

Joint Committee on Employee Benefits
Questions and Answers for the Department of Labor
based on meeting with staff
May 9, 2001

The following questions and answers are based on informal discussions between private sector representatives of the JCEB and Department of Labor officials. The questions were submitted by ABA members and the responses were given at a May 9, 2001 meeting of JCEB and government representatives. The responses reflect the unofficial, individual views of the government participants as of the time of the discussions, and do not necessarily represent agency policy. This report on the discussions was prepared by designated JCEB representatives, based on the notes and recollections of the JCEB representatives at the meeting, and has been reviewed by Labor Department staff who were present at the meeting. The questions were submitted in advance to the agency, and it was understood that this report would be made available to the public.

QUESTION 1.

A multiemployer plan requires that 8 weeks of contributions be submitted on behalf of a new hire before the employee becomes eligible for coverage on the first day of the following calendar month. These contributions pay for the two months of extended coverage the employee will get when he is terminated. If a newly hired employee declines coverage under the multiemployer plan due to other coverage, and then loses that coverage, he will be entitled under section 701(f) of ERISA to enroll in the multiemployer plan. However, Reg. §2590.701-6(a)(7) states that the enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received. Can the multiemployer plan still require eight weeks' of contribution on this employee's behalf before it will pay claims, as it does with all other employees?

PROPOSED/SUGGESTED ANSWER 1.

Yes. The enrollment is effective immediately, but actual coverage must wait until the plan's regular eligibility rules are satisfied, including the eight weeks of contributions.

DEPARTMENT OF LABOR ANSWER 1.

The enrollment and actual coverage must be made effective no later than the first day of the calendar month after the request for enrollment is received, as provided under 29 C.F.R. § 2590.701-6(a)(7).

QUESTION 2.

To comply with ERISA § 404(c), is it sufficient to supply fund profiles (for the mutual fund offerings) and to notify participants how they may obtain prospectuses, or are actual prospectuses required to be provided to participants?

PROPOSED/SUGGESTED ANSWER 2.

Based on a literal reading of the regulations, an actual prospectus must be provided.

DEPARTMENT OF LABOR ANSWER 2.

Staff stated that an Advisory Opinion addressing this issue is under active consideration. Accordingly, staff would not comment on the proposed answer.

QUESTION 3.

What are the requirements and time frames for a plan that has two levels of appeals? In particular, the preamble to the claims regulation at note 29 and the accompanying text indicates that the regulation permits two levels of appeal, but the two levels must be concluded in the same overall time frame as a one-level appeal process. The footnote states that both levels of a post-service appeal, for example, must be completed in 60 days. In contrast, the regulation, at (i)(2)(iii)(A), states that notification of an adverse determination shall be provided with respect to any one of the two levels not later than 30 days after receipt by the plan of the claimant's request for review. A fair reading of the regulation would indicate that the plan has 30 days to provide notification of adverse determination on the first level, and the claimant has 180 days to appeal from the first level [(h)(3)(i)], after which the plan has another 30 days to respond. Is this reading of the regulation consistent with the preamble's requirement that both levels be concluded in the same overall time frame?

PROPOSED/SUGGESTED ANSWER 3.

A two-level appeals procedure will be reasonable under the regulation if half the overall time frame of a one-level appeal of the claim denial in question is used for the first determination, after which the claimant may appeal any adverse determination in the first level to the second level. Should the claimant appeal to the second level, no more than the other half of the overall time frame for the claim denial in question may be used in responding to the appeal at the second level. For example, for appeals of post-service claims denials, a plan with a single level of appeal may take up to 60 days to conclude that appeal; plans with two levels of appeal must complete the first level in 30 days. Should the claimant appeal to the second level, the plan must complete the second level in 30 days from receipt of such appeal.

DEPARTMENT OF LABOR ANSWER 3.

Staff stated that, for post-service claims under a plan that has a second appeal level, the maximum amount of time that may be taken to decide both appeals is 60 days. In calculating this time period, staff explained that the amount of time actually taken by the participant to prepare and file the submission for the second level of review is not counted. Although there is an indication in the regulation and preamble that the 60-day period must be split in half where there are two levels of appeal, such a split may not be required. The Department is reviewing this issue.

QUESTION 4.

Unlike the regular appeals mechanism, the multiemployer exception does not explicitly provide for a two-level appeal. For example, (i)(2)(iii)(B) provides that in the case of a multiemployer plan with a board that meets at least quarterly, the above described (i)(2)(iii)(A) provisions (which include the two-level appeals provision) do not apply. Instead the board must make its determination at the next scheduled meeting (with certain unrelated exceptions). Multiemployer plans typically have two levels of appeals. Comments submitted by multiemployer plans to permit two levels of appeals, reflected the inefficiency of bringing all appeals to board of trustees' quarterly meetings. The final regulations, while otherwise permitting two levels of appeal, do not provide this for multiemployer plans. Was this a drafting oversight?

PROPOSED/SUGGESTED ANSWER 4.

Yes, this was an oversight. The intent of the regulations was to permit multiemployer plans with regularly scheduled (at least quarterly) meetings to utilize two levels of appeals for any appeal for which plans that are not multiemployer plans can utilize two levels of appeals. The time frame for the first level of appeal of the claim denial in question is no more than the time required for the first level of a two level of appeal of such claim denial for plans that are not multiemployer plans. For example, for appeals of post-service claims denials, a plan with a single level of appeal that is not a multiemployer plan may take up to 60 days to conclude that appeal; so, a multiemployer plan with two levels of appeal must complete the first level of a post-service claim appeal in 30 days. Should the claimant appeal an adverse determination after the first level, the second level appeal must be submitted to the board at its next scheduled meeting after receipt of such appeal, as detailed in the current provisions of the regulations.

