

**Questions for the Department of Labor Staff for the
2005 Joint Committee of Employee Benefits Technical Session
Held on May 18, 2005, at 10:00 A.M.**

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: As part of their requirement of a “full and fair review” of adverse benefit determinations, the ERISA claim and review regulations require that employee benefit plans’ claims procedures provide the claimant with copies of all documents “relevant” to the claimant’s claim for benefits. In the case of a plan providing disability benefits through an insurance policy, where the insurer acts as claims fiduciary and makes all decisions to approve or deny claims, certain documents defined as relevant by 29 C.F.R. § 2560.503-1(m)(8) are usually in the possession of the insurer, who is often not the plan administrator named in the plan. These include, among others, documents relied on in making the benefit determination; the records submitted, considered, or generated during the course of making the benefit determination; documents demonstrating compliance with administrative processes and safeguards; and documents constituting a statement of policy or guidance concerning the denied treatment option or benefit for the claimant’s diagnosis. *See* 29 C.F.R. § 2560.503-1(m)(8).

ERISA § 502(c) allows claimants to recover penalties for failure to produce documents during the claim and review process, but as phrased, it limits its reach to “any administrator” who fails to produce such documents within 30 days. However, many insurers acting as claims fiduciaries do not meet ERISA’s definition of administrator if, indeed “administrator” in the regulation is construed to mean “administrator” within the meaning of ERISA § (3)(16)(A): they are often not formally designated as the “plan administrator” in the plan document, are not the plan sponsor, and have not been designated an administrator by the regulations. *See, e.g., Moran v. Aetna Life Ins. Co.*, 872 F.2d 296 (9th Cir. 1989). Insurers thus often avoid liability for failure to produce documents to claimants. The named plan administrator does not generally have possession of the documents listed above.

Is it the intent of the Department of Labor (DoL) that an ERISA claims fiduciary in possession of documents required to be produced to claimants avoid liability when it fails to produce those documents to claimants?

Proposed

Answer 1: The ERISA claims fiduciary must produce those documents that are relevant to the claims denial.

DoL

Answer 1: Staff agreed that for a plan's claims procedure to meet the full and fair review requirements in 29 C.F.R. § 2560.503-1(h)(2), the claimant must be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records other information relevant to the claimant's claim for benefits. Whether a document, record or other information is relevant is to determined by reference to 29 C.F.R. § 2560.503-1(m)(8). Staff noted that the claims procedure regulation does not limit this disclosure obligation to documents in the possession of the plan administrator. Accordingly, staff does not agree that ERISA § 502(c)(1)'s provisions on court imposed civil penalties governs the issue of what documents must be provided to claimants in order for the plan to have a reasonable claims procedure that complies with ERISA section 503 and the Department's claims procedure regulation.

Furthermore, as staff indicated in response to a similar question last year, when entering into service contracts, plan fiduciaries must ensure that they have access to all plan records necessary to fulfill their obligations in accordance with the plan documents and ERISA (including the ability to make required disclosures under the plan's claims procedure regulation). Staff noted that, consistent with the Department's views on electronic recordkeeping, plan recordkeeping arrangements may not be subject to any agreement or restriction that would, directly or indirectly, compromise a fiduciary's ability to comply with obligations under Title I of ERISA. Staff suggested as a means of addressing this issue that the plan fiduciary entering into the contract ensure the contract's terms describe the rights of the plan to documents, records and information and the obligations of the service provider to make the documents, records and information available.

Question 2: Suppose that with the assistance of a plaintiff's lawyer, an alternate payee receives benefits under a QDRO or a participant or beneficiary is awarded benefits under the terms of a lawsuit. If the plaintiff's lawyer provides proper notice, under applicable state law, of an attorney's lien on a portion of the benefit payable to the alternate payee, participant, or other beneficiary, is the plan required to pay the amount claimed under the lien to the attorney or required to refrain paying the individual the full amount awarded per the court order?

Proposed

Answer 2: No. The attorney's lien relates to an employee benefit plan, changes the amount payable to the participant or beneficiary, and requires significant changes in the plan's administrative processes, and thus is preempted. The lien amounts to an attachment of benefits. *See Trustees of the Western Conf. of Teamsters Pension Trust Fund v. Kramer*, No. C81-554, 1981 U.S. Dist. LEXIS 17588 (D. Mass. Dec. 30, 1981). The Federal District Court decision, noted in *LeFevre, Zeman, Oldfield & Schwarm Law Group v. Wal-Mart Stores, Inc.*, 706 N.E.2d 130 (Ill. App. Ct. 1999), was incorrect in determining that an attorney's lien does not relate to an ERISA plan.

DoL

Answer 2: DoL staff agreed with the result set forth in the proposed answer for pension benefit plans, but based on a different analysis than provided. Rather than preemption, the staff would base their analysis on the anti-alienation clause, over which the IRS has interpretive jurisdiction. IRS regulations interpret it broadly, and existing guidance specifically prohibits alienation by way of an attorney's lien. *See I.R.S. P.L.R. 7920005* (Feb. 14, 1979) and 26 CFR § 1.401(a)-13(b)(1).

Question 3: Does the plan administrator have an obligation to allow parties to assign interest credits under a cash balance plan as of a prior date even if the plan administrator must manually determine the division of the interest credits? Can a plan administrator require the parties to assign interest credits only prospectively? For example, a QDRO is qualified on 7/1/05. The QDRO states that the AP is due to 50% of the balance as of 1/1/05. Can the plan administrator require that the parties assign interest credits only from 7/1/05 onward, or does the plan administrator have to allow the parties to assign interest credits from 1/1/05 to 7/1/05?

