

**Questions and Proposed Answers for the Department of Labor Staff for the
2010 Joint Committee of Employee Benefits Technical Session
Held on May 5, 2010**

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

Question 1: Fiduciary Status

HIPAA privacy and security officials arguably are ERISA fiduciaries based on the ERISA definition. For example, the privacy official arguably exercises discretion in administration or management of a plan when the privacy official makes determinations as to whether a breach notice is reportable or not under the HITECH Act breach notice requirements. Do the February 17, 2010 HITECH Act changes with respect to business associates, such as the breach notice requirements and other requirements, create ERISA fiduciary status for business associates? For example, would a third party administrator ("TPA") formerly falling squarely within the ministerial exception under DOL Reg. Sec. 2509.75-8, Q/A D-2, suddenly become a plan fiduciary under ERISA simply because of the TPA's duties under the HITECH Act?

**Proposed
Answer 1:**

No, HITECH Act obligations would not create automatic fiduciary status for business associates. It is true that a third party administrator might be a business associate of a plan with obligations under the HITECH Act. Although the HITECH Act determination as to whether an unsecured breach is reportable or not might be an exercise of discretion with respect to the plan's privacy official, the determination is distinguishable with respect to the TPA to the extent that the obligation is mandated by HITECH Act as an obligation of the TPA. The privacy official may be exercising discretion with respect to plan administration or management, but the TPA is not exercising discretion with respect to plan administration or management, but rather with respect to TPA management or administration. Of course, if the facts were different, such as if the TPA were delegated responsibilities that fell to the privacy official regarding breach

reporting, then the TPA might be considered to be a plan fiduciary.

The Department of Labor does not believe that the intent of Congress in passing the HITECH Act was to make every business associate of an ERISA plan an automatic ERISA fiduciary.

DOL
Answer 1:

Under the HITECH ACT, a "business associate" with respect to a covered entity is a person who performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information and who provides, among other things, management, administration or financial services to a covered entity, such as a health plan. The breach notification requirements of the HITECH Act require that a business associate of a covered entity shall, following the discovery of a breach or disclosure of unsecured protected health information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach. Pub. L. No. 111-5, sec. 13402(b), 123 Stat. 115, 260 (2009).

Staff questions the premise of the question. In particular, a determination that a breach is reportable in accordance with the statutory provisions of HIPAA or the HITECH Act does not appear to be an exercise of discretion regarding the management or administration of a plan within the meaning of section 3(21) of ERISA. Accordingly, neither the privacy official nor the business associate, such as a TPA, becomes a fiduciary of an ERISA covered plan merely by being tasked with the reporting obligations attendant to the breach notification requirements of the HITECH Act. These reporting obligations appear to be the types of functions that a business associate, such as a TPA, would perform in the normal course of rendering services to an ERISA covered plan. See 29 C.F.R. 2509.75-8, Q/A D-2.

Question 2: Fiduciary Status

The preamble to the re-proposed investment advice regulation, in response to comments on the previous final regulation, "clarifies" that, under a fee-leveling arrangement, an affiliate of a fiduciary adviser is not itself subject to the contingent-fee prohibition, but that any value provided by the affiliate to the fiduciary adviser

would be taken into account in applying that prohibition to the adviser. Specifically, the DOL states that, “. . . even though an affiliate of a fiduciary adviser may receive fees that vary depending upon investment options selected, any provision of financial or economic incentives by an affiliate. . . to a fiduciary adviser . . . to favor certain investments would be impermissible.”

- a. Since the term “fiduciary adviser” is defined to include affiliates (§2550.408g-1(c)(2) and (5)), how does the described situation arise?
- b. If there were such an arrangement, i.e., where a fiduciary adviser under a fee-leveling program receives no incentive payments but its non-fiduciary-adviser “affiliate” does, even if the affiliate passes no value along to the fiduciary adviser, why would that arrangement not constitute a violation of 406(b)(1) (e.g., of the type described in 2550.408b-2(e)(1)), and perhaps (b)(2) and (b)(3)?

**Proposed
Answer 2:**

We do not believe such a situation could arise.

**DOL
Answer 2:**

With respect to (a) above, section 408(g)(11)(A) defines fiduciary adviser to mean a person who is a plan fiduciary by reason of rendering investment advice *and* who is described in any of (g)(11)(A)(i) through (vi) [a registered investment adviser, certain types of banks, an insurance company, a registered broker dealer, or an affiliate of the foregoing * * *]. Further, it is clear from section 408(g)(2)(A)(i) that only the fees or other compensation of the fiduciary adviser may not vary. In this regard we note that, in contrast to other provisions of section 408(b)(14) and section 408(g), section 408(g)(2)(A)(i) references only the fiduciary adviser, not the affiliate of a fiduciary adviser. As stated in Field Assistance Bulletin 2007-1 and the proposed regulation, a person must both be a fiduciary by reason of rendering investment advice and fall within one of the categories enumerated in any of (g)(11)(A)(i) through (vi) to be a fiduciary adviser under the statute. Thus, under the statutory exemption section 408(b)(14), an affiliate of the fiduciary adviser may receive varying fees as a result of the recommendations of the fiduciary adviser as long as that affiliate is not itself a fiduciary by reason of providing investment advice. If, however, the person providing the fiduciary advice receives any financial benefit based on the varying fees paid to the affiliate, then the statutory exemption would not apply.

