

**Questions and Proposed Answers for the Department of Labor Staff for the  
2006 Joint Committee of Employee Benefits Technical Session  
Held on May 3, 2006 at 10:00 AM**

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 Department of Labor. Further, this report on the discussions was prepared by JCEB representatives, based on their notes and recollections of the meeting.

**Question 1:** Company A, publicly traded corporation, owns a 50.1% membership interest but not voting control of Company B, a joint venture limited liability company which is owned by a total of three publicly traded members including Company A. Company A sponsors a Health Plan in which most of its wholly-owned direct and indirect subsidiaries participate. Company B would like to become a participating employer in the Health Plan sponsored by A provided the arrangement would not be deemed a Multiple Employer Welfare Arrangement (MEWA). DoL has never issued regulations regarding what constitutes a control group for purposes ERISA § 3(40) although the statute states such a percentage may not be less than 25%. Would Company B's participation in the Health Plan sponsored by Company A result in the arrangement being deemed a MEWA?

**Proposed**

**Answer 1:** No. Based on DoL Reg. 2520.101-2(c)(2) the regulation describing the Form M-1 filing requirements, it appears that permitting a 25% or greater owned entity to participate in a Health Plan would not take the arrangement outside of the exception for the annual filing of the M-1 form and such an arrangement would not constitute a MEWA under ERISA § 3(40).

**DoL**

**Answer 1:** Staff disagrees with the proposed answer. Although DOL Reg. 2520.101-2(c)(2) provides an exemption from the M-1 filing requirements for an entity that would not constitute a MEWA but for the fact that it provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25 percent at any time during the plan year (applying the principles applied under section 414(b) or (c) of the Internal Revenue Code), the use of the 25 percent threshold is limited to the exemption from the M-1 filing requirement and does not apply for purposes of the MEWA definition in section 3(40) of ERISA. See 68 FR 17494, 17496 (2003) (preamble to the M-1 filing final regulation).

**Company B's participation in the Health Plan sponsored by Company would make the Health Plan a MEWA because the plan would provide benefits to**

**the employees of more than one employer. In contrast, a plan maintained by a single employer for the exclusive purpose of providing benefits to that employer's employees, former employees, or their beneficiaries is not a MEWA. For purposes of section 3(40), employers in the same control group are deemed a single employer. Under section 3(40)(B)(ii) the term "control group" means a "group of trades or businesses under common control." Whether a trade or business is under "common control" with another trade or business is to be determined under regulations issued by the Secretary of Labor "applying principles similar to the principles applied" in determining whether there is "common control" under section 4001(b) of Title IV of ERISA, except that common control shall not be based on an interest of less than 25 percent. ERISA § 3(40)(B)(iii).**

**Absent regulations, the Department would generally look to section 4001(b) for the principles to be applied. The regulation under section 4001(b) of Title IV of ERISA, which also treats trades or businesses under common control as a single employer, adopts the definition of common control set forth in the regulations under section 414(c) of the Internal Revenue Code of 1986 (Code). See 29 C.F.R. § 4001.3. It is our understanding that under Code section 414 (c), common control generally means, in the case of a parent-subsidary group, the entities are connected through at least an 80% ownership interest or an 80% voting interest. See 26 CFR §1.414(c)-2. Company A owns only 50.1% of Company B and lacks voting control over company B. Accordingly, Companies A and B do not appear to be under common control.**

**Question 2:** The new instructions for the 2005 Form 5500 provide guidance regarding a multiple-employer defined benefit plan, but they do not address what must be filed for a multiple-employer defined contribution plan. In prior years coverage information was requested for each employer in a multiple-employer plan on Schedule T (a separate Schedule T was provided for each employer). The Schedule T has been eliminated in the 2005 Form 5500 and some coverage information is to be included on the Schedule D—but the information requested is not as detailed as in the past, and there is no mention of what to do if there is a multiple-employer defined contribution plan. I would like to assume that the IRS and/or the DoL simply do not want to know whether or how each employer in a multiple-employer plan defined contribution meets coverage; however, I fear that the intent (although not stated) is for each employer in a multiple-employer defined contribution plan to file a separate 5500.

**Proposed**

**Answer 2:** Report only what is asked for on the form, and don't worry about information that was requested in the past but is no longer requested. A multiple-employer defined contribution plan can still file one 5500 for the plan, and employers who have adopted the multiple-employer defined contribution plan do not have to file separate 5500s.

**DoL**

**Answer 2:** **Coverage information for multiple-employer pension plans is included on line 9 of the Schedule R of the 2005 Form 5500 Annual Return/Report. Filers should reference the Who Must File section of the instructions to the Schedule R. A multiple-employer defined contribution plan may file one Form 5500 for the plan. As stated on page 14 of the instructions to the Form 5500, participating employers in a multiple-employer plan are not required to file individually for these plans.**

**Question 3:** An employer negotiates with a third-party administrator (TPA) to provide services to the employer's plan. Under the agreement, all administrative expenses are paid from the plan's assets. The employer negotiates a provision in the agreement that, in the event the TPA fails to provide administrative services to the Plan in accordance with the contract, the TPA must pay a penalty to the employer. Has the employer violated ERISA § 406 in negotiating the penalty provision in the contract, and is the payment a prohibited transaction?

**Proposed**

**Answer 3:** The employer has violated ERISA § 406(b)(2) in negotiating the agreement, and the payment of the penalty violates § 406(b)(1). There is no applicable statutory or class exemption.

**DoL**

**Answer 3:** Staff agrees that there has been a violation of ERISA § 406(b)(2) in negotiating the agreement and the payment of the penalty, and there is no applicable statutory or class exemption. However, staff believes that the employer has also violated ERISA §§ 406(b)(1) and (b)(3), as well as § 406(a)(1)(D). The plan has not received all of the services and/or the level of services for which it contracted, and for which the plan paid. Therefore, any detriment is suffered by the plan, and any benefit of the arrangement should be received by the plan. Accordingly, any penalty payment should be made to the plan. Inasmuch as the arrangement is not reasonable—because the arrangement benefits the employer as a result of a detriment to the plan—the arrangement would not be subject to the ERISA § 408(b)(2) exemption. Accordingly, the arrangement would also violate ERISA § 406(a)(1)(C).

**Question 3A:** Same facts except, the TPA also provides investment-related services. The TPA charges the plan nothing for the administrative services it provides; the TPA does charge the plan investment-related fees; the plan pays those fees. Assume for purposes of the example that those investment-related fees are reasonable. Under the agreement negotiated by the employer, if the TPA fails to provide administrative services to the plan in accordance with the contract, the third-party administrator must pay a penalty to the employer. Has the employer violated ERISA § 406 in negotiating the penalty provision in the contract, and is the payment a prohibited transaction?

#### **Proposed**

**Answer 3A:** The employer has violated ERISA § 406(b)(2) in negotiating the agreement, and the payment of the penalty violates § 406(b)(1). There is no applicable statutory or class exemption.

#### **DoL**

**Answer 3A:** Staff agrees that there has been a violation of ERISA § 406(b)(2) in negotiating the agreement and the payment of the penalty, and there is no applicable statutory or class exemption. However, staff believes that the employer has also violated ERISA §§ 406(b)(1) and (b)(3), as well as § 406(a)(1)(D). Staff views this as a bundled service arrangement, where the plan has not received all of the services and/or the level of services for which it contracted and for which it paid. Therefore, any detriment is suffered by the plan, and any benefit of the arrangement should be received by the plan. Accordingly, any penalty payment should be made to the plan. Inasmuch as the arrangement is not reasonable—because the arrangement benefits the employer as a result of a detriment to the plan—the arrangement would not be subject to the ERISA § 408(b)(2) exemption. Accordingly, the arrangement would also violate ERISA § 406(a)(1)(C).