Proposed

Answer 3: The period for giving notice of the issuance of the Disability Determination Letter had 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 until after the end of the 18 month period, the rule in Regulation 29 C.F.R. § 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 3: DoL staff stated that the response to the question was fact dependant and there was not enough information in the question to respond. DoL staff stated that the answer would not always be no. For example, it would be necessary to know when the distribution took place in order to properly respond.

Question 4: This question involves special enrollment rights upon reaching a lifetime limit. In the December 2004 final HIPAA portability regulations, “[s]pecial enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible.” 29 CFR § 2590.701-6(d)(2). The provisions of the 2004 final regulations that address special enrollment for individuals who lose coverage include as a loss of eligibility “[a] situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits[.]” 29 CFR § 2590.701-6(a)(3)(i)(D). In addition, the language describing when the special enrollment right is available was changed to delete references to “other” coverage and when coverage under the plan “was declined by the employee[.]” (The 1997 interim regulations provided that an employee was eligible for special enrollment, in part, “if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was *declined* by the employee, the employee was covered under *another* group health plan or had *other* health insurance coverage[.]” 29 CFR § 2590.701-6(a)(2) (emphasis added). The 2004 final regulations read: “When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage[.]” 29 CFR § 2590.701-6(a)(2)(i)(B).) Do these provisions, when read together, mean that if a plan offers several options, with different lifetime limits (for example, some have a \$1 million lifetime limit and others have a \$2 million lifetime limit), or if all options under a plan have the same lifetime limit but the benefits are not integrated (i.e., benefits paid under one option do not count as benefits paid under a different option) an employee who is enrolled in the plan and has reached the lifetime limit under one option has a special enrollment right in another option of the same employer’s plan?

Is the answer the same if the different options are not offered under a single plan but, instead, are offered under separate plans?

Proposed

Answer 4: An employee or dependent who reaches a lifetime limit under one option of an employer's multi-option plan has a special enrollment right and may enroll in a different option of the same employer’s plan. If all options under the plan have the same lifetime limit, but the benefits are not integrated, reaching the lifetime limit under one option would constitute a loss of eligibility that would trigger a special enrollment right, and the employee could enroll in a different option under the same plan. (For example, an employee who enrolled in an option with a \$1

million lifetime limit, and reached the limit, could enroll in another option, also with a \$1 million lifetime limit, but because the benefits are not integrated, the employee would have a brand new lifetime limit and would have \$1 million in benefits available.) If the benefits are integrated, but various options under the plan have different lifetime limits, an employee who reached the lifetime limit under one option could enroll in a different option with a higher lifetime limit. (For example, an employee who enrolled in an option with a \$1 million lifetime limit could, upon reaching that limit, enroll in a different option under the same plan with a \$2 million lifetime limit. Even if the plan integrated the benefits under all options, the employee would, upon enrolling in the option with a \$2 million lifetime limit, still have \$1 million in benefits left.)

However, because the 2004 final regulations (like the 1997 interim regulations) provide that “[a] group health plan . . . is required to permit [certain individuals] to enroll for coverage under the terms of the *plan*[,]” 29 CFR § 2590.701-6(a)(1) (emphasis added), an employee who reaches a lifetime limit under one plan is not eligible for special enrollment in a different plan of the same employer.

DoL

Answer 4: DoL staff agreed with the first paragraph of the proposed answer, but not with the second. If a person reaches a lifetime limit for benefits, then it is considered a loss of eligibility for coverage and it triggers special enrollment rights. If the person loses coverage under one option in a plan due to a lifetime limit, they may use a special enrollment period to enroll in another option of the same plan if there is coverage available under the other option (that is, an HMO and an indemnity package in the same plan could be separate options). If a person loses eligibility the special enrollment rights apply to all benefit packages in the same plan. If the lifetime limit covers all benefit options, then there is no ability to change. Accordingly, when coverage is organized as two benefit package options under one plan, special enrollment rights depend on whether a lifetime limit is integrated. In contrast, when an employer organizes his coverages into two separate plans, because lifetime limits cannot be integrated across plans, employees can generally special enroll in the second plan when a lifetime limit is reached in the first plan.

Question 5: A plan’s benefit consulting firm/service provider is paid entirely through revenue sharing, the terms of which are fully disclosed. The service provider contracts to provide plan consulting/document services at no additional charge. In year two, the service provider provides consulting services relating to a plan design issue and implements the design via a formal amendment. Does this arrangement violate ERISA?

Proposed

Answer 5: Yes. The consulting service will be deemed to be paid via revenue sharing which in turn will be tantamount to paying such expense with plan assets. The ERISA violation occurs due to the fact that a settlor function expense, in this case the design decision, will be deemed to have been paid with plan asset in violation of ERISA.

DoL

Answer 5: The DoL staff was skeptical as to whether the amount received by the service provider could represent no more than reasonable compensation for the services provided in year one, if that provider can provide the additional plan design and amendment services for no additional compensation. However, if that is the case, it is not violative for a service provider to provide services that are considered settlor in nature if it is not receiving additional compensation. On the other hand, if the service provider is either receiving additional compensation, or is reducing the other services it provides to the plan, then the plan design and amendment services that are paid for through revenue sharing based on plan investments would be deemed to be paid through the use of plan assets, and would constitute a violation. In the alternative, it is possible that the amount received by the provider in years in which it does not provide plan design and amendment services is more than reasonable, in which case the arrangement would not satisfy the conditions of section 408(b)(2).