With respect to (b) above, to the extent the described arrangement would result in a prohibited transaction, it would be entitled to the relief provided by section 408(b)(14) provided the conditions of that exemption were met.

Question 3: Fiduciary Conflict of Interest

Assume that several years ago a benefits consulting firm discontinued a practice of charging contingent commissions payable by insurance companies or TPAs it recommends in connection with the provision of insurance coverage or services to Title I of ERISA welfare benefit plans. Assume it did so in response to State attorney generals' concerns about such practices.

More recently, the consulting firm begins a practice of pre-negotiating a preferred vendor arrangement with a group of insurance companies and TPAs. In return for the insurers and TPAs agreeing to reduce their premiums or fees by the cost to a plan customer of the consulting firm's services, the consulting firm agrees to categorize cooperating insurance companies or TPAs as "preferred vendors" in RFPs conducted by that consulting firm regarding insurance or TPA service placements by its customers, including ERISA Title I welfare plans.

Assuming full disclosure, is this arrangement a conflict of interest if during RFPs, the consultant screens out insurers or TPAs who refuse to agree to such a premium or fee reduction (often referred to as an "implementation credit"). Does the answer differ depending upon the method used to screen them out (e.g., (i) not designated to receive an RFI invitation; (ii) not designated to receive an RFP invitation; (iii) not designated as a finalists; or (iv) not recommended).

Does the answer differ if refusal to offer the premium or fee reduction is not used by the consultant to automatically screen out the insurer or TPA, but leads plan fiduciaries other than the consultant to prefer other bidders?

**Proposed
Answer 3:**

Disclosure is critical, but may not be sufficient if the consultant controls the decision and uses a screening process to steer business to only vendors who agree to this premium or fee credit. Areas of concern, depending on the specific facts are: (i) the prohibition on transfer or use of plan assets for the benefit of a

party in interest in ERISA §406(a)(1)(D); (ii) the prohibitions of fiduciary self-dealing in ERISA §§406(b)(1), (b)(2) and (b)(3); and (iii) the kick back provisions of 18 USC §1954. The inclusion of some bidders who do not agree to this credit may or may not resolve these issues, depending on the precise facts and circumstances. In any event, this is a pattern of conduct that could attract enforcement scrutiny from the Department.

**DOL
Answer 3:**

Staff believes that before they can address whether a prohibited transaction occurs they need more facts than provided and therefore declines to answer this question. However, they note that, assuming that the consultant is an ERISA fiduciary and if the consultant limits its recommendation to vendors that agree to the premium or fee reduction without consideration of other factors related to the quality of services, issues regarding the consultant's duty of prudence and loyalty under ERISA could be at issue.

Question 4: Fiduciary Training Programs

In recent years the DOL has taken steps to foster best practices for fiduciaries, including participation in fiduciary training programs. One of the more significant ways in which this has been done is through mandatory fiduciary training conditions in enforcement action settlement agreements. Sometimes those agreements require that the specific fiduciary training programs utilized to satisfy the settlement agreement's terms must be satisfactory to the DOL.

Are there any general guidelines regarding the elements that the DOL believes should be included in fiduciary training programs?

**Proposed
Answer 4:**

The Department believes there are a variety of general use fiduciary training programs that should prove helpful in assuring fiduciaries have been adequately informed of their duties. The Department would consider offering guidance regarding the elements that might be appropriate for inclusion in fiduciary training programs and would welcome any suggestions concerning content, credentials and testing standards it might consider using for that purpose.

The Department is more inclined to recommend specific minimum standards for fiduciary training used to satisfy a settlement agreement, although each case is different and settlement based fiduciary training must often focus on case specific fiduciary deficiencies. The Department is not inclined to release guidelines

regarding the specific factors that might affect its judgment regarding the adequacy of a fiduciary program used to satisfy a settlement agreement. Such guidelines must be developed on a case by case basis.

**DOL
Answer 4:**

Staff believes that there may be many worthwhile and suitable fiduciary training programs available. Where the Department has required training as part of its settlements, the fiduciaries involved are able to identify such programs subject to the Department's approval on a facts and circumstances basis.

Question 5: Plan Assets

For purposes of subsection (f)(1) of the plan assets regulation (29 CFR §2510.3-101(f)), will a "benefit plan investor" in an unregistered investment partnership, who only holds a 10% limited partnership interest in the investment partnership, be deemed to be the owner of 100% of the value of a "separate class of equity interests" in the investment partnership if the fees that are payable by such benefit plan investor to the general partner of the investment partnership are 50% less than the fees that are payable by all other partners in the investment partnership notwithstanding the fact that the rights and obligations of all limited partners of the investment partnership are otherwise identical?

**Proposed
Answer 5:**

Since the interests of all limited partners in the profits, losses, assets and liabilities of the investment partnership are identical, the general partner's agreement to reduce the fees that are payable by the benefit plan investor to the general partner should not result in the creation of a "separate class of equity interests" in the investment partnership for purposes of the plan assets regulation.

**DOL
Answer 5:**

The Department believes that this issue is best addressed through the advisory opinion process where the Department can examine and address the specific facts of a particular investment.

