coverage of any beneficiary entitled to plan continuation coverage benefits under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). The COBRA amendments to the ERISA require plan sponsors to extend temporary continuation insurance benefits to individuals who lose coverage due to specified qualifying events. See 29 U.S.C. § 1161(a). “Qualifying events” include the “termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.” 29 U.S.C. § 1163(2). Once a beneficiary qualifies for and has elected continuation coverage, such coverage extends for eighteen or thirty-six months depending on the qualifying event. See 29 U.S.C. § 1167(3)(A).

However, COBRA also permits a plan to terminate continuation coverage earlier than the full coverage term, on “[t]he date on which the qualified beneficiary first becomes, after the date of the election . . . entitled to [Medicare].” 29 U.S.C. § 1162(2)(D)(ii). *Accord* 26 C.F.R. § 54.4980B-7 Q&A – 3. See *Blue Cross & Blue Shield of Texas, Inc. v. Shalala*, 995 F.2d 70 (5th Cir. 1993).

Under this provision:

- If a beneficiary becomes entitled to Medicare benefits *before* electing COBRA, the beneficiary’s *COBRA coverage would be extended* to a 36-month period from the date of Medicare entitlement. See 29 U.S.C. § 1162(2)(A)(vii). In order to ensure extended continuation coverage, then, a beneficiary must apply for Medicare and the three month period to eligibility must have elapsed.
- If a beneficiary becomes entitled to Medicare benefits *after* electing COBRA, the plan has the discretion to *terminate the COBRA coverage* as of Medicare entitlement.

Whether or not a plan can terminate COBRA coverage therefore depends on whether a COBRA qualifying event occurs and the beneficiary elects COBRA after applying and becoming eligible for Medicare, in which case COBRA

continues and is extended, or before the beneficiary applies and becomes eligible for Medicare, in which case the plan could terminate COBRA coverage. A Medicare premium payment benefit would provide an incentive for beneficiaries to apply for Medicare, while allowing the manipulation of the COBRA election and Medicare application processes to procure the latter result, and increases the probability of the latter result even without manipulation.

The key issue is the timing of COBRA election. ESRD is a debilitating condition and typically requires the patient to dialyze at least two or three times a week, for some four hours per session. When the beneficiary is the employee, there is therefore a material risk the Beneficiary's employment will be terminated or employment hours reduced upon commencement of dialysis. Since the beneficiary will also by this point have been diagnosed with ESRD, three out of four conditions for Medicare eligibility will be met at the same time that a COBRA qualifying event occurs.

When a qualifying event occurs the employer must notify the plan administrator within 30 days of notice of the event. The administrator then must provide the employee with a COBRA election form within 14 days of notice of the event, and the employee has 60 days to elect COBRA coverage. The maximum period from qualifying event is therefore 104 days, while the minimum period could in principle be as short as 61 (if the employer and administrator coordinated with each other to provide the election form in an exit interview, for example). The COBRA election period could therefore be made shorter than the 90-plus days required between Medicare application and Medicare coverage.

If a plan includes a Medicare premium payment benefit, it provides an incentive for Medicare application which might be manipulated along with the COBRA election to ensure that COBRA would be elected before the date of effective Medicare coverage. The plan could therefore terminate coverage altogether as of the latter date. The same result could follow without deliberate manipulation whenever a beneficiary elected COBRA before the Medicare effective date.

While it is to be hoped few if any plans would take advantage of this loophole, it does follow logically if a Medicare premium payment benefit is permitted. A plan with a Medicare premium payment benefit may therefore be more likely to procure the ability to terminate all coverage for employee beneficiaries who have ESRD. In such an event, the plan would be able to shift not only dialysis but all medical coverage from the plan to Medicare. And if Medicare premium payment benefits are widely adopted the probability of a shift of financial burdens to Medicare increases to certainty.

The payment of Medicare premiums as a benefit would also violate the antikickback statute ("AKL"). The AKL is violated when remuneration is purposefully paid to induce or reward referrals of items or services payable by a Federal health care program. See 42 U.S.C. 1320a-7b. For purposes of the AKL

“remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. See 42 U.S.C. 1320a–7a(i)(6).