**Question 4:** Do IRS Rev. Rul. 2004-10 and DoL FAB 2003-3 provide authority for defined contribution plans to assess forfeited accounts of missing participants a share of plan administrative expenses during the period of forfeiture?

**Proposed**

**Answer 4:** No. Once forfeited, the account of a missing participant may not be assessed a share of plan expenses. If a later claim is made by the participant or beneficiary, the account must be restored to the level in effect at the time of forfeiture.

**Rationale for**

**Proposed**

**Answer 4:** IRC § 411 requires that an employee's accrued benefit be non-forfeitable after satisfying the vesting rules. An accrued benefit in a defined contribution plan is the employee's account. An exception to the forfeiture rules applies to lost beneficiaries. Reg. § 1.411(a)-4(b)(6) states:

“(b) Special rules. For purposes of paragraph (a) of this section, a right is not treated as forfeitable---

(6) Lost beneficiary; escheat. In the case of a benefit which is payable, merely because the benefit is forfeitable on account of the inability to find the participant or beneficiary to whom payment is due, *provided that the plan provides for reinstatement of the benefit if a claim is made by the participant or beneficiary for the forfeited benefit*. In addition, a benefit which is lost by reason of escheat under applicable state law is not treated as a forfeiture.” (emphasis added)

The regulation does not directly address whether the restored account balance may be assessed a share of plan expenses after the forfeiture and before reinstatement. However, it is implicit that a forfeited account is no longer available to be charged a share of plan expenses or to share in earnings or losses incurred during the period of forfeiture.

We think this conclusion flows from IRC § 411(a)(7) and Treas. Reg. § 1.411(a)-4(b)(6) in that the accrued benefit is the balance in the account as of the date of forfeiture and Treas. Reg. § 1.411(a)-7(d)(4)(v) which states that the restored amount is “unadjusted by any subsequent gains or losses.” Technically, Treas. Reg. § 1.411(a)-7(d)(4)(v) falls under the cash out and plan repayment provisions rather than the provisions of Treas. Reg. § 1.411(a)-4(b)(6) regarding the temporary forfeiture of benefits of lost participants and beneficiaries. However, it appears to serve the same purpose, i.e. to prevent an impermissible forfeiture of accrued benefits.

DoL FAB 2003-3 allows plans to assess a share of expenses to the accounts of separated, vested participants but does not mention the forfeited account situation. See the following excerpt from DoL FAB 2003-3:

**Accounts of Separated Vested Participants.** Some plans, with respect to which the plan sponsor generally pays the administrative expenses of the plan, provide for the assessment of administrative expenses against participants who have separated from employment. In general, it is permissible to charge the reasonable expenses of administering a plan to the individual accounts of the plan's participants and beneficiaries. Nothing in Title I of ERISA limits the ability of a plan sponsor to pay only certain plan expenses or only expenses on behalf of certain plan participants. In the latter case, such payments by a plan sponsor on behalf of certain plan participants are equivalent to the plan sponsor providing an increased benefit to those employees on whose behalf the expenses are paid. Therefore, plans may charge vested separated participant accounts the account's share (e.g., pro rata or per capita) of reasonable plan expenses, without regard to whether the accounts of active participants are charged such expenses and without regard to whether the vested separated participant was afforded the option of withdrawing the funds from his or her account or the option to roll the funds over to another plan or individual retirement account.

Nothing in DoL FAB 2003-3 appears to allow plans to reduce a restored account balance by a share of plan administrative expenses incurred during the period of forfeiture.

Likewise, IRS Rev. Rul. 2004-10 does not address forfeited accounts. That Revenue Ruling reviewed whether the allocation of plan administrative expenses to the individual accounts of former participants who do not consent to a distribution is a significant detriment within the meaning of § 1.411(a)-11(c)(2)(i). The IRS concluded that as long as the allocation is reasonable and otherwise satisfies the requirements of Title I of ERISA, it would not be a significant detriment to charge expenses to the accounts of former employees on a pro rata basis. However, the fact pattern presented in Rev. Rul. 2004-10 does not appear to involve forfeited accounts. Thus, it is implicit that once an account is forfeited, it does not share in earnings or losses nor should it be assessed a share plan expenses.

**DoL**

**Answer 4:** **DOL staff can only respond to this question as it pertains to DOL's Field Assistance Bulletin 2003-3. DOL staff agrees that this FAB allows plans to assess a share of proper and reasonable expenses to the accounts of separated, vested participants in defined contribution plans, but does not address the forfeited benefit situation permitted under Reg. § 1.411(a)-4(b)(6).**

**DOL staff presumes that a benefit that is forfeited under Reg. § 1.411(a)-4(b)(6) would, for accounting and bookkeeping purposes, be transferred to a plan's Forfeiture Account where amounts would be reallocated or used in accordance with plan provisions and governing law; consequently, the**

**forfeited benefit would cease to exist separately and would not be available to bear any plan expenses. DOL staff observed that this situation contrasts with continuing to account for such benefit on the plan's books where reasonable and proper and expenses could be borne by the benefit.**

**However, DOL staff notes that authority to interpret the meaning of "forfeited benefit" as used in Reg. § 1.411(a)-4(b)(6) resides with IRS/Treasury.**

**Question 5:** May defined benefit plans charge participants for the cost of processing QDROs? Is there any plan to issue further guidance on this subject?

**Proposed**

**Answer 5:** Yes, but further guidance will have to be issued because IRS Rev. Rul. 2004-10 and DoL FAB 2003-3 do not provide direct authority for charging fees to participants in DB plans for processing QDROs.

**Rationale for Proposed**

**Answer 5:** DoL Field Assistance Bulletin 2003-3 permits defined contribution plans to charge certain types of administrative expenses (including costs related to QDROs) to the accounts of plan participants as long as the expenses are reasonable and the method of allocation satisfies the requirements of Title I of ERISA. In 2004, the IRS also supported this right by stating that the imposition of administrative fees is not a significant detriment as long as the allocation method is reasonable (e.g., allocated pro rata) and does not discriminate in favor of highly compensated employees. [Rev. Rul. 2004-10, 2004-8 I.R.B. 484] However, FAB 2003-3 and Rev. Rul. 2004-10 only address the allocation of expenses in defined contribution plans, not defined benefit plans.

Assuming that defined benefit plans may charge a participant the cost of QDRO processing, the following issues arise, some of which are unique to defined benefit plans:

How is it determined whether the fees to review and process a QDRO are reasonable and appropriate?

May a flat fee or a variable fee be charged?

If the fee is variable, what expenses are recoverable?

Do they include the plan's administrative and legal cost of reviewing the domestic relations order to determine if it is a QDRO?

Do they include the cost of the actuary to calculate the benefit payable over the AP's lifetime?

May the money be collected by deduction from future benefit payments? Or is this considered a violation of the non-alienation rules? See IRC § 401(a)(13) and ERISA § 206(d).

May the plan offset the cost of QDRO processing against future accruals of the participant?

How is the cost apportioned between the participant and the spouse?