Question 6: COBRA and Employee Discounts

A health center offers discounts to its employees for medical services. Specifically, the health center provides a 10% discount off of any outstanding medical bill after all insurance is considered, as long as the employee makes full payment within 30 days of the invoice. Does this result in a group health plan resulting in the application of COBRA?

**Proposed
Answer 6:**

No. Treas. Reg. section 54.4980B-2, Q/A-1(c) discusses employer discounts to employees with regard to health care items. Specifically, it states that if "the employer maintaining the discount program is a health clinic, so that the program is used exclusively by employees with health or medical needs, the program is considered to be a plan providing health care and so is considered to be a group health plan." However, the health center in question is not offering a discount across the board to its employee population. Instead, it is merely used as a financial incentive to receive prompt payment of outstanding invoices. We do not consider this to arise to the level of a group health plan subject to COBRA.

**DOL
Answer 6:**

Whether a particular arrangement meets the statutory definition of "employee welfare benefit plan," is a question of fact, to be answered in light of all the surrounding circumstances. Donovan v. Dillingham, 688 F.2d 1367, 1368 (11th Cir. 1982) (en banc). Unfortunately, there are not enough facts provided in the question to allow the Department to definitively make this determination. However, after consulting with staff at the IRS, DOL staff believes that, if an employer sponsors a plan that is otherwise subject to the federal COBRA requirements, the discount is a benefit that must be available to COBRA qualified beneficiaries.

Question 7: COBRA Subsidy

Is an individual whose employment terminates because the individual is unable to return to work from a leave due to disability or illness eligible for the COBRA subsidy under the American Recovery and Reinvestment Act of 2009 (ARRA), as further modified by the Temporary Extension Act of 2010?

**Proposed
Answer 7:**

No. Treasury Notice 2009-27, Q&A 1, provides that an involuntary termination for purposes of the definition of an assistance eligible individual under the ARRA means a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services (emphasis added).

However, Notice 2009-27 also provides in Q&A 4 that an involuntary termination occurs when the employer takes action to end the individual's employment while the individual is absent from work due to disability or illness (but mere absence from work

due to illness or disability before the employer has taken action to end the individual's employment status is not an involuntary termination).

Q&A 1 clearly indicates that an employee has to be willing and able to continue performing services. If an employee cannot ever return to work due to disability or illness or is unable to return to work after exhausting all leave provided by the employer due to disability or illness then the employee is not able to continue performing services and is not involuntarily terminated for purposes of the ARRA. Q&A 4 refers to a situation where an employee on disability leave is terminated for reasons other than being unable to return to work. For example, the employer terminates the employee on disability leave in a reduction in force or at the end of the employee's leave due to performance issues discovered by the employer while the employee is on leave.

Although the Temporary Extension Act of 2010 provides that an involuntary termination following a reduction in hours in certain circumstances is a qualifying event for purposes of the COBRA subsidy, the Act does not change the meaning of involuntary termination.

If similar facts and circumstances were presented to the DOL on an individual's appeal of a denial of the COBRA subsidy, the DOL would likely determine that the individual who cannot return to work due to a disability or illness has not been involuntarily terminated and is not eligible for the COBRA subsidy.

**DOL
Answer 7:**

Staff notes that the response to this question involves application of guidance issued by, and related to provisions of the American Recovery and Reinvestment Act (ARRA) over which interpretive authority rests with, the Treasury Department. Staff also notes that the question is unclear in that it uses the phrase "whose employment terminates" as opposed to "whose employment is terminated by the employer" or some other characterization of the facts related to the employee's separation from employment. Assuming that the question relates to action by an employer to terminate the employee's employment, staff believes that Q&A 4 of Treasury Notice 2009-27 applies.

Q&A 4 of Treasury Notice 2009-27 provides that an involuntary termination occurs when the employer takes action to end the individual's employment while the individual is absent from work due to disability or illness (but mere absence from work due to illness or disability before the employer has taken action to end

the individual's employment status is not an involuntary termination).

Staff notes that, generally, the decision whether to terminate an individual's employment while that individual is absent from work due to disability or illness is one that is within an employer's discretion (notwithstanding other legal requirements, such as FMLA).

While again pointing out that this area involves application of guidance issued by, and related to provisions of the American Recovery and Reinvestment Act (ARRA) over which interpretive authority rests with, the Treasury Department, staff agrees that the Temporary Extension Act of 2010 does not change the meaning of involuntary termination.

Assuming the phrase in the question was intended to reflect a situation where an employer took action to terminate an employee's employment, if similar facts and circumstances were presented to the DOL on an individual's appeal of a denial of the COBRA subsidy, the DOL would likely determine that the individual whose employment was terminated while not at work due to a disability or illness has been involuntarily terminated and is eligible for the COBRA subsidy.

Question 8: HIPAA Privacy and Security Application

Employer A contracted with Insurer Z to be the third party administrator of Employer A's self-funded group health plan and the insurer of Employer B's dental plan from 1994 to 1999. Employer A subsequently hires other providers. In 2005, Employer B acquires substantially all the assets of Employer A in an asset acquisition. In 2010, Insurer Z contacts more than 700 individuals who were employees of Employer A in 1997 to 1999 to inform them that a laptop has been stolen from Insurer Z and that the laptop contained the individual's name, address, Social Security number, and claim information. Does Employer B have any obligations under HIPAA's privacy and security regulations with respect to the stolen information? If instead of an asset acquisition Employer B acquired Employer A by means of a stock acquisition, would Employer B have any obligations under HIPAA's privacy and security regulations with respect to the stolen information?