Question 6: A plan has a loan provision. It provides that loans are available to all participants in the plan on a uniform basis, and that loans must be repaid through payroll withholding. It also contains a suspension provision for loan repayments for authorized leave of absences. A participant goes out on a leave of absence without pay. Can the participant take a loan from the plan?

Proposed

Answer 6: No. Because the loan policy requires that loans must be repaid via payroll withholding, a participant on a leave of absence without pay at the time a loan is initiated cannot obtain a loan from the plan. To allow a loan would be an improper distribution. The terms of the loan policy would be violated, since at the time of issue there is no intent or ability to repay via payroll withholdings.

DoL

Answer 6: First, the statement in the proposed answer concluding this was an improper distribution was not a Department of Labor issue, and staff would not address it.

Second, DoL staff analyzed whether these facts presented a circumstance whereby the loans would not be available on a reasonably equivalent basis to all participants and beneficiaries as required by ERISA § 408(b)(1) (a prohibited transaction exemption). According to staff's analysis, that determination is made

looking at all of the facts and circumstances. Staff noted in particular that the preamble to Labor Regulations § 2550.408b-1 discussed a plan administrator's flexibility to permit some differentiation in the availability of loans. Assuming that the plan administrator in this question had the authority to interpret the plan documents' loan provisions, this loan provision could satisfy the reasonably equivalent standard. It could then be a reasonable determination by the fiduciary not to loan (or to loan) in these circumstances.

In the follow-up discussions after the answer, it was stated that this could be viewed as a plan drafting issue. DoL staff stated that it would be permissible in these circumstances to state in the plan document that no loans would be available to those who, for example, cannot repay the loans through payroll withholding and then to deny loans in this situation on that basis. They also stated that analyzing the borrower's ability to repay a loan could be another basis for a denial in this situation because the regulations permit different treatment on the basis of financial factors which a commercial lender would deem important.

Question 7: Does this change if the leave is military leave?

Proposed

Answer 7: No. The result would not change. If the terms of the loan - repayment via payroll withholding - cannot be met at the time the loan is initiated, then a loan is not allowed, regardless of the reason for the leave of absence.

DoL

Answer 7: Assuming the plan administrator has made a reasonable interpretation of the plan documents' loan provisions, DoL staff agrees with the proposed answer that the result would not change. It was noted that this fact pattern may raise issues under the Servicemembers Civil Relief Act.

Question 8: If the loan policy does not require payment via payroll withholding, can the participant take a loan?

Proposed

Answer 8: Yes. Since the loan is available to all participants equally, and no stipulation on the method of repayment applies, the participant can receive a loan and make payments outside of payroll withholdings.

DoL

Answer 8: DoL staff agreed with the proposed answer.

Question 9: If more than 25% of the equity interests in a limited partnership (“LP”) are owned by benefit plan investors (“BPIs”), none of which is subject to ERISA (e.g., state and foreign pension plans), is the LP a BPI under 29 C.F.R. § 2510.3-101(f)(2)(iii)?

Proposed

Answer 9: No. The underlying assets of the LP are not “plan assets” because none of the BPIs investing in the LP is subject to ERISA. Therefore, this LP is not covered by § 2510.3-101(f)(2)(iii).

DoL

Answer 9: DoL has this issue under consideration and therefore staff declined to answer.

Question 10: Assume a standard master-feeder arrangement. Is the 25% test of 29 C.F.R. § 2510.3-101(f) applied at the feeder level? If it is applied at the feeder level and BPIs hold more than 25% of the feeder, is the feeder counted as a 100% BPI investor for testing at the master level?

Proposed

Answer 10: No and N/A. Inasmuch as the master is actually the investment entity in question, testing should be done only at the master level without regard to the existence of intermediary entities, which are created for tax and other non-ERISA-avoidance reasons. If the answer to the first question is, nevertheless, ‘yes,’ in testing at the master level, intermediary entities should be “looked through” to ascertain the real BPI participation level.”

DoL

Answer 10: DoL has this issue under consideration and therefore staff declined to answer.

Question 11: What time limit may a group health plan impose for notice of a second qualifying event provided by a covered employee or qualified beneficiary to the plan?

Proposed

Answer 11: A plan may require notice of a second qualifying event to be provided within 60 days after the later of: (i) the date on which the second qualifying event occurs; or (ii) the date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the plan's general COBRA notice, of both the responsibility to provide the second qualifying event notice and the plan's procedures for providing such notice to the administrator.

DoL Reg. § 2590.606-3(c)(1) sets forth the deadline that a plan may impose both for notice of qualifying events and for notice of second qualifying events, on a combined basis, as follows: 60 days after the latest of: (i) the date on which the

relevant qualifying event occurs; (ii) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (iii) the date on which the qualified beneficiary is informed, through the furnishing of the plan's summary plan description or the plan's general COBRA notice, of both the responsibility to provide the notice and the plan's procedures for providing such notice to the administrator. The date mentioned in clause (ii) immediately above (the date on which plan coverage is lost) is not relevant when a qualified beneficiary or covered employee provides notice of a second qualifying event because plan coverage already was lost as a result of the first qualifying event and COBRA coverage in effect at the time of a second qualifying event cannot be terminated due to the second qualifying event. A deadline that is 60 days from the loss of coverage is relevant in the context of a qualifying event, but not in connection with a second qualifying event.

DoL

Answer 11: Staff felt the suggested answer was basically correct with a caveat. As stated in the preamble to the final regulation (69 Fed. Reg. 30084 30087 (May 26, 2004)), the time limits included in the regulation for the furnishing of notices by qualified beneficiaries of qualifying events (including second qualifying events) are minimum time limits that may be imposed by a plan and there is nothing in the regulation that would prevent a plan from providing longer periods for furnishing these notices. As such, it is best to read the regulation as requiring a plan to provide a qualified beneficiary at least 60 days after the later of: (i) the date on which the second qualifying event occurs; or (ii) the date on which the qualified beneficiary is informed of both the responsibility to provide the second qualifying event notice and the plan's procedures for providing such notice to the administrator.