Do the plan's QDRO procedures have to describe the details about charging the cost of QDRO processing? See ERISA § 206(d)(3)(G) and IRC § 414(p)(6).

**DoL**

**Answer 5:** **DOL FAB 2003-3 provides that ERISA does not preclude the allocation of reasonable expenses attendant to QDRO determinations to the account of a defined contribution plan participant seeking the determination. Staff believes that the principles set forth in the FAB applicable to determining the permissibility of allocating specific expenses to the account of an individual participant, rather than the plan as a whole (i.e., among all participants) would apply to QDRO determinations in a defined benefit plan. Staff noted that the Department would be willing to consider providing further guidance on this subject if specific issues were submitted and, since there may be qualification and anti-alienation issues within the jurisdiction of the IRS, the Department would coordinate with the IRS on such guidance.**

**Question 6:** Assume that the arrangement between the employer that sponsors a self-funded medical plan and the entity that processes the claims for benefits (“Claims Paying Agent”) provides that the Claims Paying Agent has complete discretion over whether or not to pursue claims based on subrogation and coordination of benefits (“Reimbursement Claims”). Assume further that the Claims Paying Agent decides not to pursue any of the claims, without even considering whether the claims had any validity. Would the Claims Paying Agent be deemed a fiduciary of the plan? Would the failure to even investigate whether any of the Reimbursement Claims had any merit be a breach of fiduciary duty?

**Proposed**

**Answer 6:** The Reimbursement Claims are assets of the plan and the discretion whether or not to pursue them is inherently a fiduciary role. The failure to even investigate whether or not the Reimbursement Claims is breach of fiduciary duty, even if it turns out that none of them have any merit. Whether those claims actually have

any merit only goes to the amount of the damages, not to whether there has been a breach of fiduciary duty.

**DoL**

**Answer 6: DoL staff assumed that there are participant contributions or other plan assets in the self-funded plan and agreed with the answer.**

**Question 7:** Assume that an insurance company both processes the claims for benefits under a self-funded medical plan (“Claims Paying Agent”), but it also issued the stop-loss policy to the plan. In its capacity as Claims Paying Agent, it processed claims in excess of the dollar amount of the threshold for triggering reimbursements under the stop loss policy, but never contacted the portion of the insurance company that authorized payments under the stop loss policy. Was that action a prohibited transaction?

**Proposed**

**Answer 7:** It is a prohibited transaction for the portion of the insurance company serving as the Claims Paying Agent to fail to submit claims for reimbursement under the stop loss policy because it was dealing with the assets of the plan (*i.e.*, the claim for reimbursement under the stop loss policy) for its own benefit (*i.e.*, by effectively forfeiting those claims for reimbursement for no consideration).

**DoL**

**Answer 7:** **DoL staff responded that if you assume that participant contributions or other plan assets were included in the plan, the answer depends on who has the responsibility to determine the threshold amount and who must submit the claim for stop loss reimbursement. They recommended reviewing Tech. Release 92-01 (or 94-1) and Advisory Opinion 92-24 (or 92-1). DoL staff stated that if the Claims Agent is responsible for tracking the claims limit and fails to make the stop loss claim or notify the responsible plan fiduciary of the need to submit a claim, there would be a prohibited transaction. DoL staff stated that they did not think the result would change if the employer owns the policy but the result might be different if the employer pays the entire premiums on the stop loss policy.**

**Question 8:** Corporation A, which maintains the Corp A 401(k) plan, acquires all the stock of Corporation B, which maintains the Corp B 401(k) plan. Both the Corp A 401(k) plan and the Corp B 401(k) plan offer employer securities as one of the investment options under the plan. Corporation A pays cash for all shares of Corporation B stock. After the acquisition, Corporation A continues to maintain the Corp B 401(k) plan. As part of the acquisition, Corporation B shares held in the Corp B 401(k) plan are converted to cash (and subsequently invested as directed by the participants or in the Corp B 401(k) plan’s default fund). The conversion requires more than three days during which the assets held in the Corporation B stock fund are not available for participants to direct the investment of the assets in the fund or to receive a distribution from the fund. Do the restrictions constitute a blackout period for purposes of section 101(i) of ERISA? If Corporation A paid Corporation A stock rather than cash for Corporation B stock and Corp B 401(k) plan participants have stock in the Corporation B stock fund converted to Corporation A stock instead of cash, does this change the answer?

**Proposed**

**Answer 8:** The exception from the blackout period for a merger involving a plan sponsor under 29 C.F.R. § 2520.101-3(b)(2)(ii)(C) does not apply because individuals are not becoming or ceasing to be participants or beneficiaries as a result of the merger of the plan sponsors. Nevertheless, because the Corporation B stock fund is being permanently discontinued under the Corp B 401(k) plan, there is no blackout period. This is the case whether the assets in the Corporation B stock fund are converted to cash or Corporation A shares of stock.

**DoL**

**Answer 8:** Staff disagrees with the proposed answer.

**The term “blackout period” means, in connection with an individual account plan, any period for which any ability of participants or beneficiaries under the plan, which is otherwise available under the terms of such plan, to direct or diversify assets credited to their accounts, to obtain loans from the plan, or to obtain distributions from the plan is temporarily suspended, limited, or restricted, if such suspension, limitation, or restriction is for any period of more than three consecutive business days.**

**As described in the language in the preamble to 29 C.F.R. § 2520.101-3, the permanent restriction on new contributions to an investment option or the replacement of one investment option with another would not in and of themselves be events that give rise to a blackout notice obligation under the regulation. However, as further described in the preamble language, if, in connection with implementing a permanent restriction, rights would be temporarily suspended, limited or restricted, the blackout notice requirements would apply to such temporary restriction.**

**Staff assumes that the conversion here involves a permanent restriction as described in the preamble, which does not itself give rise to a blackout notice obligation. This would be the same result whether the change is described as a permanent discontinuance of the Company B Stock Fund or a replacement of one investment option in the Fund (B Stock) with another (A Stock). However, assuming the conversion requires more than three consecutive business days, the blackout notice requirements would apply to the Corporation B 401(k) Plan temporary suspension of participant direction (and participant access to distributions) of the assets in the Stock Fund. This would be the same result regardless of whether Corporation B shares are converted to cash and subsequently invested as directed by the participants (or in the default fund) or converted to Corporation A stock.**

**In the fact pattern presented, staff agreed that the exception to the 30-day advance notice requirement did not apply for blackout periods applicable to**

**one or more participants or beneficiaries solely in connection with their becoming, or ceasing to be, participants or beneficiaries of the plan as a result of a merger, acquisition, divestiture, or similar transaction. Staff notes that even in cases where that exception applies, the administrator is still required to provide notice as soon as reasonably possible under the circumstances, unless such notice in advance of the termination of the blackout period is impracticable.**

**Question 9:** Is a COBRA notice procedure reasonable if it denies the participant the right to the 11-month extension for disabled persons if the participant cannot produce a copy of the original letter from the Social Security Administration stating that the participant was disabled as of a specific date, even though the participant can provide other correspondence from the Social Security Administration stating that it has determined that he became disabled on that date?

**Proposed**

**Answer 9:** No. There is no justification for requiring a copy of the original letter if that information is contained in subsequent correspondence from the agency. Thus, it would not be a reasonable procedure within the meaning of regulation § 2590.606-3(b)(1). Accordingly, furnishing a copy of any correspondence from the Social Security Administration that contains the requisite information would suffice, pursuant to regulation § 2950.606-3(b)(4).