The AKL specifically prohibits “offers to or transfers [of] remuneration to any individual eligible for benefits under [Medicare] . . . that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under [Medicare.]” 42 U.S.C. 1320a–7a(a)(5). Significantly, the AKL exempts payment of cost shares from prohibited remuneration only when they are unadvertised, not routine, and made on the basis of individual financial need or failure of reasonable collection efforts. 42 U.S.C. 1320a–7a(i)(6)(A). Because payments made under a plan provision would be “routine” and not be based on financial need, this exemption would not apply.

Medicare premium payment would therefore violate the AKL because it would induce the beneficiary to become eligible for Medicare sooner than s/he might otherwise have chosen. If the beneficiary is on COBRA this could trigger termination of plan coverage, meaning Medicare would pay sooner than it would have if the beneficiary had not signed up for Medicare. Even if the beneficiary is not on COBRA the beneficiary might have been “induced” to sign up for Medicare sooner than s/he would otherwise have chosen. In either case, Medicare will then pay “in whole or in part” for care provided to the beneficiary, and the premium payments were “remuneration” which “induced” the beneficiary to purchase Medicare to pay for those services.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

17. Medicare Question

Question: Can a plan pay the difference between an out-of-network reimbursement rate for outpatient dialysis under the plan and the dialysis provider’s charges, during the three month period between a beneficiary’s application for Medicare and the date on which the beneficiary is eligible for Medicare coverage due to ESRD?

Initial Proposed Answer: No. This kind of balance payment benefit would violate the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) nondiscrimination requirements, by denying a benefit available to beneficiaries requiring outpatient dialysis due to ESRD to beneficiaries requiring outpatient

dialysis for conditions other than ESRD. It would also violate the MSP and the AKL.

The nondiscrimination rules issued under HIPAA require that “benefits provided under a [plan] . . . must be uniformly available to all similarly situated individuals.” 29 C.F.R. § 2590.702(b)(2). Differences in benefits are permissible if they are based on distinctions including bona fide employment-based classifications; relationship to the plan participant; marital status; age or student status of children; or “[a]ny other factor if the factor is not a health factor.” 29 C.F.R. § 2590.702(d)(2). “Health factors” include health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. 29 C.F.R. § 2590.702(a)(1).

Balance payment benefits equal to the difference between a plan’s generally applicable terms for determining outpatient dialysis rates and the provider’s charges which are payable because the beneficiary has applied for but is not yet eligible for Medicare, would discriminate between beneficiaries requiring outpatient dialysis due to ESRD and those requiring outpatient dialysis for any other condition. This is because the former beneficiaries qualify for Medicare only because they have ESRD. ESRD is clearly a medical condition and affects their health status, and so is a “health factor.” Balance payment benefits available to otherwise similarly situated beneficiaries who have ESRD which are not available to those who do not would therefore violate HIPAA.

There are four conditions to Medicare coverage for individuals with ESRD. An individual is “eligible to enroll under” Medicare Part B due to ESRD if that individual is (1) “fully or currently insured,” (2) has been diagnosed with ESRD, and (3) has filed an application for Medicare benefits. 42 U.S.C. § 426-1(a). Once these three conditions are met, (4) once the individual begins a “regular course of dialysis,” Medicare coverage begins the third month after the month in dialysis commenced. 42 U.S.C. § 426-1(b)(1)(a).

Once Medicare coverage for such an individual commences, existing plan coverage is required to be primary to Medicare for a 30 month “coordination period” which begins on the date the individual becomes eligible for Medicare Part B. 42 U.S.C. § 1395y(b)(1)(C). Medicare benefits may therefore not be payable as primary benefits with respect to such an individual until 33 months from the month in which the individual has met all four conditions to coverage.