Proposed Answer 8:

If the acquisition is an asset acquisition and Employer B did not assume Employer A's liabilities, then Employer B has no obligations under HIPAA's privacy and security regulations with

respect to the stolen information.

If instead the acquisition was a stock acquisition and Employer B assumed Employer A's liabilities, then it is likely Employer B does have obligations. If a violation of HIPAA's privacy or security rules occurs after the effective date of the relevant portion of HIPAA, then it does not matter when the protected health information was obtained before or after the relevant effective date. In other words, the HIPAA rules that are currently in effect apply to all protected health information no matter when the health information was gathered.

Employer B is not likely to have a business associate agreement with Insurer Z. Nevertheless, Employer B should contact Insurer Z and work to determine the scope of the breach. If Insurer Z has not provided notice to the affected 700 individuals, Employer B may be obligated to do so. Employer B is also obligated to notify HHS and a major media outlet.

**DOL
Answer 8:**

This question addresses matters outside of the DOL's jurisdiction, and should be directed to HHS.

Question 9: HIPAA Certificate of Creditable Coverage

Does a health plan have an adequate written procedure for individuals to request a HIPAA certificate of creditable coverage if the summary plan description (SPD) specifies that a request for a certificate can be made by calling the toll-free number on the insurance card (provided to all plan participants and beneficiaries upon enrollment in the plan) or by contacting the plan administrator and in a separate section within the SPD, the name, address and telephone number of the plan administrator is listed?

**Proposed
Answer 9:**

Yes. A plan must establish a written procedure for individuals to request and receive certificates of creditable coverage. The written procedure must include all contact information necessary for an individual to request a certificate including a name and telephone number or address to which the request should be made. 29 CFR 2590.701-5(a)(4)(ii).

The SPD outlines the procedure for an individual to request a certificate of creditable coverage. Although the procedure in the SPD does not specify a name, address, and contact information, it does specify that the request can be made to the plan administrator or that an individual can call the toll-free number on the back of the insurance card. The insurance card is provided to

all plan participants and beneficiaries upon enrollment in the plan. The SPD also defines who is the plan administrator and provides an address and telephone number for the plan administrator. Therefore, the SPD as a whole provides all information necessary for an individual to determine how and to whom to request a certificate of creditable coverage as required by 29 CFR 2590.701-5(a)(4)(ii).

**DOL
Answer 9:**

A plan must establish a written procedure for individuals to request and receive certificates of creditable coverage that includes all contact information necessary to request a certificate. 29 C.F.R. 2590.701-5(a)(4)(ii). Therefore, the DOL believes that a written procedure should include all information that a participant or beneficiary would need to request a certificate of creditable coverage (such as name and telephone number or address to which the request should be made). If a procedure directs a participant or beneficiary to another document such as an insurance card to find a contact name and telephone number, the procedure would not meet this standard. If the contact information is included within the document that contains the procedure, the DOL recommends, as a best practice, that the procedure include a reference to the page number or section title where the contact information can be found in the document.

Question 10: Form 5500 Corrections

A client has a series of welfare arrangements with no 5500s filed even though they were required. Going forward, there will be a wrap plan document to limit the 5500 filings to a single plan. Is there any way under the correction program to group them under a wrap plan retroactively to avoid multiple \$4000 payments?

**Proposed
Answer 10:**

Yes.

**DOL
Answer 10:**

Although an employer can change whether it has one welfare plan or multiple welfare plans to provide a combination of benefits on a going forward basis, it must file prior year filings for the plan or plans it had during those prior years.

Whether the plan sponsor used a “wrap document” is only one of the facts and circumstances that would be taken into account in determining whether the plan sponsor intended to offer an array of welfare benefits through a single plan or multiple plans. As noted in the instructions to the Form 5500, as a matter of plan design, plan sponsors can offer benefits through various

structures and combinations. For example, a plan sponsor could create (i) one plan providing major medical benefits, dental benefits, and vision benefits, (ii) two plans with one providing major medical benefits and the other providing self-insured dental and vision benefits; or (iii) three separate plans. The governing documents and actual operations together must be taken into account in determining whether welfare benefits are being provided under a single plan or separate plans. The fact that there are separate insurance policies for each different welfare benefit does not necessarily mean that there are separate plans. Some plan sponsors use a “wrap” document to incorporate various benefits and insurance policies into one comprehensive plan. In addition, whether a benefit arrangement is deemed to be a single plan may be different for purposes other than Form 5500/Form 5500-SF reporting. For example, special rules may apply for purposes of HIPAA, COBRA, and Internal Revenue Code compliance.

Delinquent filers who wish to participate in the Delinquent Filer Voluntary Correction Program may call the Office of Chief Accountant to get more information on what and how to file in a particular situation.

Question 11: Form 5500 Application

An employer has 90 employees on January 1, 2009. As of January 1, 2010, the employer has 140 employees. On January 1, 2010, 130 of the 140 employees are eligible for the employer’s group health plan. Of the 130 employees who are eligible for the group health plan, only 75 employees elect to be covered under the group health plan for 2010. The group health plan is a fully insured group health plan and the plan year for it is the calendar year. Does the employer need to file an annual report (Form 5500) for 2010 plan year for the group health plan?