**DoL**

**Answer 9:** **Regulation § 2590.606-3(a)(4) provides that covered employees and qualified beneficiaries who wish to extend COBRA coverage due to a disability are responsible for providing a “[n]otice that a qualified beneficiary entitled to receive continuation coverage with a maximum duration of 18 months has been determined by the Social Security Administration . . . to be disabled at any time during the first 60 days of continuation coverage.” The notice regulation § 2590.606-3(b) requires plans to establish reasonable procedures for the furnishing of notices by covered employees and qualified beneficiaries. For such a procedure to be reasonable, it must, among other things, describe the information concerning the determination of disability that the plan deems necessary in order to provide continuation coverage rights. The regulation also states at § 2590.606-3(b)(4) that, if the plan has not established reasonable procedures, the notice “shall be deemed to have been provided when a written or oral communication identify a specific event is made in a manner reasonably calculated to bring the information to the attention of” the plan.**

**The type of information that a plan can require from a covered employee or qualified beneficiary in order to provide continuation coverage seems to involve a substantive COBRA coverage question such that this question may involve issues under the interpretive jurisdiction of the Department of the**

**Treasury. In the fact pattern presented, the participant is able to provide copies of other correspondence from the SSA. In the Department's view, it would not be reasonable for a plan to deny disability extension coverage where the participant can provide other correspondence from the SSA that includes all the information the plan would need from the original SSA letter to decide whether the person is eligible for the extended coverage.**

**Question 10:** Assume the following facts: (i) individual T was covered by a health plan by T's former employer ("Prior Employer"), (ii) T's employment with Prior Employer ended and T elected to continue to participate in Prior Employer's health plan pursuant to COBRA, (iii) T later began working for another company ("Current Employer") who sponsors a group health plan, (iv) T will soon become eligible to participate in Current Employer's health plan, but prefers instead to continue participating in Prior Employer's health plan pursuant to COBRA. Can Prior Employer require that T elect to participate in Current Employer's Plan so that T can terminate her COBRA coverage?

**Proposed**

**Answer 10:** Prior Employer's efforts to "persuade" T to drop her COBRA coverage are a violation of ERISA § 510.

**DoL**

**Answer 10:** DoL staff stated that a former employer providing COBRA coverage cannot require the qualified beneficiary to drop coverage if other coverage becomes available. Based on facts presented, it is hard to determine whether the efforts to "persuade" would violate ERISA § 510. Section 510 only applies where a person discharges, fines, suspends, expels, disciplines or discriminates against a participant or beneficiary for exercising any right to which he/she is entitled under the provisions of a plan. In order for section 510 to apply, the action would have to amount to a cut off of benefits. Certain types of "persuasion," could constitute a violation of section 511 (coercive interference).

**Question 11:** Can a person elect multiple coverages (medical and vision benefits) on the COBRA election form, but only make the premium payment for the medical coverage when the premium becomes due without having both coverages cancelled by reason of the (total amount of the) COBRA premium being deficient by more than a *de minimis* amount?

For this purpose, assume that no guidance was provided to the person regarding the manner in which the person is supposed to give notice of the desire to terminate some but not all of the coverages the person selected pursuant to the COBRA election. Further assume that the amount of the premium shortfall was

exactly the amount of the premium for the vision coverage, and that the premiums for the vision and medical premiums were always paid by unrelated parties.

**Proposed**

**Answer 11:** The employer has the obligation to prepare the documentation necessary to supply persons eligible for COBRA with the information needed to take actions that the employer could reasonably anticipate. (This information could be provided in the COBRA notice, the COBRA election form, the SPD, or some other document.) Thus, the failure of the employer to provide the information to the person precludes the employer from objecting to the manner in which the person notifies the plan of his or her intent to terminate such coverage. Accordingly, the employer must treat that the failure to pay the premium for the vision coverage as notice of the desire to terminate the vision coverage where the premiums are paid by unrelated parties. Accordingly, the employer is precluded from using this “premium shortfall” as a pretext for terminating the person’s medical coverage.

**DoL**

**Answer 11:** **Staff notes that whether a particular qualified beneficiary has a premium shortfall and the consequences of such a shortfall raises issues within the jurisdiction of the IRS. Neither COBRA nor the DoL notice regulations impose a notice requirement on qualified beneficiaries who decide to terminate all or part of their COBRA coverage. Staff further notes that if COBRA coverage is terminated earlier than the maximum period applicable to a qualifying event due to non-payment of a premium, the plan administrator would be required to provide the qualified beneficiary with a notice of termination of continuation coverage. See § 2590.606-4(d)(1).**

**Question 12:** Assume that an employer elects to pay all of a former employee’s health insurance premiums for 18 months after termination of employment. Assume further that the employer never told the employee that this coverage was in lieu of COBRA coverage and of the need to provide timely notice to the plan that the Social Security Administration has issued a determination that a person receiving COBRA coverage is disabled (“Disability Determination Letter”). When that employer-subsidized coverage ends, it informs the former employee that the coverage that he was receiving was in lieu of COBRA (so that he has no right to elect COBRA now) and because he didn’t provide timely notice to the plan of the Disability Determination Letter, the 11-month extension period is not available to him.

**Proposed**

**Answer 12:** The period for giving notice of the issuance of the Disability Determination Letter has not expired. It doesn’t begin until the person is notified of the notice obligation. Stated in a different manner, to the extent that the person wasn’t notified of the notice obligation under after the end of the 18 month period, the

rule in Regulation § 2590.606-3(c)(2)(ii) (that requires that notice be given before the end of the 18 month period) is wrong, because it permits employers to avoid the 11-month extension for disabled individuals simply by not telling them of the notice requirement.

**DoL**

**Answer 12:** This was question 26 in the 2005 Questions and Answers .

**The Department’s COBRA Notice Regulations (29 C.F.R. § 2590.606-3(c)(2)(i)) provide that the time period for a qualified beneficiary to furnish a notice of disability determination is at least 60 days running from the latest of (1) the date of the Social Security Administration’s disability determination, (2) the date of the qualifying event, (3) the date on which coverage is lost, or (4) the date on which the qualified beneficiary is informed through the plan’s SPD or the general COBRA notice of the obligation to provide notice. Section 2590.606-3(c)(2)(ii) of the regulations provide that “[n]otwithstanding paragraph (c)(2)(i) of this section, a plan may require the notice [of disability determination] be furnished before the end of the first 18 months of continuation coverage.”**

**In the fact pattern presented, the 60-day time period for furnishing a notice of disability has not expired because the employer never disclosed to the employee the requirement to provide timely notice to the plan of an SSA disability determination nor was the employee informed that the employer-provided coverage was in lieu of COBRA coverage. It is the Department’s view that a qualified beneficiary should not be adversely affected in efforts to exercise his or her COBRA rights by a plan’s failure to provide adequate disclosures to participants and qualified beneficiaries. As expressed in the preamble to the final regulations, because a qualified beneficiary may be denied COBRA coverage due to his or her failure to provide a timely notice, the Department believes that disclosing the notice obligations and the procedures for providing such notice is critical to the exercise of statutory rights. (69 Fed. Reg. 30084, 30087 (May 26, 2004)).**

**Although Section 2590.606-3(c)(2)(ii) of the COBRA notice regulation provides that a plan may require the disability notice to be provided before the end of the first 18 months of continuation coverage, the plan is under an affirmative obligation to notify the participant or qualified beneficiary of the obligation to provide the SSA determination within the 18 month period before it can enforce such a requirement. The use of “notwithstanding” in section 2590.606-3(c)(2)(ii) merely reinforces the statutory provision under which the plan can require the SSA determination be provided before the end of the 18 month initial COBRA continuation coverage period even in a circumstance where the date of the SSA disability determination is less than**

**60 days before the expiration of the original 18 month COBRA continuation coverage period.**

**Question 13:** If a qualified beneficiary receiving COBRA coverage notifies the plan administrator of a second qualifying event (i.e., divorce, legal separation, or a child's ceasing to be a dependent under the terms of the plan) that extends the maximum COBRA coverage period under ERISA § 602(2)(A)(ii) ("Special rule for multiple qualifying events"), is the plan administrator required under ERISA § 606(a)(4)(B) to provide the qualified beneficiary with a notice "of such beneficiary's rights" if the plan administrator determines that the qualified beneficiary is entitled to an extension of the COBRA coverage period?