Question 12: Bona fide wellness program rewards. May an employer take reasonable steps, in designing a reasonable alternative for individuals whose medical condition unreasonably prevents them from satisfying the otherwise applicable bona fide wellness program standard, to ensure that the reasonable alternative is made available only to such persons? For example, assume Employer X requires employees, in conjunction with an annual open enrollment period, to certify that they are smoke-free, and participants who do not provide the certification are assessed a monthly surcharge equal to 10% of the monthly cost of employee-only coverage. The employer also allows persons who have a nicotine condition, and for whom it would be unreasonably difficult to provide the smoke-free certification, to avoid the surcharge by agreeing to participate in a 6-week smoker cessation program. The employer, however, only offers this reasonable alternative to employees who timely complete a “nicotine addiction certification form” co-signed by a physician. The form requires the employee to provide information concerning his or her smoking habit, and requires a physician to opine that, based on such information, the employee has a nicotine addiction and

that the addiction is sufficiently long-standing and severe that it would be unreasonably difficult for such a person to promptly stop smoking. The form does not impose any standards on the physician. It is left to the discretion of the physician to certify whether the employee has a nicotine addiction. All employees who fail to submit a fully completed form on a timely basis (by end of open season), will be assessed the surcharge, regardless of whether the person participates in the smoking cessation program.

Proposed

Answer 12: Prop. Reg. § 2590.702(f)(iii) allows employers and insurers to make a wellness reward program available to all similarly-situated individuals, and employers and insurers are free to take reasonable steps to assure which individuals are, in fact, similarly situated. This allows employers and insurers to take objective measures to allow them to reasonably determine whether an individual, due to a medical condition, would find it unreasonably difficult to satisfy the otherwise applicable standard for bona fide wellness rewards. The measures proposed in your example are reasonable and permissible measures by which an employer may determine which of its employees suffer from a medical condition and would be unreasonably prevented from satisfying the smoke-free standard to obtain the reward.

DoL

Answer 12: The DoL agrees with the proposed answer. Proposed & interim Regulation § 2590.702(f)(iii) does allow employers and health insurance issuers to take objective measures to adequately determine whether an employee or covered individual has a “medical condition,” or due to a health factor would find it unreasonably difficult to satisfy the otherwise applicable standards for a bona fide wellness program reward. A plan may request evidence that the individual cannot meet the standard because of a health factor. The measures required by Employer X in the question are reasonable measures reasonably calculated to determine if an individual has a medical condition or if it would be unreasonably difficult for such a person to meet the standard necessary to obtain the program reward. If an individual cannot meet a standard related to health (e.g., weight or smoking), the plan must have a reasonable alternative.

Question 13: Does the automatic rollover safe harbor apply to mandatory distributions greater than \$1,000 which are made to participants who have attained the later of age 62 and the plan's normal retirement age?

Proposed

Answer 13: The DoL Regulations were not intended to exclude such distributions from the applicability of the safe harbor and written clarification is forthcoming. Section 2550.404a-2 of the Department of Labor Regulations provides a safe harbor under which a fiduciary of an employee benefit pension plan will be deemed to have

satisfied his or her fiduciary duties under § 404(a) of ERISA in connection with an automatic rollover of a mandatory distribution. Specifically, § 2550.404(a)-2 provides that the safe harbor applies to (i) mandatory distributions described in § 401(a)(31)(B) of the Internal Revenue Code of 1986 (the “Code”), and (ii) mandatory distributions of \$1,000 or less, even though such mandatory distributions are not described in § 401(a)(31)(B) of the Code.

However, Q&A-2 of IRS Notice 2005-5 defines the term “mandatory distribution” to exclude, for purposes of § 401(l)(31)(B) of the Code, a mandatory distribution which is made to a participant who has attained the later of age 62 and normal retirement age. Thus, the safe harbor as described in the DoL Regulations does not appear to extend to mandatory distributions greater than \$1,000 which are made to participants who have attained the later of age 62 and normal retirement age.

DoL

Answer 13: DoL staff disagreed with the Proposed Answer and stated that no written clarification or guidance is forthcoming.

DoL Regulation 29 C.F.R. § 2550.404a-2 was intended to provide a safe harbor for mandatory distributions to individual retirement accounts or annuities made pursuant to § 401(a)(31)(B) of the Code. The safe harbor set forth in 29 C.F.R. § 2550.404a-2 does not and cannot attempt to define what constitutes a mandatory distribution under that (or any) section of the Code. That is under the control of the IRS and the Department would defer to the Service on the determination of what is a mandatory distribution. *See Q & A -2, Notice 2005-5*, which states that for the purpose of § 401(a)(31)(B), the term “mandatory distribution” **excludes** a distribution made to a participant who has attained the later of age 62 and normal retirement age. The safe harbor applies only to the extent that a distribution is a mandatory distribution under Code § 401(a)(31)(B) as interpreted by the IRS.

Question 14: *In Sheckley v. Lincoln Nat’l Corp. Employees’ Ret. Plan*, 366 F.Supp.2d 140 (D. Me., 2005), a U.S. District Court enforced a retirement plan’s 6-month limitation period for filing lawsuits. The court stated that the applicable federal regulations do not “require that the Plan’s notification of his right to file a civil action include the contractual time period within which such action must be filed.” Does the Department of Labor agree with this statement?