**Proposed
Answer 11:**

Yes. If 100 or more employees are eligible for a welfare benefit plan (including health insurance, dental, and a cafeteria plan with a health flexible spending account), then even if fewer than 100 employees elect to be covered under the plan or use the benefit the plan administrator must file a Form 5500. See 29 C.F.R. § 2520.104-44. Therefore, even though only 75 employees elect to be covered under the group health plan on January 1, 2010, because 130 employees were eligible under the group health plan on January 1, 2010 the employer must file a Form 5500 for the 2010 plan year for the group health plan.

DOL
Answer 11:

For plan year 2010, a determination of the number of participants covered under the plan for purposes of the annual report filing requirements is based on the total number of participants at the beginning of the plan year as reported on Line 5 of the 2010 Form 5500, "Annual Return/Report of Employee Benefit Plan." See "2010 Instructions for Form 5500 Annual Return/Report of Employee Benefit Plan" ("Form 5500 Instructions") at 3, 7.

The determination as to whether an individual has become a participant covered under the plan and is to be counted as a participant at the beginning of the plan year for purposes of Line 5 of the Form 5500 is based on a number of factors. An individual becomes a participant covered under an employee welfare benefit plan on the earliest of: the date designated by the plan as the date on which the individual begins participation in the plan; the date on which the individual becomes eligible under the plan for a benefit subject only to occurrence of the contingency for which the benefit is provided; or the date on which the individual makes a contribution to the plan, whether voluntary or mandatory. Form 5500 Instructions at 16; see 29 CFR § 2510.3-3(d)(1)(i); 29 CFR § 2510.3-3(d) (definition of "participant covered under the plan").

It is important to note that the welfare plan rules for counting participants on the Form 5500 is not governed by the Form 5500 instructions for 401(k) plans under which employees are counted as participants if they are eligible to make a salary reduction contribution even if they do not make any contributions and do not have an account balance in the plan. Thus, for example, if the employer has a group health policy, and the plan provides that employees are covered under the plan automatically on employment, an employee would be required to be counted as a participant for Form 5500 purposes on employment. On the other hand, if employees are eligible to participate in a group health plan but the plan provides that they must complete an election form or pay an employee portion of the required premium before being covered by the plan, an employee would not need to be counted as a participant on the Form 5500 until they completed the election form or paid the required premium.

Question 12: GINA

Is a group health plan's provision of a premium discount to participants who provide evidence to the plan that they had an annual physical in which the health care provider may ask for

family medical history a violation of the Genetic Information Nondiscrimination Act (GINA)?

**Proposed
Answer 12:**

No. The Interim Final Rules prohibit a group health plan from collecting genetic information for underwriting purposes. §54.9802-3T(d). Underwriting purposes include the computation of premium amounts under the plan (including discounts or other premium differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program). §54.9802-3T(d)(1)(ii)(B). To collect genetic information means to require, request or purchase. §54.9802-3T(a)(1).

A health plan's provision of a premium discount would be an underwriting purpose under GINA. However, in the question presented, the plan is not collecting genetic information or any health information at all. The plan is simply collecting evidence that the enrollee underwent a physical examination. The plan should clarify to enrollees in any written materials regarding the premium discount that enrollees should not provide any genetic or health information as evidence of an annual physical but submit only a statement from the participant's physician that a physical was completed.

**DOL
Answer 12:**

GINA prohibits a group health plan from collecting genetic information for underwriting purposes, 29 CFR 2590.702-1(d)(1), or prior to or in connection with enrollment, 29 CFR 2590.702-1(d)(2). The Interim Final Rules establish an incidental collection exception to GINA's prohibition against collecting genetic information prior to or in connection with enrollment if a group health plan obtains genetic information incidental to the collection of other information, as long as: (1) the collection is not for underwriting purposes; and (2) it is not reasonable to anticipate that health information will be received, or the collection request explicitly states that genetic information should not be provided. 29 CFR 2590.702-1(d)(2)(ii). However, the incidental collection exception does not apply in connection with any collection where it is reasonable to anticipate that health information would be received, unless the collection explicitly states that genetic information should not be provided. See 29 CFR 2590.702-1(d)(2)(ii)(B). (Note, nothing under GINA prevents a health care professional who is providing health care services from asking an individual about family medical history.)

A health plan's provision of a premium discount would be an underwriting purpose under GINA. However, in the question

presented, the plan is not collecting genetic information for the purpose of providing a premium discount. For best practices, the DOL suggests that the plan include a statement on all materials describing the premium discount that a participant should not submit any health information or the results of the physical to the plan but only evidence that the participant had a physical. Including such a statement would help ensure that participants understand that the plan administrator does not want the results of the physical or any health information. This will help ensure compliance with HHS's HIPAA Privacy rules regarding limiting disclosures to the minimum necessary under 45 CFR 164.502 and the EEOC GINA rules applicable to employers, as well as ensuring that any incidental collection of genetic information falls within GINA's exception. If the plan receives any genetic information, although not requested, the receipt of the information may fall under the incidental collection exception. In addition to compliance with GINA, the plan should ensure that the premium discount complies with the HIPAA Nondiscrimination rules and the Patient Protection and Affordable Care Act.