**Proposed**

**Answer 13:** No, assuming that the plan administrator provided a COBRA election notice containing the information required under DoL Reg. § 2590.606-4(b) at the time of the qualified beneficiary's initial qualifying event, the plan administrator will have met its obligation under ERISA § 606(a)(4)(B) to provide a notice "of such beneficiary's rights" and is not required to provide another notice in connection with the second qualifying event. DoL Reg. § 2590.606-4(c) requires the plan administrator to provide a notice of unavailability of COBRA coverage if the plan administrator determines that the qualified beneficiary is not entitled to an extension of the COBRA maximum coverage period as a result of the second qualifying event, but the DoL's regulations do not require a notice to the qualified beneficiary if the extension is available. Note, however, that a notice to the qualified beneficiary at the time of the second qualifying event may be necessary, although not required under ERISA § 606(a)(4)(B), to inform the qualified beneficiary of any changes (for example, a change in the COBRA premium) resulting from the second qualifying event.

**DoL**

**Answer 13:** Regulation section 2590.606-4 provides guidance on the requirements of section 606(a)(4) and 606(c) of ERISA regarding plan administrator notice obligations. Section 2590.606-4(b) addresses the specific timing and content requirements for an election notice. Section 2590.606-4(b)(4)(ix) provides that the election notice must include a description of any circumstances (if any) under which the maximum period of continuation coverage may be extended due to the occurrence of a second qualifying event. Section 2590.606-4(b)(4)(x) provides that, in the case of an election notice that offers continuation coverage with a maximum duration of less than 36 months, such notice must include a description of the plan's requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event, along with a description of the plan's procedures for providing the notice of second qualifying event, including the time frame within which such notice must be provided, and the consequence of failing to provide such notice. It is the Department's view that a plan administrator

**would not be required to provide a qualified beneficiary who has experienced a second qualifying event with a second election notice if the election notice furnished to the qualified beneficiary following the first qualifying event was written in a manner calculated to be understood by the average plan participant and contained the information described in section 2590.606-4(b).**

**Question 14:** Participant X has reached the age that X could qualify for Medicare benefits. X is employed by Company W. Company W is “encouraging” X to disenroll in its health plan and to enroll in Medicare because that will save Company W significant amounts on its health care premiums. Does this violate ERISA § 510?

**Proposed**

**Answer 14:** Company W’s actions are a violation of ERISA § 510.

**DoL**

**Answer 14:** Whether actions violate section 510 depends on the facts. There are not sufficient facts in the question to make a determination. However, DoL staff opined that there may be ways to encourage a participant to disenroll that would not violate section 510, but would encourage the desired disenrollment (such as a payment to the employee). Further discussion involved the fact that an encouragement to disenroll, such as a payment, would be a clear violation of the Medicare Secondary Payor Rules, which prohibit employers from engaging in such encouragement. Further discussion raised the unanswered question of whether the violation of another federal law (Medicare, for example) by a plan fiduciary would create a violation of the fiduciary’s duties under ERISA.

**Question 15:** Many employers have initiated disease management programs as a means to hold down the rising cost of group health insurance. Some employers are frustrated at covered individuals who fail or refuse to cooperate with the health care plan’s disease management professionals. For example, the plan may refer a diabetic to a disease manager, who offers to assist the individual in understanding the need to control diet, check blood sugar and take insulin as needed, have hemoglobin checked annually, have regular eye examinations, etc. The disease management protocol typically is based on generally accepted standards of treatment. The plan’s hope and expectation is that the individual will agree to work with the disease manager and do the things recommended by the disease manager as a means to control the effects of the disease.

Some employers desire to install punitive-type triggers in the health care plan, under which individuals who fail or refuse to cooperate with the disease management professionals may pay a higher health care premium, or higher deductible. In no case does an individual’s condition prevent him or her from

cooperating with the disease management professionals. Under the facts presented, must such sanctions operate within the confines of, and comply with, HIPAA's bona fide wellness program rules?

**Proposed**

**Answer 15:** No. The sanctions are imposed not because of any health status-related factors affecting or related to the individual, but rather due to the individual's failure or refusal to cooperate with a disease management professional. For example, in the case of an employer that offers a smoker's rate and non-smoker's rate under a health plan, the more expensive smoker's rate is imposed because the individual smokes. The plan may impose such higher rate only to the extent the plan abides by the bona fide wellness program rules. While it is true that the smoker who declines to participate in the smoking cessation program will pay the higher rate, he pays the higher rate because he smokes, not because he refused to participate in the wellness program per se.

On the other hand, where an individual who is referred to disease management refuses to cooperate in his or her care and thus triggers a higher premium or deductible, the penalty is imposed strictly for the failure to cooperate. Were the individual to cooperate, he or she would avoid the sanction whether or not the disease management protocol actually mitigated the disease, and whether or not--if the disease management protocol failed to mitigate the disease--the failure was due to a health status-related factor of the individual.

**DoL**

**Answer 15:** **Generally, yes. The health plan is in fact requiring individuals to satisfy a standard related to a health factor in order to avoid the punitive charge. Let's take your example of a diabetes disease management program and a premium surcharge for those individuals who fail or refuse to cooperate with the disease management program. The initial standard to avoid the premium surcharge would be that the individual does not have diabetes. These non-diabetic individuals would not be subject to the premium surcharge. In contrast, individuals who do have diabetes would be subject to a surcharge unless the individual participates in the disease management program. Participation in the disease management program may be a reasonable alternative standard to the initial standard of not having diabetes. It may be that in no case does an individual's condition prevent him or her from satisfying this alternative standard of cooperating with the disease management program. Nonetheless, the plan is varying premiums based on a health factor—whether or not a person has diabetes and therefore, must comply with HIPAA's wellness program rules. Under the proposed rules, the plan will need to ensure that the reward does not exceed 20% of the cost of coverage, that the opportunity to qualify for the reward is offered at least once per year, that for any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet the standards**

**imposed by the disease management program an additional reasonable alternative standard is offered, and that any plan materials that disclose the terms of the program disclose the availability of a reasonable alternative standard. CMS/HHS and the IRS/Treasury share parallel authority with respect to HIPAA. Therefore, the DOL coordinates with CMS/ HHS and IRS/Treasury to provide consistent regulatory guidance on this issue.**

**Question 16:** Pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) (see 38 U.S.C. § 4318), DoL regulations (see 20 C.F.R. § 1002.262) provide that an employer may require an employee returning from a qualified military leave who lost any benefits under a defined contribution plan during the leave to make up his or her missed contributions or elective deferrals (“employee contributions”) during a certain period in order to receive any employer contributions that are contingent on or attributable to such employee contributions. Certain profit sharing plans that are qualified under Code § 401(a), or tax-sheltered annuity programs that satisfy the requirements of Code § 403(b), provide for additional employer contributions only if employees make a one-time irrevocable salary reduction election (“irrevocable participant contributions”) when the employee first becomes eligible to participate in that plan or program. Are irrevocable participant contributions treated as employee contributions for purposes of such USERRA requirements, as a result of which an employee returning from a military leave may be required to make up missed irrevocable participant contributions before any employer contributions attributable to those missed irrevocable participant contributions are made up by the employer?