Proposed

Answer 14: No. The claims procedure regulations require notices of adverse benefit determinations on review to include a statement of the claimant’s right to bring an action under ERISA § 502(a). If a plan’s provisions limit the time period in which an action may otherwise be brought under ERISA

§ 502(a), the statement of the claimant's right to bring an action must clearly describe this limitation.

DoL

Answer 14: The claims procedure regulation provides, in the case of an adverse benefit determination, that the notification shall set forth a “statement of the claimant’s right to bring an action under section 502(a) of the Act” See 2560.503–1(g)(iv) & (j)(4). In most cases, such a statement would not have to include the applicable statute of limitations for filing an action under section 502(a) of the Act. However, staff felt that where a plan includes terms that shorten the otherwise applicable limitations period, the statement of the claimant’s rights in the notification would be incomplete, possibly even misleading, unless it identified the shorter timeframe. Staff also noted that issues beyond the scope of the Department’s claims procedure regulation may be presented by the question. See *Wang Laboratories, Inc. v. Kagan*, 990 f.2d 1126 (9th Cir. 1993), and *Central States, Southeast and Southwest Areas Pension Fund v. The Kroger Co.*, 2003 WL 1720023 (N.D. Ill.) (choice of law clause in an ERISA contract should be not be upheld if unreasonable or fundamentally unfair). See also 29 C.F.R. 2560.503-1(b)(3).

Question 15: Does the \$110 a day civil penalty in ERISA § 502(c)(1) apply to failures to provide relevant documents under the ERISA claims procedures? If the employer is the named Plan Administrator, but a TPA or insurer handles the initial determination and appeal and refuses to provide the claim documents, who would be subject to the penalty?

Proposed

Answer 15: The \$110 a day civil penalty may be assessed against a Plan Administrator who fails or refuses to comply with a request for information which the Plan Administrator is required to furnish to the participant or beneficiary under Title I of ERISA. The claims procedures are in Title 1 of ERISA. Therefore, the Plan Administrator's failure to provide relevant documents under the ERISA claims procedures could result in the Plan Administrator's personal liability for the civil penalty. However, the penalty would not apply if the failure or refusal resulted from matters reasonably beyond the Plan Administrator's control, such as the TPA or insurer refusing to provide the necessary documents.

DoL

Answer 15: Staff agreed that the ERISA section 502(c)(1) penalty reaches requests for relevant documents under the claims procedure, and that the penalty is limited to plan administrators and is imposed by the court not assessed by the Department. Whether the failure or refusal by a TPA or insurer to provide relevant documents is “reasonably beyond the plan administrator’s control,” however, is a factual

question that can only be answered based upon the individual circumstances. Staff noted that in the preamble to the final rule under section 2520.104a-8 implementing ERISA section 104(a)(6) (DOL requests for plan documents), the Department stated that in the event another fiduciary of a plan has custody of or control over a document requested under ERISA section 104(a)(6), or if an administrator engages a third party to perform services for the plan and, pursuant to the engagement, the third party has custody of or control over such documents, the administrator's lack of custody would not be considered by the Department to be a matter reasonably beyond the administrator's control. As staff noted in response to Question 1 above, when a plan administrator enters into a contract with any service provider, the plan administrator must ensure that he/she has access to all records necessary to fulfill his/her obligations in accordance with the plan's documents and Title I of ERISA.

Question 16: Under ERISA § (3)(40), a MEWA by definition provides benefits “to the employees two or more employers (including one or more self-employed individuals).” A partnership maintains a health plan for its employees and partners. All the partners are self-employed. Is the health plan a MEWA because it provides benefits to the employees of two or more employers (including self-employed)?

Proposed

Answer 16: Although the health plan is technically a MEWA, the Department of Labor is not interested in pursuing enforcement where all health plan participants are employees and partners of the same partnership.

DoL

Answer 16: Staff thought the proposed answer misapplies the reference in section 3(40) of ERISA to self-employed individual. Staff indicated that assuming the partners are working owners with respect to the partnership, a self-employed partner in a partnership should be treated as an “employee” of the partnership as that term is used in section 3(40) for purposes of determining whether a plan that covers partners and other common law employees of the partnership is a MEWA. Thus, staff felt that 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 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, 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, partners in a partnership and the partners' spouses 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 not 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).

A follow-up question was asked regarding an arrangement offering or providing health benefits maintained by one employer and covering common law employees of the employer and several independent contractors. DoL staff indicated that they would generally read the reference to self-employed individuals in section 3(40) as resulting in such arrangements being MEWAs. DoL staff said they were assuming for purposes of the discussion that none of the exceptions to the MEWA definition applied and further assuming that the question did not involve any issue of independent contractors who were former employees of the employer receiving coverage under the arrangement based on being former employees. DoL staff also indicated that because they have a pending advisory opinion request on the subject, they were not prepared to provide an answer in this context on the issue of whether a health plan maintained by a single employer would be a MEWA if it were extended to cover non-employee members of the employer’s board of directors.

Question 17: An employer transmits money to be used for health and welfare benefits to a third party administrator (TPA). In some instances, the money is put into a trust and in other instances it is only put into a bank account. Whatever funds are not used by the end of the year to provide self funded health benefits is then forwarded to a qualified pension/retirement plan. Does this arrangement violate ERISA?