Question 13: GINA

A group health plan contracts with a wellness program vendor (a health care provider) to provide health evaluations to plan participants and provide an individualized program of recommended steps for each participant to improve their health. The group health plan provides a premium discount to participants who achieve improved health as defined by the wellness program vendor at each step of the program. The wellness program vendor may request the participant's family medical history in providing health evaluations under the program and formulating the standards under each step for the participant's improved health. However, the wellness program vendor does not provide any health information to the plan or employer-sponsor of the plan and is contractually prohibited from doing so by agreement with the plan. The plan provides the premium discounts based only on a report from the wellness program vendor that the participant has successfully completed a step in the program.

The group health plan adheres to all requirements for the wellness program under the HIPAA nondiscrimination rules, including adhering to the premium discount limitation, providing a reasonable alternative standard for participants to qualify for the discount and explaining the availability of the reasonable alternative standard in all written plan materials describing the

wellness program. Is the health plan in violation of the Genetic Information Nondiscrimination Act (GINA)?

**Proposed
Answer 13:**

No. Because the plan does not “collect” (as that term is defined by the Interim Final Rules) any genetic information from the wellness program vendor, the plan does not violate GINA.

**DOL
Answer 13:**

The DOL initially notes that whether any wellness program complies with GINA is based on the facts and circumstances of the program and there are not sufficient facts presented in the question for the DOL to offer an opinion as to whether this specific arrangement complies with GINA. Whether a particular program is permissible is very facts and circumstances specific and depends in part on the rules of Department of Labor regulation 2590.702-1, which among other things, address health risk assessments, disease management programs, and requests for genetic information by medical professionals who are providing health care services to an individual. The DOL notes, however, that a wellness program vendor may be acting as an agent of the employer in collecting 702(d) information, and therefore, the wellness program vendor’s actions are viewed as the actions of the plan administrator and the vendor must fully comply with all of GINA’s requirements. The DOL notes that a plan’s service provider cannot do indirectly what the plan cannot do directly. If a wellness vendor’s practices comply with GINA and a plan then provides a reward (underwriting) based on notice from the vendor that an individual satisfied a step in the wellness program, this generally would not violate GINA. However, in addition to compliance with GINA, the plan must ensure that the premium discount and wellness program comply with the HIPAA Nondiscrimination rules and the Patient Protection and Affordable Care Act.

Question 14: Service Crediting

Does §2530.200b-2(a)(2) of the DOL Regulations require that a tax qualified retirement plan subject to ERISA credit hours of service with respect to periods for which a participant receives severance pay?

**Proposed
Answer 14:**

Based on the following, it appears that it was the intent of the DOL and the IRS to credit hours of service for periods during which a participant receives severance pay.

Section 2530.200b-2(a)(2) of the DOL regulations provides that an "hour of service" is credited for each hour for which an

employee is paid, or entitled to payment, by an 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, layoff, jury duty, military duty or leave of absence. The term "severance" is notably absent from the final regulations. However, the preamble to the final regulations provides in one place that "[t]he approach taken in §2530.200b-2(a)(3), which was announced in ETR 2001, requires that hours of service be credited for all purposes for periods during which no duties are performed due to vacation, holiday, illness, incapacity, severance or layoff." (*emphasis added*).

In Private Letter Ruling ("PLR") 8031091 the IRS ruled that periods for which severance is paid may be required to be included in the definition of hour of service. The IRS determined that the list of events under Section 2530.200b-2(a)(2) was not exclusive, but merely illustrative. The IRS further relied on the information in the preamble to the final DOL regulations cited above and ruled that if the payment is made on account of an employment relationship for which compensation is paid, then the hours must be counted.

DOL
Answer 14: Staff declines to answer this question because it concerns matters that are within the purview of the Treasury Department.

Question 15: Eligibility Exclusion

An employer maintains an ERISA covered 403(b) plan. As permitted under the Internal Revenue Code, the 403(b) plan excludes employees who normally work less than 20 hours per week. See Code § 403(b)(12)(A). The employer employs 100 employees, 40 of whom are part-time employees (40% of the workforce). Does the exclusion of the part-time employees violate the coverage requirements under ERISA?

Proposed
Answer 15: An employer may exclude employees who normally work less than 20 hours per week as a class from a 403(b) plan. Normally, ERISA limits exclusions based on service. 29 U.S.C. § 1052(a) 2006 (ERISA § 202(a)) ("No pension plan may require, as a condition of participation in the plan, that an employee complete a period of service with the employer or employers maintaining the plan extending beyond the later of the following dates - (ii) the date on which he completes 1 year of service."). Federal laws, however, are to be construed in a manner that does not abrogate a provision of one federal law and, therefore, because Congress

specifically provided for the exclusion of employees who normally work less than 20 hours per week as a class from a 403(b) plan under the Internal Revenue Code, this exclusion is permitted under both the Code and ERISA.

**DOL
Answer 15:**

The DOL answer to JCEB Q & A 7 from 2007 indicated that the staff declines to answer this question because it concerns matters that are within the purview of the Treasury Department.