The MSP provides that a group health plan “may not take into account that an individual is entitled to or eligible for [Medicare] benefits” and “may not differentiate in the benefits it provides between individuals having [ESRD] and other individuals covered by such plan on the basis of the existence of [ESRD], the need for renal dialysis, or in any other manner[.]” 42 U.S.C. § 1395y(b)(1)(C)(i), (ii). Non-exclusive examples of prohibited differentiation are provided in the MSP regulations, including -

- Terminating coverage of individuals with ESRD when there is no basis for such termination unrelated to ESRD.
- Benefit limitations such as less comprehensive coverage, reduced or excluded benefits, higher deductibles or copayments, a longer waiting period, lower annual or lifetime benefit limits, or more restrictive preexisting condition limitations, on individuals who have ESRD which do not apply to individual who do not.
- Charging individuals with ESRD higher premiums.
- Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD.
- Failure to cover routine maintenance dialysis or kidney transplants for members who have ESRD, when the plan covers other dialysis services and organ transplants.

42 C.F.R. § 411.161(b).

A balance payment benefit would clearly “take into account” that a beneficiary is eligible for Medicare – the benefit is only available if the beneficiary has Medicare coverage. Likewise, a balance payment benefit available based on the beneficiary’s Medicare eligibility, which in turn is necessarily based on the beneficiary having ESRD, clearly “differentiates in the benefits” provided to such individuals by providing a benefit which is available only to those individuals. Such a requirement is therefore contrary to the plain statutory language of the MSP.

It may be argued that a balance payment benefit nonetheless does not violate the MSP because it would not affect Medicare financially. Courts have held that Congress enacted the MSP in order to “reduce federal spending and to protect the financial well being of the Medicare program.” *United States v. Travelers Insurance Co.*, 815 F. Supp. 521, 522 (D. Conn. 1992). The purpose of the MSP was therefore to require Medicare beneficiaries to exhaust all available private insurance coverage before resorting to Medicare. See *United States v. Rhode Island Insurers' Insolvency Fund*, 80 F.3d 616, 618 (1st Cir. 1996). For this reason, “where the fiscal integrity of the Medicare program [is] not jeopardized, the MSP statute ha[s] no application[.]” *Harris Corporation v. Humana Health Insurance Co.*, 253 F.3d 598 (11th Cir. 2001) at 604.

This argument necessarily assumes that a balance payment benefit would not increase the fiscal burden on Medicare over that of a plan which does not include such a benefit. However, the effect of balance payment benefit is to provide an incentive for beneficiaries who have ESRD to apply for Medicare. The law does

not require an individual who is “fully or currently insured,” has been diagnosed with ESRD and has commenced a regular course of dialysis to apply for Medicare, even though application is the only remaining condition to eligibility.

The increased risk to Medicare is presented because Medicare enrollment would permit a plan to terminate coverage of any beneficiary entitled to plan continuation coverage benefits under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). The COBRA amendments to the ERISA require plan sponsors to extend temporary continuation insurance benefits to individuals who lose coverage due to specified qualifying events. See 29 U.S.C. § 1161(a). “Qualifying events” include the “termination (other than by reason of such employee’s gross misconduct), or reduction of hours, of the covered employee’s employment.” 29 U.S.C. § 1163(2). Once a beneficiary qualifies for and has elected continuation coverage, such coverage extends for eighteen or thirty-six months depending on the qualifying event. See 29 U.S.C. § 1167(3)(A).

However, COBRA also permits a plan to terminate continuation coverage earlier than the full coverage term, on “[t]he date on which the qualified beneficiary first becomes, after the date of the election . . . entitled to [Medicare].” 29 U.S.C. § 1162(2)(D)(ii). Accord 26 C.F.R. § 54.4980B-7 Q&A – 3. See *Blue Cross & Blue Shield of Texas, Inc. v. Shalala*, 995 F.2d 70 (5th Cir. 1993).

Under this provision:

- If a beneficiary becomes entitled to Medicare benefits *before* electing COBRA, the beneficiary’s *COBRA coverage would be extended* to a 36-month period from the date of Medicare entitlement. See 29 U.S.C. § 1162(2)(A)(vii). In order to ensure extended continuation coverage, then, a beneficiary must apply for Medicare and the three month period to eligibility must have elapsed.
- If a beneficiary becomes entitled to Medicare benefits *after* electing COBRA, the plan has the discretion to *terminate the COBRA coverage* as of Medicare entitlement.