**Proposed**

**Answer 16:** Yes, contributions made pursuant to a one-time irrevocable election upon initial eligibility are treated as employee contributions for such USERRA requirements. This is consistent with how such contributions are treated under ERISA’s fiduciary responsibility rules (see 29 C.F.R. § 2510.3-102).

This USERRA treatment is contrasted with how such contributions are treated for tax purposes. Pursuant to Treas. Reg. § 1.401(k)-1(a)(3)(iv), such irrevocable participant contributions are treated as employer contributions and are not treated as a cash or deferred election. Similarly, Code § 403(b)(12) provides that a contribution is treated as an employer contribution and not made pursuant to a salary reduction agreement for purposes of the nondiscrimination requirements of Code § 403(b)(12)(A) if it is made pursuant to an employee’s one-time irrevocable election upon initial eligibility.

**DoL**

**Answer 16:** Staff began by caveating that EBSA is not the agency that interprets USERRA. VETS interpret USERRA. Their informal answer is that they think they agree with the proposed answer even though USERRA § 4318 has a reference to a one time irrevocable election, the regulations under

**USERRA 102.262 do not make any distinction between types of employee contributions.**

**Question 17:** An employee who participates in both a multiemployer defined benefit pension plan and a multiemployer health plan leaves covered employment for uniformed service. Upon discharge from uniformed service, the employee is reemployed by a different contributing employer than his/her pre-service employer and the employee's pre- and post-service employers *do not* share a common means or practice of hiring the employee, such as common participation in a union hiring hall. The employee otherwise meets the requirements for reemployment rights under USERRA. Is the employee entitled to the USERRA pension rights described in 20 C.F.R. § 1002.259 (such as vesting and eligibility credit and benefit accruals for the period of uniformed service), and is the employee entitled to immediate reinstatement in the multi-employer health plan under 20 C.F.R. § 1002.168?

**Proposed**

**Answer 17:** No. Under 20 C.F.R. § 1002.266(c), a participant in a multiemployer pension plan who is reemployed by a different contributing employer than his/her pre-service employer is not entitled to the USERRA pension rights described in 20 C.F.R. § 1002.259 if his/her pre- and post-service employers do not share a common means or practice of hiring the employee, such as common participation in a union hiring hall. Further, although the final USERRA regulations do not address health plan reinstatement rights in this situation, the statute's legislative history, as described in the preamble at 70 Fed. Reg. 75246, 75284, indicates that Congress did not intend to provide USERRA health plan reinstatement rights under these circumstances.

**DoL**

**Answer 17:** **DoL Staff noted that primary jurisdiction with respect to the USERRA regulations is vested in the Veterans' Employment and Training Service. Staff agrees with the proposed response as to pension rights. Under 20 C.F.R. § 1002.266(c), a participant in a multiemployer pension plan who is reemployed by a different contributing employer than his/her pre-service employer is not entitled to the USERRA pension rights described in 20 C.F.R. § 1002.259 if his/her pre- and post-service employers do not share a common means or practice of hiring the employee, such as common participation in a union hiring hall. Staff also agrees with the proposed response as to health plans, except to the extent that the Plan provided hours bank accounts and the participants under the plan who separate for other types of leave are permitted re-entry based upon hours bank credits.**

**Question 18:** Under the situations described below, should a participant be credited with hours of service attributable to accrued vacation. In each case assume the employer maintains a calendar year vacation policy under which employees accrue their

vacation for the upcoming calendar year as of the first day of the year. The participant becomes entitled to two weeks vacation on January 1. He has not taken any vacation as of the date his employment is terminated. Under the first scenario, the participant's accrued vacation is cashed out. He is paid for an additional two weeks of accrued vacation on his termination date. In the second scenario, the participant's last day of actual work is May 31. The participant is paid the accrued vacation by continuing to receive wages over the next two weekly payroll cycles. Thus, the date of his termination from employment is effectively extended to June 14.

**Proposed**

**Answer 18:** Yes, whether the participant is cashed out or his termination date is deferred, the employer is required to credit him with hours of service attributable to the accrued vacation. Department of Labor Regulation § 2530.200-2(a) provides in relevant part that:

An hour of service which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, is an hour of service as defined in paragraphs (a)(1), (2) and (3) of this section...

(2) An hour of service is each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability)...

DoL Reg. § 2530.200-2(b)(3)(i) provides that:

Notwithstanding paragraphs (b) (1) and (2) of this section, an employee is not required to be credited on account of a period during which no duties are performed with a number of hours of service which is greater than the number of hours regularly scheduled for the performance of duties during such period.

DoL Reg. § 2530.200-2(b)(3)(ii)(A) provides that:

Employee A has a regular 40-hour workweek. Each year Employee A is entitled to pay for a two-week vacation, in addition to receiving normal wages for all hours worked, regardless of whether A actually takes a vacation and regardless of the duration of his vacation. The vacation payments are, therefore, calculated on the basis of units of time (weeks). In computation period I, A takes no vacation but receives vacation pay. A is entitled to no credit for hours of service for the vacation payment made in computation period I because the payment was not made on account of a period during which no duties were performed. In computation period II, A takes a vacation of one week in duration, although receiving pay for a two-week vacation. A is entitled to be credited with 40 hours of service for his one-week vacation in computation period II even though paid for two weeks of vacation. In computation period III, A takes a vacation for a period lasting

more than 2 weeks. A is entitled to be credited with 80 hours of service for his vacation in computation period III (40 hours per week multiplied by 2 weeks) even though the vacation lasted more than 2 weeks.

Under the definition of an hour of service, credit must be given for an hour for which an employee is paid on account of a period during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation. Furthermore, the crediting of service for the accrued vacation does not violate the rule against double crediting under DoL Reg. § 2530.200-2(b)(3)(i). The employee is not receiving wages and payment for accrued vacation for the same period. Therefore, based on the above DoL regulations, the hours of service attributable to the accrued vacation must be included.

**DoL**

**Answer 18:** Staff declined to answer because the Treasury Department has interpretive authority on this issue.

**Question 19:** A law partnership maintains a health plan for its employees and partners. Some lawyers are not direct partners in the law partnership. Instead, the lawyer establishes a professional corporation (PC), and the PC is the partner in the law partnership. Does this arrangement make the law partnership's health plan a MEWA for purposes of ERISA § (3)(40)?

**Proposed**

**Answer 19:** No. A plan sponsored by a single partnership and covering only partners of the partnership and common law employees of the partnership would not be a MEWA for purposes of ERISA § 3(40). Adding the layer of the PC between the working partner and the partnership does not change this result.