Question 16: Plan Endorsement

An employer offers employees a voluntary dental plan. The employer makes no contributions toward the premiums for the plan and receives no consideration in cash, or otherwise, in connection with the plan. The employer includes information provided by the insurer for the plan in annual enrollment materials for all other benefit plans of the employer. Does the employer “endorse” the voluntary dental plan such that the plan becomes an ERISA plan by including information about the plan in benefit enrollment materials?

**Proposed
Answer 16:**

No. [Labor Reg. § 2510.3-1\(j\)](#) provides a safe harbor from ERISA coverage for plans in which:

- (1) No contributions are made by an employer or employee organization;
- (2) Participation the program is completely voluntary for employees or members;
- (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
- (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

An employer’s inclusion of information about the availability of the voluntary dental plan in an annual enrollment packet with

information about other benefits plans, including ERISA plans, does not constitute endorsement of the voluntary dental plan. Provided that the employer adheres to the remaining factors of the safe harbor and does not otherwise explain or provide information about the plan to employees, the voluntary dental plan does not become an ERISA plan of the employer.

**DOL
Answer 16:**

Staff does not believe there is enough information provided in the question to express a view on the application of DOL's safe harbor regulation at 29 C.F.R. § 2510.3-1(j), or to determine whether the voluntary dental plan is an employee welfare benefit plan established or maintained by an employer within the meaning of section 3(1) of ERISA.

The Department has taken the position that the issue of whether an employer has endorsed a program offered to the employees is inherently factual in nature. A determination of whether an employer has in fact "endorsed" a program or otherwise engaged in activities that exceed the scope of regulation section 2510.3-1(j)(3) can be made only by a review of the relevant facts and circumstances of the employer's program. See, e.g., Advisory Opinions 94-22A and 90-08A.

Question 17: ESOP Put Options

The IRS clearly has taken the position that the two 60-day put option periods in Code Section 409(h)(4) supersedes the old 15 month put option period language in its 1977 regulations, but the DOL recently has taken the position in an audit that the 15 month definition in its 1977 regulations has not been superseded by Code Section 409(h)(4). So, the question is: can the DOL still require the 15 month definition in ESOP's?

**Related
Question:**

The DOL also stated that the put option has to be available to the distributee on EACH DAY of the 15 month period. If the 15 month definition has not been superseded by 409(h)(4), is this interpretation correct?

**Proposed
Answer 17:**

Section 409(h)(4) superseded the IRS and DOL 1977 regulations defining the put option period for leveraged ESOP's. ERISA section 408(b)(3) provides that the loan must be to an "employee stock ownership plan" as defined in section 407(d)(6). ERISA section 407(d)(6)(B) then says that the definition is subject to the requirements "as the Secretary of the Treasury may prescribe by regulation", thus granting direction on this issue to Treasury, whose regulation then was superseded by Congress in 1978 by

adding the language to Code section 4975(e)(7) that requires satisfaction of Code section 409 (h) to meet the definition of an ESOP.

With regard to the DOL position that their 15 month put option period apply EACH day during the period, we do not believe authority for that interpretation exists.

DOL Answer 17: EBSA staff is examining this issue in an unrelated context and declines to provide an answer at this time.

Question 18: Funding Notice

The "known events" disclosure standard of the PPA Funding Notice (ERISA Section 101(f)(2)(B)(vi)) uses language that is similar to securities law "known events" disclosure obligations. By regulation, the SEC requires a public company's annual report to include a management's discussion and analysis section that includes forward looking statements about material "known events." Does the DOL believe that authoritative interpretations of what constitutes a "known event" for securities law purposes will be relevant to the interpretation of the same language relating to the annual PPA funding notice?

Proposed Answer 18: Since both the securities law disclosure rule and the ERISA PPA funding notice requirement require "forward looking statements" about material known events, principles of statutory interpretation suggest that securities law interpretations of the term "known events" prior to enactment of PPA will be relevant in interpreting the "known events" requirement of the PPA funding notice.

DOL Answer 18: The DOL answer to JCEB Q & A 22 from 2009 indicated that staff does not believe there is enough information in the question for the staff to express a view on the question.

Question 19: Preemption

401(k) and other plan administrators typically retain third party record keeping firms and other service providers to assist in plan administration, including independent investment advisors selected to offer participants investment advice or investment management services. In an era of enhanced privacy protections, some participants have complained that personally identifiable information (PII) releases have occurred under State privacy laws when plan administrators provide their names and other personal information to these service providers so they may generate plan

administrator approved participant communications.

Does the DOL agree that State privacy laws regarding PII releases are not applicable to plan administration communications from authorized third party service providers?

**Proposed
Answer 19:**

Based on the leading case, *In re GM*, 3 F.3d 980 (6th Cir. 1993), state privacy statutes are preempted by ERISA §514 to the extent that such statutes would otherwise apply to ERISA plan administration. Based on this principle, the Department believes the communications described in the question are exempt from State privacy statute restrictions.

**DOL
Answer 19:**

Staff declines to answer this question due to insufficient information. ERISA section 514(a) provides that the provisions of Title I of ERISA “supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b).” For a state law cause of action to be preempted, however, the relationship between the state law and the ERISA plan cannot be “too tenuous, remote or peripheral.” *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100, n.21 (1983). Staff notes that without specific statutory language and a description of how the statute relates to an ERISA-covered employee benefit plan, staff is unable to determine whether a particular state privacy statute is preempted by ERISA.