Whether or not a plan can terminate COBRA coverage therefore depends on whether a COBRA qualifying event occurs and the beneficiary elects COBRA after applying and becoming eligible for Medicare, in which case COBRA continues and is extended, or before the beneficiary applies and becomes eligible for Medicare, in which case the plan could terminate COBRA coverage. A balance payment benefit would provide an incentive for beneficiaries to apply for Medicare, while allowing the manipulation of the COBRA election and Medicare application processes to procure the latter result, and increases the probability of the latter result even without manipulation.

The key issue is the timing of COBRA election. ESRD is a debilitating condition and typically requires the patient to dialyze at least two or three times a week, for some four hours per session. When the beneficiary is the employee, there is therefore a material risk the beneficiary's employment will be terminated or employment hours reduced upon commencement of dialysis. Since the beneficiary will also by this point have been diagnosed with ESRD, three out of four conditions for Medicare eligibility will be met at the same time that a COBRA qualifying event occurs.

When a qualifying event occurs the employer must notify the plan administrator within 30 days of notice of the event. The administrator then must provide the employee with a COBRA election form within 14 days of notice of the event, and the employee has 60 days to elect COBRA coverage. The maximum period from qualifying event is therefore 104 days, while the minimum period could in principle be as short as 61 (if the employer and administrator coordinated with each other to provide the election form in an exit interview, for example). The COBRA election period could therefore be made shorter than the 90-plus days required between Medicare application and Medicare coverage.

If plan includes a balance payment benefit, it provides an incentive for Medicare application which might be manipulated along with the COBRA election to ensure that COBRA would be elected before the date of effective Medicare coverage. The plan could therefore terminate coverage altogether as of the latter date. The same result could follow without deliberate manipulation whenever a beneficiary elected COBRA before the Medicare effective date.

While it is to be hoped few if any plans would take advantage of this loophole, it does follow logically if a balance payment benefit is permitted. A plan with a Medicare balance payment benefit may therefore be more likely to procure the ability to terminate all coverage for employee beneficiaries who have ESRD. In such an event, the plan would be able to shift not only dialysis but all medical coverage from the plan to Medicare. And if Medicare premium payment benefits are widely adopted the probability of a shift of financial burdens to Medicare increases to certainty.

The payment of balance benefits would also violate the antikickback statute ("AKL"). The AKL is violated when remuneration is purposefully paid to induce or reward referrals of items or services payable by a Federal health care program. See 42 U.S.C. 1320a-7b. For purposes of the AKL "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. See 42 U.S.C. 1320a-7a(i)(6).

The AKL specifically prohibits "offers to or transfers [of] remuneration to any individual eligible for benefits under [Medicare] . . . that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment

may be made, in whole or in part, under [Medicare.]” 42 U.S.C. 1320a–7a(a)(5). Significantly, the AKL exempts payment of cost shares from prohibited remuneration only when they are unadvertised, not routine, and made on the basis of individual financial need or failure of reasonable collection efforts. 42 U.S.C. 1320a–7a(i)(6)(A). Because payments made under a plan provision would be “routine” and not be based on financial need, this exemption would not apply.

Balance payments would therefore violate the AKL because it would induce the beneficiary to become eligible for Medicare sooner than s/he might otherwise have chosen. If the beneficiary is on COBRA this could trigger termination of plan coverage, meaning Medicare would pay sooner than it would have if the beneficiary had not signed up for Medicare. Even if the beneficiary is not on COBRA the beneficiary might have been “induced” to sign up for Medicare sooner than s/he would otherwise have chosen. In either case, Medicare will then pay “in whole or in part” for care provided to the beneficiary, and the premium payments were “remuneration” which “induced” the beneficiary to purchase Medicare to pay for those services.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

18. Electronic Delivery Without Consent Question

Question: A plan administrator provides summary plan descriptions (SPDs) by sending (via first class mail) a flash drive or CD containing an electronic copy of the SPDs to participants' and beneficiaries' last-known addresses. The administrator includes in the mailing a written notice apprising participants and beneficiaries that the flash drive/CD contains the SPDs, the significance of the SPDs and of their right to request a paper version of each SPD free of charge upon request. The participants and beneficiaries receiving the flash drive/CD do not access documents required to be disclosed under Title I of ERISA as an integral part of their job duties, as described in DOL Reg. § 2520.104b-1(c)(2)(i). Also, the administrator has not obtained prior consent from any of these participants or beneficiaries to receive these types of documents electronically, in accordance with DOL Reg. § 2520.104b-1(c)(2)(ii). Does this manner of SPD distribution comply with the general requirements for SPD disclosure in DOL Reg. § 2520.104b-1(b)(1)?