**DoL**

**Answer 19:** Assuming the partners are working owners with respect to the partnership, and that the PC itself has no employees, staff agrees with the proposed answer to the extent that the activities of the PC are limited to holding the partnership interest(s) of the partner(s) who establish the PC and perform services for the partnership. It is, however, important to note that to the extent the PC's activities are not limited as described in the preceding sentence, the given facts are insufficient to determine whether or not the healthcare arrangement of the partnership may be a MEWA for purposes of ERISA §3(40). If the PC has employees other than the partners, then we would need to evaluate whether its existence as a separate entity should be recognized for purposes of applying section 3(40) of ERISA.

The Department's regulation at 29 C.F.R. § 2510.3-3(c) provides that for purposes of Title I of the Act and this chapter, the term "employee benefit

**plan” shall not include any plan, fund or program, other than an apprenticeship or other training program, under which no employees are participants covered under the plan. The regulation goes on to provide that, for this limited purpose, a partner in a partnership and his or her spouse shall not be deemed to be employees with respect to the partnership. Thus, a plan under which only partners are participants covered under the plan will not be covered under Title I. The regulation also noted, however, that a plan under which one or more common law employees, in addition to partners, are participants covered under the plan, will be covered under Title I. The regulation does address whether a partner is to be treated as an “employee” of a partnership for other purposes under Title I. See *Yates v. Hendon*, 124 S. Ct. 1330, 1334 (2004).**

**Staff believes section 3(40) of ERISA contemplates that a self-employed individual, such as a partner in a partnership, would be treated as an employee of the partnership for purposes of determining whether a plan that covers partners and other common law employees of the partnership is a MEWA. Thus, based on that view, staff felt that a plan sponsored by a partnership and covering only partners of the partnership (as described above) and common law employees of the partnership would be a single employer plan for purposes of section 3(40) of ERISA.**

**Question 20:** ERISA § 609 requires group health plans to establish reasonable procedures to determine whether medical child support orders are “qualified medical child support orders” (QMCSOs). As part of its reasonable procedures, can the plan require that the request to enroll the child be submitted no later than 30 days after the date the order is issued?

**Proposed**

**Answer 20:** No. Such a restriction would limit the group health plan’s ability to comply with the order, and would disadvantage the child for whom enrollment is sought.

**DoL**

**Answer 20:** **Staff agreed with the result in the proposed answer, but did not agree with the rationale. The primary reason should be that the QMCSO is intended to be portable and in 1997 Congress removed the requirement that the QMCSO specify the name of the plan to keep the order portable. The proposed restriction would frustrate that goal and, therefore, is not reasonable.**

**Question 21:** Under the ERISA claims procedures for group health plans, a claimant must be given at least 180 days to appeal an adverse benefit determination. If a group health plan provides for two levels of review, must the claimant be given 180 days to appeal to the first review level, and an additional 180 days to appeal to the second review level?

**Proposed**

**Answer 21:** Yes. Group health plans must afford claimants a reasonable opportunity to pursue a full and fair review at the second review level. Department of Labor Regulation § 2560.503-1(h)(3)(i) states that a group health plan will not be deemed to provide a reasonable opportunity for a full and fair review unless it provides at least 180 days to appeal.

**DoL**

**Answer 21:** Staff disagrees with the proposed answer. The Department has previously addressed this question in its “FAQs About The Benefit Claims Procedure Regulation,” question D-5. In that question, we stated that in the case of a plan with a two-level review process, the 180-day rule applies to the period to be afforded claimants to appeal to the first review level. While the regulation does not specifically address the period of time to be afforded claimants to pursue the second level of review, the regulation requires that a plan’s procedures must nonetheless be reasonable and, therefore, it is the view of the Department that plans must afford claimants a reasonable opportunity to pursue a full and fair review at the second review level. See 29 CFR § 2560.503-1(h)(1) and (3)(i).

**Question 22:** Participant divorces and former spouse waives all rights to participant's employee benefits. Participant informs employer that he desires to change beneficiary, but participant fails to provide new beneficiary forms to plan administrator. Shortly thereafter, participant dies. Participant's girlfriend provides to plan administrator beneficiary forms (purportedly completed by participant before his death) indicating girlfriend and participant's children as new beneficiaries. Beneficiary form on file with plan identifies former spouse as beneficiary. Plan's claim procedures include a “conflicts between claimants” provision which permits plan to withhold benefit until the conflict is resolved. Under these facts, must the plan administrator immediately process all “claims” for benefits (i.e., claims from girlfriend, children, and former spouse) within the time periods indicated in the claims procedures regulations, and then withhold payment of approved claims pending resolution of conflict of claimants? Alternatively, can the plan administrator require the claimants to first resolve the conflict (including a judicial determination, if necessary) before the plan administrator processes the claims?

**Proposed**

**Answer 22:** The plan administrator can require the claimants to resolve the conflict before processing the claims. To require the plan administrator to process claims first, then withhold payment pending conflict resolution, would be pointless since the court (or the claimants) will ultimately decide which claimant(s) will receive the benefit and how much.

**DoL**

**Answer 22:** There are not sufficient facts for staff to express a view on the question presented. However, suspending claims processing where there is a dispute between claimants, as described in the question, does not appear consistent with a plan fiduciary's duty to act in the interest of participants and beneficiaries pursuant to plan documents. That duty includes providing claimants with benefit claims determinations in accordance with the terms of the plan and the plan's benefit claims procedure. In a situation where there is a conflict between claimants over certain benefits, there may be circumstances where the plan fiduciary cannot resolve the dispute based on the terms of the plan and the plan may be justified in providing a benefit determination to both claimants indicating the nature of the impasse. With respect to the "conflict between claimants" provision, even where the plan fiduciary has made a determination based on the terms of the plan that one claimant is entitled to the benefits, it may be prudent for the plan fiduciary to withhold payment of the benefits while steps are taken to protect the plan from liability if a court were later to reverse the plan fiduciary's determination, e.g., filing an interpleader action.

**Question 23:** Suppose a plan (probably a defined benefit pension plan) generally does not allow lump sum distributions, except that prior to 2005 it forced cash outs at termination of employment if the then present value of the accrued benefit was no more than \$5,000. That practice provided a lump sum distribution form of benefit (albeit not an optional one) for participants with present values in that particular range.

Then, when the automatic rollover rules require automatic rollovers for lump sum distributions between \$1,000 and \$5,000, the plan drops its forced cash out threshold to \$1,000 and eliminates the lump sum distribution benefit between \$1,000 and \$5,000. We know from the regulations that lowering the forced cash out threshold in general does not violate 411(d)(6), but in most plans the participants still have an OPTION to get a lump sum distribution between \$1,000 and \$5,000 because most plans (particularly defined contribution plans) have a lump sum distribution option for the entire accrued benefit. For a plan that does NOT otherwise have a lump sum distribution, is there a 411(d)(6) issue with eliminating the entire lump sum distribution form of benefit within that \$1,000-\$5,000 range?

**Proposed**

**Answer 23:** Plans are permitted to lower the threshold for forced cash outs, and 411(d)(6) does not prevent that even if it means that a lump sum form of benefit is no longer available to participants who would otherwise have received a lump sum distribution

**DoL**

**Answer 23:** **Staff declined to comment on the proposed answer because the question concerns matters that are within the purview of the Treasury Department.**

**Question 24:** P, a participant in a multiemployer defined contribution pension plan (“Plan”) is called to active military service. P’s employer at the time is X Corp. P’s active military service lasts two years. During P’s period of military service, X Corp. files for bankruptcy and is liquidated.