Proposed

Answer 17: Yes. Funds segregated from an employer’s general assets, designated to provide employee benefits, and held for more than 90 days must be held in a trust. Such funds specified to provide health and welfare benefits cannot be re-classified at a later point in time to provide retirement benefits; yet, in this situation the funds are being sent from one account (which may be a trust account or a bank account) to a qualified retirement plan. If the funds are properly considered retirement funds, then they are not contributed to the plan within the quarter that they were earned in all instances. The funds being used for the employee’s retirement accounts are simply surplus funds not needed for the self-funded health benefit plan

DoL

Answer 17: DoL staff generally agrees with the proposed conclusion that employer funds segregated from the employer’s general assets and designated to provide health and welfare benefits cannot subsequently be re-designated and then contributed to

a retirement plan. Staff assumes that only employer contributions are involved (a violation would clearly exist if employee contributions were involved). The issue presented is whether the employer funds transmitted to the TPA become assets of the employer's welfare plan (or its self-funded health plan if maintained as a separate plan) when deposited in a trust or in a bank account. If so, then contributing those assets to a qualified retirement plan would violate ERISA § 406(b)(2) and the exclusive benefit rule. In addition, if that retirement plan contribution reduced the employer's pension funding obligation, then § 406(b) and the anti-inurement rule of § 403(c)(1) would be further implicated. These conclusions would not apply if the retirement plan contribution is made after the health plan is properly terminated and all of its claims and obligations are satisfied.

Staff observed that the plan asset status of the employer funds is generally determined based on ordinary notions of property rights, taking into account the facts and circumstances. Relevant facts and circumstances include: (i) whether the employer funds are deposited in a trust or in a bank account in the name of the health plan (that fact alone would preclude contributing the funds to a retirement plan), (ii) whether participants and beneficiaries are given representations stating or implying that the employer funds are held separately from the employer's general assets for the benefit of the health plan or alternatively for the benefit of both plans (if participants are told these are for both plans then may not be health plan assets), and (iii) whether the TPA contract makes the TPA responsible for the payment of benefits upon forwarding of funds by the employer or merely processes payments on behalf of the employer. Whether and when employer funds become plan assets is an inherently factual question.

Staff considered the alternative that the employer funds might be held by an escrow agent, which would have authority to distribute some portion of the funds to the retirement plan. Under this alternative, title to the employer funds would be in the escrow agent, which would not have authority to return funds to the employer. Staff did not express a conclusion regarding this alternative, but noted two possible analyses: (i) the escrow agent is a plan fiduciary acting under a conflict of interest, or (ii) the escrow agent is acting for the employer to facilitate payment of employer funds, in which case the escrow agent might not be a fiduciary and the escrowed funds might not be plan assets. Additional information about the facts and circumstances is needed for further analysis. One factor relevant to determining the plan asset status of the escrowed funds is whether the escrow agent exercises discretion in allocating the funds between the health and retirement plans.

In follow up discussion, DoL staff stated that employee contributions are always plan assets subject to the fiduciary rules of ERISA regardless of their characterization by the IRC.

Question 18: The Wage and Hour Division enforces the regulations enacted under the Davis Bacon Act and the Service Contract Act. These regulations require that a government contractor, pay its employees additional fringe dollars or provide “bona fide” benefits with those dollars. Does the DoL consider a Health Savings Account (HSA) to be a “bona fide” benefit for which a contractor could take credit against its fringe benefit requirement?

Proposed

Answer 18: Yes.

DoL

Answer 18: The Department is currently considering the issue and guidance is expected later in 2005.

Question

19A: Automatic enrollment 401(k) pension plans increase the employee's likelihood of actually having a retirement income. And, automatic enrollment medical benefit plans also increase the likelihood that employees and their beneficiaries will actually have medical benefits. Does the DoL agree that there would be a breach of fiduciary duty under § 404(a)(1)(D) if a plan fiduciary complies with a plan's automatic enrollment provision in the face of a state law prohibiting deductions from employee's paychecks without express permission?

Proposed

Answer

19A: A plan fiduciary who complies with a plan's automatic enrollment provision, who received a court order under state law preventing the diversion of employee pay to the plans without express employee permission, would face a breach of fiduciary duty claim under § 404(a)(1)(D)--if nothing else—as a result of such state law court order.

DoL

Answer

19A: Staff stated that this issue is currently under consideration and anticipates that a response will be forthcoming in the reasonably near future. In light of the status of the issue, staff could not comment on the proposed answer.

Question

19B: Same facts as above. Does ERISA preempt state laws that prohibit deductions from employee's paychecks without express permission?

Proposed

Answer

19B: Yes because it relates to a plan and isn't saved under the savings clause.

DoL

Answer

19B: Staff stated that this issue is currently under consideration and anticipates that a response will be forthcoming in the reasonably near future. In light of the status of the issue, staff could not comment on the proposed answer.

Question 20: IRC §105(b) requires that for amounts paid under an employer sponsored group health plan for an employee's dependents to be excluded from the employee's gross income, the dependent must meet the qualifications of IRC §152. Under the Working Families Tax Relief Act of 2004, the definition of qualified child requires that the individual share the same principal place of abode as the taxpayer (IRC §152(c)(1)(B)) and who has not provided for more than one-half of his/her own support (IRC §152(c)(1)(D)). This limitation on the eligibility of dependent children applies to group health plans, health care flexible spending accounts and health reimbursement accounts.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) amended the Social Security Act to require that states amend their laws so that insurers (and for the purposes of this provision ERISA plans were included within the definition of insurers (*see* 42 USC § 1396g-1(b)), were prohibited from denying enrollment under a parent's health care coverage on the grounds that: (a) the child was born out of wedlock, (b) the child is not claimed as a dependent on the parent's federal income tax return, or (c) the child does not reside with the parent or in the insurer's service area. On information and belief, all 50 states have passed such laws.