Initial Proposed Answer: Yes. Under the general rule for disclosure under DOL Reg. § 2520.104b-1(a) and (b), information required to be disclosed to participants must be sent by a method or methods of delivery likely to result in full

distribution and actual receipt of the material. The distribution method described above provides the SPDs in a commonly accessible fashion for participants and beneficiaries and apprises them of the availability of a full written copy at no additional cost upon request for anyone who cannot access the information through the flash drive or CD. Admittedly, distribution of SPDs via a flash drive or CD is a form of electronic media. According to the preamble to DOL Reg. § 2520.104b-1(c) (see 67 Fed. Reg. 17263 (Apr. 9, 2002)):

The regulation does not categorize particular electronic media as either permissible or impermissible methods through which required disclosures may be provided as long as the conditions of the safe harbor are met. For example, as noted above, under the safe harbor, participants and beneficiaries must be provided with a notice in accordance with § 2520.104b-1(c)(1)(iii) apprising them of the document(s) to be furnished electronically, the significance of the document (e.g., the document describes changes in the benefits provided by your plan) and the participant's or beneficiary's right to request and receive a paper version of each such document. The purpose of the notice requirement is to ensure that participants and beneficiaries who receive an electronic disclosure will be put on notice that the communication contains important information relating to their plan or to their rights and obligations under the plan. Thus, a plan administrator could provide a participant with a CD-ROM containing the plan's SPD, for example, so long as the CD-ROM was accompanied by a paper notice or was clearly labeled to provide the notification required by § 2520.104b-1(c)(1)(iii) and the other conditions in the safe harbor were satisfied.

In this regard, the DOL regulations provide that distribution of material through electronic media is deemed to satisfy the general distribution rule by complying with the safe harbors in DOL Reg. § 2520.104b-1(c). Compliance with the electronic media distribution regulation is not the *exclusive* means of fulfilling the general distribution requirement, particularly when it comes to distribution through commonly accepted media such as flash drives or CDs.

Interestingly, the preamble to the DOL electronic media regulation explains that if the administrator sends the ERISA-required disclosure via CD or DVD to the participants' or beneficiaries' last known mailing addresses, the administrator does not need to obtain the participants' or beneficiaries' email address and electronic confirmation. This is a recognition that disclosure of material by mailing a CD is different from other types of electronic media distribution.

In this case, because the flash drive or CD is accompanied with a notice apprising participants and beneficiaries that the flash drive/CD contains the SPDs, the significance of the SPDs and of their right to request a paper version

of each SPD free of charge upon request, this type of disclosure should be able to meet the general disclosure rules without having to satisfy the safe harbor for electronic distribution in DOL Reg. §§ 2520.104b-1(c).

DOL Answer: Department of Labor regulations at 29 CFR 2520.104b-1(b)(1) contain general standards governing the delivery of all information required to be furnished to participants, beneficiaries, and other specified individuals under Title I of ERISA. These standards require that plan administrators use delivery methods reasonably calculated to ensure full distribution and actual receipt of such information by plan participants, beneficiaries and other specified individuals. These regulations also contain an electronic disclosure safe harbor. See § 2520.104b-1(c). Following the conditions of the safe harbor provides assurance that the general delivery requirements under § 2520.104b-1(b)(1) have been satisfied.

EBSA staff is of the view that the method of delivering the SPD described in this question does not satisfy the general standards of § 2520.104b-1. Ordinarily, the use of first class mail to furnish a disclosure would be considered a delivery method “reasonably calculated to ensure actual receipt” under these general standards. However, in this case, even though participants and beneficiaries might actually receive the flash drive or CD in the mail, staff would not consider the information to have been furnished if participants and beneficiaries are unable to read or access it. In this regard, staff is of the view that it is not reasonable to assume that participants will be able to access and read the CD or flash drive merely because it is formatted “in a commonly accessible fashion.” The facts, for example, do not suggest that the plan administrator has adopted any procedures, or taken any other measures, to determine if participants and beneficiaries have the necessary technology and ability to retrieve the information from these electronic media.