Question 20: Excluding Surrogate Coverage

The question is to what extent may a group health plan exclude coverage for expenses related to a surrogate pregnancy where, in exchange for compensation, a plan participant acts as a surrogate for third parties who are unrelated to the plan and unrelated to the participant.

For purposes of this question, please assume the following facts. The HR Director of Company X attends a benefits conference where she hears the VP, Human Resources, of Company Q complain about his plan having to pay for benefits where a participant sells surrogacy services. After the conference, the HR Director reviews X's group health plan and learns that it generally provides pregnancy benefits, including benefits for hospital lengths of stay in connection with childbirth for a mother of newborn child, but does not address surrogacy arrangements.

The HR Director asks her in-house ERISA counsel whether X can amend its group health plan to exclude expenses related to a

surrogate or otherwise. Company X's group health plan is self-funded.

**Proposed
Answer 20:**

The Plan may be amended to exclude expenses for all health benefits incurred by any participant or beneficiary for which the participant or beneficiary receives compensation. However, provided that the plan continues to provide benefits for a hospital length of stay in connection with childbirth for any mother or any newborn child, then under the Newborns' and Mothers' Health Protection Act (NMHPA") the plan must carve out from the exclusion hospital lengths of stay that are required by NMHPA, whether or not the participant is legally considered the mother of the child. Provided the exclusion applies equally to male and female employees and their spouses, and applies to pregnancy in the same manner it applies to other medical conditions, it should not violate Title VII generally or the Pregnancy Discrimination Act specifically. An express exclusion for surrogacy benefits alone would violate the PDA If the plan otherwise provides pregnancy benefits.

**DOL
Answer 20:**

The DOL believes that its jurisdiction in respect of the question is limited to issues that concern the Newborns' and Mothers' Health Protection Act (the Newborns' Act). The Newborns' Act generally provides that self insured group health plans that provide benefits for hospital lengths of stay in connection with childbirth may not restrict benefits for the stay to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. (Note, in most cases State law applies to insured group health plans that provide benefits for hospital lengths of stay in connection with childbirth.)

To the extent that a plan that is subject to the Federal Newborns' Act includes a broad exclusion that may restrict benefits for hospital lengths of stay in connection with childbirth, the exclusion must carve out an exception that clearly states that in the case of a childbirth covered under the plan, the exclusion does not apply to benefits required under the Newborns' Act. In addition, the DOL suggests that to the extent that this question may raise issues under the Pregnancy Discrimination Act, inquiry would best be made to the Equal Employment Opportunity Commission.

Question 21: SPD Distribution

An employer wishes to limit the costs a plan incurs with respect to the distribution of a paper summary plan description (SPD) to the plan's participants and beneficiaries. The employer mails a letter

or postcard to all participants alerting them that a new SPD is available and states that a participant may call a telephone number and request that a copy of the SPD be sent to the participant at no charge. All participants have access to a telephone. Does the ability of every participant to obtain a copy by calling the telephone number satisfy the electronic distribution rules?

**Proposed
Answer 21:**

Yes. Both active and former employees who are participants may obtain a copy of the SPD. See 29 C.F.R. § 2520.104-b(1)(b); 29 C.F.R. § 2520.104-b(1)(c). In addition, the employer may make it even more convenient for participants to obtain a copy by posting the SPD on its intranet. Although this in itself may not satisfy the electronic distribution rules, because it supplements the ability to obtain a paper copy it further enhances good communication with participants at no cost or a minimal additional cost.

In the alternative, at a minimum the distribution of a letter or postcard is effective with respect to the active employees of the employer. See 29 C.F.R. § 2520.104-b(1)(b); 29 C.F.R. § 2520.104-b(1)(c).

**DOL
Answer 21:**

Staff disagrees with the proposed answer. ERISA section 104(b)(1) provides that the plan administrator shall “furnish” an SPD automatically to each participant within 90 days of being covered by a plan and to pension beneficiaries within 90 days of receiving benefits and, generally, every 5 years thereafter. With respect to the furnishing of SPDs, the general disclosure standards set forth in 29 C.F.R. § 2520.104b-1(b) require that the plan administrator use measures reasonably calculated to ensure actual receipt of the material by participants and beneficiaries. In addition, regulation section 2520.104b-1(b) requires that the SPD must be sent by a method or methods of delivery likely to result in full distribution.

The Department has long held the view that, where documents are required to be furnished to participants, it is not acceptable merely to make the documents available in a location frequented by participants. See Preamble to regulation section 2520.104b-1(c) (citing regulation section 2520.104b-1(b)). Staff believes that the facts presented above are analogous to posting required disclosure materials in a location frequented by participants. Similar to posting an SPD, requiring participants and beneficiaries to affirmatively seek out an SPD by placing a phone call is not a method likely to result in actual and full distribution of the SPD.

The electronic distribution rules set forth in regulation section 2520.104b-1(c) do not apply in this example. Regulation section 2520.104b-1(c) applies to the use of electronic media as the actual means through which plan information is delivered. Use of the telephone to request a copy that will ultimately be provided in a non-electronic format is not covered by regulation section 2520.104b-1(c). It should be noted that the Department does believe that using a company's website may be an acceptable method of "furnishing" an SPD, if certain requirements are met. See Preamble to regulation section 2520.104b-1(c).