These requirements appear to be conflict because in order for a dependent child to be entitled to receive health care coverage under an employer-sponsored plan or arrangement on a tax-qualified basis, he or she must qualify as a dependent under IRC § 152 and/or be claimed as a dependent on the taxpayers income tax returns, while the state laws mandated by OBRA '93 expressly prohibit insurers, including ERISA-regulated plans, from imposing these requirements in order for children to be eligible for coverage under their parents' health care coverage.

Proposed

Answer 20: While it is possible to resolve this apparent conflict by allowing children that do not qualify as tax dependents under IRC §152 to be eligible for health care coverage under their parents' coverage, but to include the cost of such coverage and any amounts expended for medical expenses on their behalf in their parents' gross income, the better solution would be for natural born and adopted children,

and children for whom the taxpayer is the legal guardian, to be eligible for coverage under an employer-sponsored plan for the reasons set forth in OBRA '93 and to have the amounts paid on their behalf excluded from the gross income of their parents.

DoL

Answer 20: This is within the jurisdiction of the IRS and HHS, not the Department of Labor, and thus the DoL would defer to these other agencies

Question 21: May a claims adjudicator deciding either an initial disability claim or a disability claims appeal involving medical judgments deny the demand of counsel for the participant/claimant that it not consult with the participant/claimant's physician or any other medical professionals or other independent experts without including the participant/claimant's attorney in the meeting or conversation? Assume for this purpose the plan document makes it clear that as a condition to receiving benefits the participants must cooperate by providing the plan's claims adjudicators with access to information and that the participant has the burden of proof regarding the existence of a covered disability.

Proposed

Answer 21: One of the leading cases regarding representation by an attorney, *Grossmuller v. Int'l Union, UAW, Local 813*, 715 F.2d 853, 857 (3d Cir. 1983) stresses that it is a fundamental tenet of ERISA jurisprudence that the plan fiduciaries must be permitted "to operate claims procedures without the formality or limitations of adversarial proceedings." The case law makes it clear that although participants may act through counsel, their representative need not be permitted to attend even the final appeal deliberations. By the same token, participants should be given an opportunity to consider and respond to information that the claims adjudicators rely upon. Therefore, the claims adjudicators should be allowed to refuse to allow the participant's counsel to impede the fact gathering process as long as the claim adjudicators inform the participant or his or her representative of the advice they receive or the information they learn (to the extent it is not merely cumulative) in a timely fashion so they may respond.

DoL

Answer 21: Section 503 of ERISA and the DoL's regulation at 29 CFR 503-1, do not require, in the absence of a plan term to the contrary, that the plan agree that it will not consult with the participant'/claimant's physician or any other medical professionals or other independent experts without including the participant/claimant's attorney in the meeting or conversation. Staff noted, however, that state law issues beyond the scope of the question might arise during a plan interview of the claimant's personal doctor.

Question 22: May a claims adjudicator deciding either an initial disability claim or a disability claims appeal involving medical judgments toll the time periods to respond to a claim or appeal for the time between a scheduled physical the participant agreed to and the actual date of the physical when a participant was simply a “no show” for the first scheduled appointment? Assume for this purpose the plan document makes it clear that as a condition to receiving benefits the participants must cooperate by providing the plan’s claims adjudicators with access to information (including submitting to such physicals) and that the participant has the burden of proof regarding the existence of a covered disability.

Proposed

Answer 22: A required physical examination is a crucial part of the fact-finding process that claims adjudicators must engage in. While participants have a lengthy period within which to decide whether to appeal, once an appeal is filed the claims adjudicator is on a relatively “quick step” time clock. Some participants have engaged in conduct that claims adjudicators consider may be a stalling strategy involving missed appointments or tardy arrival for appointments. This will frustrate their ability to conduct a meaningful full and fair fact gathering process within the tight time deadlines set by the claims procedure regulations if they are not allowed to toll the time periods between such missed or tardy appointments and the date the examination can be completed.

DoL

Answer 22: Staff believes this issue has been address by Q & A C-3 and C-4 of the “Frequently Asked Questions about the Benefit Claims Procedure Regulation.” Question C-4 specifically deals with how time limits apply to circumstances where a claimant does not submit to a required medical examination by an expert of the plan’s choosing in connection with the plan’s consideration of the claimant’s claim. The answer under C-3 states that, if the reason for taking an extension to make a benefit determination is the failure of the claimant to provide information necessary to decide the claim, and the claimant is so notified of this fact, the time period for making the decision is suspended (tolled) from the date of the notification to the claimant to the earlier of the date a response is received by the plan or the date established by the plan for the furnishing of the requested information. In the case of failure to appear for a required medical examination, the tolling ends on the earliest of the date on which the claimant submits to the requested examination or the date established by the plan for the submitting to the requested examination. In the case of an appeal of an adverse disability benefit determination, a 45-day extension is permitted under “special circumstances” such as when there is a need to hold a hearing. See § 2560.503-1(i)(1), 1(i)(3). A requested medical exam at the appeal stage would need to meets the “special circumstances” requirement before tolling would apply.

Question 23: If an employer advances various administrative costs for a plan including insurance costs (e.g., the ERISA bond or a fiduciary policy “with recourse”) with the understanding that it will be reimbursed for such plan expenses as permitted by ERISA § 408(c)(2), will the plan administrator be required to obtain commission information and break such insurance costs out for purposes of Form 5500 Schedule A, or may such reimbursements merely be reported as administrative expenses on the financial schedules? Assume for this purpose that the expense reimbursements otherwise fully comply with the Department’s various releases regarding the reimbursement of plan expenses.