19. Plan Document Question

Question: An employer maintains a self-insured group health plan for its employees. A third party administrator assists in administering the plan and has prepared a booklet describing plan benefits, at a level of detail similar to the insurance certificate and booklet provided to plan participants in an insured arrangement. The booklet is designed to include the information required for a summary plan description, as well as terms that would typically be included in a plan document (such as amendment and claims review provisions). The employer, acting as plan sponsor, proposes to adopt the booklet as the plan

document, and the employer, acting as plan administrator, proposes to adopt and use the booklet as the summary plan description. Is it permissible for the same document to function as both a plan document and summary plan description under ERISA?

Initial Proposed Answer: Yes. ERISA Section 402 requires employee benefit plans to be established and maintained pursuant to a written instrument, and to include certain specified provisions (such as the basis on which payments are to be made to and from the plan, and procedures for amending the plan and allocating responsibility for plan administration). ERISA Section 102 and the regulations thereunder require a summary plan description describing plan terms and including other specified information to be furnished to plan participants. Nothing in ERISA, however, precludes the same document from serving both functions, provided it contains the elements required for both types of documents, is written in a manner which is calculated to be understood by plan participants, and is adopted by both the plan sponsor and plan administrator, in their respective capacities.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

20. Plan Document Question

Question: Same facts as for question 19, except that the plan sponsor proposes to adopt an "umbrella" document which contains certain core plan provisions (such as those regarding plan amendments and the designation of plan fiduciaries), and incorporates certain provisions of the booklet (such as those regarding eligibility and the benefits provided under the arrangement), which together include all the elements required by ERISA Section 402. Does the umbrella plan document, together with the specified sections of the booklet, constitute a valid plan document for purposes of ERISA?

Initial Proposed Answer: Yes. The written instrument constituting the plan can consist of more than one document, which in combination contain the elements required by ERISA Section 402.

DOL Answer: The JCEB and the DOL had a discussion about health reform issues and implementation generally. Any specific questions that are appropriate for FAQ guidance will be addressed by the three Departments through that guidance process.

21. HSA Question

Question: The Department has provided guidance relating to whether an employer's involvement in a tax favored Health Savings Account (HSA) arrangement will cause the arrangement to be considered an ERISA covered plan. This guidance was originally issued in FAB 2004-1, and was subsequently clarified in FAB 2006-2. Under this guidance, an employer's making or influencing investment decisions with regard to an HSA will generally cause the HSA to be considered an ERISA-covered plan. See FAB 2004-1. However, an employer's selection of an HSA trustee or custodian that offers a limited menu of investment options or investment options that replicate some or all of the employer's 401(k) plan investments will not be considered to be making or influencing investment decisions of the HSA account holder so long as employees are afforded a reasonable choice of investment options and employees are not limited in moving their funds to another HSA. See FAB 2006-2, Q/A-3 (restated in its entirety below). If a single HSA provider offers a number of alternate investment option menus (which may or may not include a menu that replicates some or all of the employer's 401(k) investment options) with differing investment options, will the employer's selection of a specific investment option menu be considered to be "making or influencing" investment decisions of employees?

Initial Proposed Answer: An employer's selection of a specific investment option menu from a number of alternate investment option menus offered by a single HSA service provider will not be considered to be "making or influencing investment decisions" of employees so long as the employer is not able to modify the specific investment options included within the investment option menu offered by the HSA provider, employees are afforded a reasonable choice of investment options within each menu, and employees are not limited in moving their funds to another HSA.

In FAB 2006-2, Q/A-3, reproduced below, the Department previously provided that an employer would not be making or influencing investment decisions of employees when it selected an HSA service provider that offers a menu with a limited selection of investment options or investment options that replicate an employer's 401(k) investment options as long as the employees are afforded a reasonable choice of investment options and employees are not limited in moving HSA funds to another HSA. Logically, it follows that if an employer can pick from among HSA service providers that offer differing investment option menus it can choose between investment option menus offered by a single HSA service provider without "making or influencing" employee investment decisions. Written confirmation of this conclusion would be helpful.