Within 90 days of the completion of P’s military service, P is employed by Y Corp., which is also a contributing employer to Plan. Under USERRA, P must receive the contributions to Plan that he would have received had he not been called to military service. 38 U.S.C. § 4318(b)(1)(B) and § 1002.266(a) of the Final USERRA regulations state that since X Corp. no longer exists, the obligation is on Plan to make P whole. All participants in Plan are 100% vested in amounts contributed to Plan on their behalf.

Given the unavailability of forfeitures, from what source can Plan get the funds necessary to make the contribution to P’s account?

**Proposed**

**Answer 24:** Plan can allocate a portion of its investment earnings to P’s account. The contributions to P’s account would be made prior to the pro rata allocation of Plan’s investment earnings to other Plan participants based on their account balances. Because the earnings had not been credited to the accounts of other Plan participants at the time of the allocation to P’s account, this arrangement is consistent with the intent of the Senate Committee on Veterans’ Affairs, which stated that “[i]t is the intent of the Committee that, with respect to allocations to individual account plans under § 3(34) of ERISA, allocations to the accounts of returning service members not be accomplished by reducing the account balances of other plan participants.” S. Rep. No. 103-158, at 65.

If Plan’s investments are participant directed pursuant to § 404(c) of ERISA, Plan may allocate a pro rata portion of the investment earnings from each investment option in order to make the contribution to P’s account.

**DoL**

**Answer 24:** In order to answer the question, DoL staff assumed that the participant's pre service and post service employers were using a common hiring hall and that the participant had obtained employment with each through this hall, otherwise there would be no obligation to provide the benefit.

DoL staff said the burden is on the plan to provide the benefit. Using plan earnings "appears" to be one acceptable method of providing required contribution reinstatement, but DoL cautioned that VETS has jurisdiction over these issues. In response to follow up questions, DoL was uncomfortable with the concept that the other preexisting participant accounts in the plan could be charged for the reinstatement even though "earnings" that would have gone to preexisting accounts would be used for the reinstatement.

**Question 25:** Does the level of coverage that a health plan must provide under USERRA mirror the coverage that must be provided under COBRA, so that non-medical benefits such as life insurance and weekly wage replacement benefits can be excluded from the continuation coverage offered under USERRA?

**Proposed**

**Answer 25:** Under USERRA, 38 U.S.C. § 4307(7), health plan includes an insurance contract or contract, Medical or hospital service agreement, membership or subscription contract or other arrangement under which health services for individuals are provided, or the expenses of such services are paid. Regulation § 1002.163 provides that USERRA covers group health plans as defined in ERISA at 29 U.S.C. § 1191b(a), which means an "employee welfare benefit plan to the extent that the plan provides medical care (as defined in paragraph (2) and including items and sources paid for as medical care) to employees and dependent (as defined under the terms of plan) directly or through insurance, reimbursement or otherwise." This section under HIPAA specifically provides that certain benefits are not subject to the requirements imposed under HIPAA to group health plans, including coverage only for accident, or disability income insurance, ERISA § 706(c)(1); § 705(b). Life insurance, accidental death and dismemberment benefits and weekly wage replacement benefits although often provided as part of an employee welfare benefit plan that also provided Medical and hospital benefits are not health services and are not provided under insurance contracts that provide for health services or the payment of such services. Consequently, USERRA § 437 would not require a health plan to offer the right to extend these benefits and other non-health benefits, including those excepted benefits under ERISA § 706(c), such as scholarships or severance benefits, even if these benefits are provided under a single employee welfare benefit plan.

**DoL**

**Answer 25:** **Yes. Staff suggested there could be further clarifications from VETS. Section 4317 does not apply. Section 4316 states what the benefits rights are, seniority may apply and furloughs are not available.**

**Question 26:** If an individual dies while in Military service that otherwise would be entitled to protection by USERRA but for the individual's failure to return to employment, is the individual entitled to USERRA protection for the period of Military service, including pension benefit accrual and vesting rights?

**Proposed**

**Answer 26:** Yes.

**DoL**

**Answer 26:** **No. Pension rights flow from reemployment and therefore if an individual dies there are no rights.**

**Question 27:** Assume a plan fiduciary causes an individual account pension plan to pay an amount which is not an expense associated with the maintenance or operation of the plan. For example, the plan is threatened with a claim for damages from an unrelated third party, arising from an asset or investment activity of the plan. Is the resulting reduction in participant accounts a violation of the anti-alienation provision of ERISA § 206(d)?

**Rationale for**

**Question 27:** The foregoing general question is based on a specific fact pattern which is currently under DoL audit. We are informed that the specific facts have been submitted by the regional office to the national office for consideration. The actual facts involve a claim against a defined contribution plan by the EPA under CERCLA. The plan acquired a parcel of real estate in 1979 (prior to the passage of CERCLA in 1980). The property was sold by the plan in 1998. A "phase I" environmental report was prepared with the sale which indicated no environmental problems. In 2004 the EPA notified the plan that the parcel was part of a larger piece which was now subject to cleanup under CERCLA due to asbestos contamination. (The asbestos was found lying free on the ground, not a normal condition, and not part of a "phase I" investigation.) The EPA has now made demand on the plan to pay a share of the cleanup costs. The amount demanded, if paid by the plan, would represent a significant percentage of plan assets.

**Proposed**

**Answer 27:** I would suggest that § 206(d) prohibits alienation of a participant's account, whether directly (a creditor of the participant) or indirectly (such as here - a creditor of the plan which impacts the participant's account). However, I can find no support, either in the cases, prior DoL guidance or legislative history for this

position. (*Guidry* does suggest that § 206(d) is to be interpreted expansively.) Under these circumstances the only option may be for the plan sponsor to pay on behalf of the plan, although that raises tough issues with the IRS about “restorative payments,” especially when there is no clear fiduciary breach, either raised or claimed. This may also be difficult for a plan sponsor with limited resources.

**DoL**

**Answer 27:** Since the specific fact pattern is the subject of an ongoing audit, the staff declined to answer. Further, staff noted that interpretation of the anti-assignment and alienation provisions in section 206(d) of ERISA are within the interpretive authority of the Treasury Department.

However, staff noted that section 514(d) provides that nothing in Title I of ERISA shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States or any rule or regulation issued under any such law. More generally, staff also noted that, under a defined contribution plan, a participant’s benefits are dependent on his account balance, which in turn is dependent on the amount of contributions made on his behalf, the gains and losses attendant to the investments made on behalf of the account, and the reasonable and necessary expenses of administering the plan. Any liability associated with an investment may affect the rate of return on such investment.

**THE PRECEDING QUESTIONS AND ANSWERS ARE BASED ON INFORMAL DISCUSSIONS BETWEEN PRIVATE-SECTOR REPRESENTATIVES OF THE JCEB AND DEPARTMENT OF LABOR STAFF. THE QUESTIONS WERE SUBMITTED BY ABA MEMBERS AND THE RESPONSES WERE GIVEN AT A MAY 3, 2006, 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 DEPARTMENT OF LABOR. FURTHER, THIS REPORT ON THE DISCUSSIONS WAS PREPARED BY JCEB REPRESENTATIVES, BASED ON THEIR NOTES AND RECOLLECTIONS OF THE MEETING.**