Proposed

Answer 23: The plan administrator should insist on receiving the commission information from the employer or the insurance company and should report the reimbursements of premiums and the commissions or fees paid from those premiums on Schedule A even if it is also required by its auditors to include such payments as a portion of the aggregate administrative expenses reported on the financial schedules.

DoL

Answer 23: For plans required to file a Form 5500, Schedule A generally is required if any benefits under the plan are provided by an insurance company, insurance service, or other similar organization (such as Blue Cross, Blue Shield, or a health maintenance organization), including investments with insurance companies such as guaranteed investment contracts (GICs) and pooled separate accounts. Staff noted that whether the employer or the plan paid the insurance premiums on such a contract would not affect the Schedule A reporting requirement. The types of insurance products listed in the question, however, (ERISA section 412 bond and fiduciary liability insurance policy) do not provide benefits under the plan or constitute investment of the plan, and, thus, those insurance contracts do not need to be reported on Schedule A.

More generally, DoL staff noted that the Department has consistently emphasized that plan fiduciaries have a duty to follow the terms of the plan and evaluate the fees and commissions that the plan will pay when entering into service provider contracts. The plan may reimburse the employer for the payment of premiums on a ERISA compliant fidelity bond or fiduciary liability insurance policy where there was a clear understanding or agreement on or before the time of such payment that the plan would reimburse the employer.

On an separate Schedule A n separate Schedule A issue raised in follow up discussions, DoL staff said the payment of fees and commissions to an agent or broker based, in whole or in part, on policies or contracts placed with or retained by ERISA plans would be reportable on the Schedule A even if the agent or broker was an employee of the insurance company. On other Schedule A

questions, staff referred to Advisory Opinion 2005-02A for EBSA's most recent guidance on Schedule A reporting requirements.

Question 24: 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 (collectively referred to as "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 24: 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 to pursue the Reimbursement Claims is a 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 24: DoL staff assumed that there are participant contributions or other plan assets in the self-funded plan and agreed with the answer.

Question 25: Assume that an insurance company both processed the claims for benefits under a self-funded medical plan ("Claims Paying Agent"), and 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 inaction a prohibited transaction?

Proposed

Answer 25: 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 25: 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 26: 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 or 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 26: The period for giving notice of the issuance of the Disability Determination Letter had 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 until 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 26: The Department's COBRA Notice Regulations (29 C.F.R. section 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.

A follow up question asked if the answer would be the same had the deadline been in the SPD, but not in the notice. Staff indicated that there would still be a violation of the obligation to provide a COBRA election notice that meets the requirements of the regulation, but they thought the remedy available for such a violation would likely depend on the individual circumstances.

Question 27: An employer adopts a cafeteria plan under I.R.C. §125 offering both group benefits and individual voluntary policies. One of the individual voluntary policies is a cancer benefit policy. The employer does not contribute to the insurance premiums associated with this policy and the cafeteria plan document clearly indicates that it is exclusively the employee's decision whether to elect the cancer benefit policy. The employer does not comment on or tout the merits of the policy. In fact, the employer's sole involvement in the program is to (1) choose to include it among the cafeteria plan benefit options, (2) process and pay over to the insurer the employees' pretax salary dollars that the employee elects to use to pay the premiums. (The employer does not make any contributions to the cafeteria plan.) The policies themselves are mailed directly by the insurance company to the employees who enroll in the cancer insurance policy.

Does the fact that the employer (1) has selected this cancer insurance policy to be a cafeteria plan benefit option and (2) obtains the benefit of not having to pay its share of FICA payments in connection with the pretax dollars an electing employee spends to pay the cancer policy premium, necessarily cause the employer to be deemed as “endorsing” the program for purposes of 29 CFR §2510.3-1(j), thus causing the policy to be an ERISA-regulated plan?

Proposed

Answer 27: No. The determination whether an employer has endorsed a particular benefit arrangement in a cafeteria plan is an inherently factual question, that will vary based on the cafeteria plan and the level of employer involvement. The mere decision by an employer to include an individual voluntary policy in an I.R.C. §125 will not, without more, cause the plan to be endorsed by the employer and, thereby, subject to ERISA. Moreover, the economic benefit to the employer stemming from its savings on FICA payments is an incidental benefit caused by the employee’s decision to participate, and does not by itself cause the employer to be endorsing the arrangement. To hold otherwise would necessarily cause all benefit options in a cafeteria plan to be ERISA plans (assuming the benefit is of the type that is a welfare benefit set forth in § 3(1) of ERISA). Such a rule would sweep too broadly and would dissuade employers from using cafeteria plans as vehicles for employees to obtain welfare benefits that the employees, in the absence of the Code § 125 tax advantages, would not be able to afford.

DoL

Answer 27: DoL staff noted that the broad question of the circumstances in which offering a product under a cafeteria plan will automatically result in the product falling outside the group and group type insurance safe harbor in 29 CFR 2520.3-1(j) might currently be an issue before the U.S. Court of Appeals for the Fourth Circuit in the case of *Cassleman v. AFLAC*. DoL staff thus declined to address the question because of concerns regarding JCEB publishing informal staff views on an issue when DoL staff was aware that the issue could be pending before a U.S. Circuit Court of Appeals. Note: S:Subsequent to the meeting, the court issued its decision at *Casselman v. Am. Family Life Assurance Co. of Columbus*, No. 04-2370, 04-2378, slip op., 2005 WL 1492208 (4th Cir. June 24, 2005).]

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 18, 2005, 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

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These are only unofficial staff comments

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JCEB REPRESENTATIVES, BASED ON THEIR NOTES AND RECOLLECTIONS OF THE MEETING.

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