DOL Answer: Current Departmental guidance regarding ERISA coverage of Health Savings Accounts (HSAs) does not address the specific factual scenario described above and the Department does not believe this to be the appropriate forum in which to provide new guidance.

22. HSA Question

Question:

DOL Field Assistance Bulletin (FAB) 2006-02, Q&A-3

Would an employer be viewed as "making or influencing" the HSA investment decisions of employees, within the meaning of the FAB, merely because the employer selects an HSA provider that offers some or all of the investment options made available to the employees in their 401(k) plan?

No. The mere fact that an employer selects an HSA provider to which it will forward contributions that offers a limited selection of investment options or investment options that replicate the investment options available to employees under their 401(k) plan would not, in the view of the Department, constitute the making or influencing of an employee's investment decisions giving rise to an ERISA-covered plan, so long as employees are afforded a reasonable choice of investment options and employees are not limited in moving their funds to another HSA. The selection of a single HSA provider that offers a single investment option would not, in the view of the Department, afford employees a reasonable choice of investment options.

Under FAB 2004-1, an employer's making or influencing investment decisions with regard to an HSA will generally cause the HSA to be considered an ERISA-covered plan. The DOL clarified in FAB 2006-2, Q/A-3 that an employer's selection of an HSA trustee or custodian that offers investment options that replicate some or all of the employer's 401(k) plan investments will not be considered to be making or influencing investment decisions of the employees so long as the employer's employees are afforded a reasonable choice of investment options and employees are not limited in moving their funds to another HSA. In light of FAB 2006-2, Q/A-3, is an employer deemed to be "making or influencing" the investment decisions of the HSA account holders where the employer and HSA custodian agree that the HSA custodian will offer an employer's employees an investment option menu, alone or in conjunction with other investment option menus, that replicates all or a portion of the employer's 401(k) investment options if (i) the HSA custodian offers all of the employer's 401(k) investment options that the HSA custodian is able to offer (i.e.

the employer has no ability to choose which of its 401(k) investment options are included in the investment option menu), (ii) the employer's employees are afforded a reasonable choice of investment options and (iii) the employer's employees are not limited in moving their funds to another HSA?

Initial Proposed Answer: The employer will not be deemed to be making or influencing the investment decisions of its employees who are HSA account holders where the employer and HSA custodian agree that the HSA custodian will offer the employer's employees an investment option menu, alone or in conjunction with other investment option menus, that replicates the employer's 401(k) menu if (i) the HSA custodian offers all of the employer's 401(k) investment options that the HSA custodian is able to offer (i.e. the employer has no ability to choose which of its 401(k) investments are included in the investment option menu), (ii) the employer's employees are afforded a reasonable choice of investment options and (iii) the employer's employees are not limited in moving their funds to another HSA.

Q/A-3 of FAB 2006-2 clearly supports the proposition that the employer is not making or influencing an employee's investment decisions if it chooses an HSA custodian that already replicates some or all of the employer's 401(k) investment options. In that case, the employer is not exercising any discretion regarding the HSA investments. Likewise, the employer is also not exercising discretion regarding HSA investments where the employer and the HSA custodian agree that the HSA custodian will offer to the employer's employees an investment option menu that replicates the employer's 401(k) investment options, even if the custodian does not typically offer such an investment option menu, so long as the HSA custodian is solely responsible for deciding whether to offer such a menu and the extent of the employer's 401(k) investment options that it will offer, based on its own internal guidelines. Although this seems to be the conclusion from Q/A-3 of FAB 2006-2, written confirmation of this would also be helpful.

DOL Answer: Current Departmental guidance regarding ERISA coverage of Health Savings Accounts (HSAs) does not address the specific factual scenario described above and the Department does not believe this to be the appropriate forum in which to provide new guidance.

23. Participant Investment Discretion Question

Question: Company A maintains a 401(k) plan with matching and profit sharing contributions which provides participants with investment discretion over their accounts in a manner intended to comply with the requirements of ERISA Section 404(c). The plan offers participants and beneficiaries the choice between 15 investment funds, including 5 stock funds, 5 bond funds, 4 balanced

funds and 1 stable value fund. The plan utilizes automatic enrollment and provides that the contributions of participants who fail to make a timely investment election will be invested in one of the balanced funds (one having approximately 60% of its assets invested in equities and 40% in bonds). Concerned that having so many funds to choose between may be difficult for some participants to handle, and that target date funds may be easier for participants to utilize than balanced funds, the plan administrator (which is the employer) decides to consolidate the funds, and simultaneously change the default fund from the 60/40 balanced fund to a family of target date funds. Assume that the existing 60/40 balance fund and the target date funds otherwise satisfy the requirements for qualified default investment alternatives under 404(c)(5). In this situation, the plan administrator is considering the following two alternatives with respect to the transition from the 60/40 fund to the target date funds as the QDIAs.

First, as of the date of the conversion, one of the target date funds, has an investment mix of approximately 60% in equities and 40% in bonds. The plan administrator is considering whether it could map participants in the 60/40 bond fund into that target date fund in a manner which would meet the requirements of Section 404(c)(4). Would that approach be available, even though many of the participants invested in the 60/40 balance fund are there by default, rather than by an affirmative election, and even though there are certain inherent differences between balanced funds and target date funds (notably, over time, the target date fund will gradually shift toward a more conservative investment profile).

Second, the plan administrator is considering having participants in the 60/40 balance fund be mapped into the target date fund which would correspond to their anticipated retirement age at the time of the conversion. In this regard, the plan administrator would notify plan participants of the change in the investment fund lineup, which of the existing funds are being mapped to which of the new funds, the fact that the balance funds are being eliminated in favor of the family of target date funds and giving participants the opportunity to effectively determine which of the new stock, bond and stable funds they are in after the conversion by determining which of the existing stock, bond or conservative funds they are invested in immediately prior to the conversion. Participants who do not elect to shift investments from the balance funds into any of the existing stock, bond, or stable funds immediately prior to the conversion would then be placed into the target date funds, based on their dates of birth. Under such a procedure, would the protection of Section 404(c)(5) be available with respect to participants whose investments in the balance funds were mapped into the target date funds?

Initial Proposed Answer: In regard to the first alternative, the relief under Section 404(c)(4) should be available in this context. Although the statute only applies in situations in which a participant has initially chosen to be in the initial investment (in this case the 60/40 balance fund) it is reasonable to read that

section in the context of Section 404(c)(5) so that participants that are in the 60/40 balance fund by default will be deemed to have made an election to be that fund for purposes of then applying 404(c)(4) to the mapping. Moreover, the requirement that the target date fund into which the 60/40 balance fund is being mapped has a similar risk and return profile, the fact that the equity and bond weightings of the two funds are approximately the same at the time of the conversion should be sufficient to satisfy this requirement. The fact that over time the target fund will gradually shift to a different equity and bond mix which is more conservative would not preclude a determination that the two funds were similar at the time of the conversion for purposes of obtaining the protection of Section 404(c)(4). Other aspects of the funds besides their risk and return characteristics at the time of the conversion would be irrelevant to the analysis.

In regard to the second alternative, the protection of Section 404(c)(5) should also be available. Although some of the participants in the balance funds would have made elections to be invested in those funds, and others would have been in the 60/40 balanced fund by default, for purposes of applying the QDIA regulations to the conversion, all of the participants who remain in the balanced funds at the time of the conversions would have failed to have provided investment direction with respect to those assets as of the time immediately following the conversion. Thus, assuming the target date fund family otherwise meets the requirements to be a QDIA, the procedures outlined above should be sufficient to allow Section 404(c)(5) to apply.

DOL Answer: Staff does not believe that the target date fund into which the 60/40 balanced fund investments are mapped would satisfy section 404(c)(4)(B)(ii) of ERISA. In particular, staff is not comfortable disregarding the fact that, by design, the target date fund is expected to change its risk-return characteristics over time. Staff notes, however, that fiduciary relief may be available under section 404(c)(5) with respect to the use of the target date fund as a QDIA. The Department has previously stated, subject to the conditions of section 404(c)(5) and those contained in implementing regulations, that section 404(c)(5) may apply in situations where a participant fails to provide investment directions following the elimination of an investment option. See 72 Fed. Reg. 60452, 60453 (Oct. 24, 2007).