DEPARTMENT OF LABOR ANSWER 4.

The regulation does not limit a multiemployer plan to one level of appeal. The proposed response has no textual basis in the regulations. Nothing in the regulation suggests that a multiemployer plan with two levels of appeal should use 30 days for the first level and the quarterly meeting rule for the second level. The regulation does not mandate a particular split of days between the first and second appeal levels. The multiemployer plan and participant may agree to an additional amount of time to adjudicate the claims.

QUESTION 5.

At what point in the claim and appeal process should experts be identified as required by § 2560.503-1(h)(3)(iv)?

PROPOSED/SUGGESTED ANSWER 5.

Although listed with the appeals procedure, the experts should be identified as part of the initial adverse benefit determination, so that the claimant is aware of such information when deciding whether to appeal such initial adverse benefit determination.

DEPARTMENT OF LABOR ANSWER 5.

If an expert is used in making the benefit determination, the participant must be told that an expert was used. The identity of the expert may – but need not – be provided in the initial determination letter. However, the participant must at least be informed that the identity of the expert will be provided upon request. Staff suggested that the better practice is disclosure earlier rather than later.

QUESTION 6.

A business has decided to adopt a new ERISA plan. A detailed statement of the plan specifications is drafted and the board of directors approves a resolution adopting the statement as the initial plan document. The resolution provides that all reasonable and necessary expenses to establish and administer the plan shall be paid from plan assets. A trust agreement is signed and funding begins. An attorney is hired to draft an SPD and a more detailed plan document that will contain more specific language reflecting the plan design and additional provisions required by law. Assume any one of the following three scenarios:

1. The attorney spends a total of 40 hours discussing the project with the employer's staff, reviewing the resolution, clarifying certain provisions with the staff, performing some research and drafting the plan document. The attorney then spends 10 hours drafting an SPD.
2. The attorney decides to draft the SPD first and then the plan document. The attorney spends a total of 40 hours discussing the project with the employer's staff, reviewing the resolution, clarifying certain provisions with the staff, performing some research and drafting the SPD. The attorney then spends 10 hours drafting the plan document.
3. The attorney decides that one document may serve as the SPD and the plan document. The attorney spends 40 hours discussing the project with the employer's staff, reviewing the resolution, clarifying certain provisions with the staff, performing some research and drafting the combined SPD/plan document.

The attorney's bill is submitted to the trust for payment. How much of the bill may be paid from trust assets in each scenario?

PROPOSED/SUGGESTED ANSWER 6.

The entire bill may be paid from trust assets in all three scenarios. ERISA § 408(b)(2) provides that a plan fiduciary may make payments for services necessary for the "establishment or operation" of a plan. The plan document and SPD are needed to establish and operate the plan. It does not make any difference whether the plan document is prepared before or after the SPD, or whether one document serves both functions.

DEPARTMENT OF LABOR ANSWER 6.

Assuming that the detailed statement of plan specifications adopted by the board of directors is sufficient to establish a plan (rather than that the employer is considering whether or not to establish a plan or plan design options), the sequence of implementing the plan by drafting the plan document and summary plan description does not affect the fact that the cost of preparing these items can be paid from plan assets. The staff noted that the exemption in section 408(b)(2) for services provided in the establishment of a plan does not provide an exemption from section 406(b)(i) or from sections 403(c)(i) and 404 of ERISA. Sections 402(a) and (b) of ERISA establishes the requisite features that a plan must have. If the statement of plan specifications and board resolution provide these items and the drafting is only an implementation of the items in the statement and resolution, then it may be permissible to pay the costs of preparing these items.

QUESTION 7.

DOL Opinion No. 99-14A discusses the employer requirement to send an "Initial Notice" regarding COBRA information to an employee and his or her covered spouse. The Opinion states that the Department of Labor will consider a single, first-class mailing addressed to the covered employee, his or her spouse, and dependent children (if any) to be good faith compliance with the notice requirements of ERISA section 606(a)(4).

Will it be considered good faith compliance if a third-party administrator sends the Initial Notice to the address provided to the third-party administrator by the employer without including a return address?

PROPOSED/SUGGESTED ANSWER 7.

Yes. As long as the employer and the third-party administrator have no basis for believing that the address is inaccurate, no second effort needs to be made to verify the accuracy of the address before or after sending the Initial Notice. (Note: The absence of a return address on the first-class mailing means that the Initial Notice will not be returned to sender in the event that the address either provided by the employer or transferred to the Notice is incorrect.)

DEPARTMENT OF LABOR ANSWER 7.

Staff takes the position that the proposed answer is not correct. Citing 29 C.F.R. § 2520.104 B-1(b) as a "guideline," unless there is a return address on the Notice envelope (on an Initial Notice regarding COBRA information to an employee or his or her covered spouse), there is no "good faith" compliance by an employer who provides such Notice mailing through a third-party administrator.

QUESTION 8.

Can a retirement plan charge participants' accounts (directly) the cost of issuing a check to the participant?

PROPOSED/SUGGESTED ANSWER 8.

Yes. To hold otherwise (where the plan bears the administrative costs) would produce untoward and unjust results, particularly in the case of a dwindling plan population. Basically, to hold otherwise benefits those who quit early, as opposed to those who stay, as illustrated in the following example, where there are five participants, with one of them leaving at a time, where the cost of issuing the check to the departing participant is \$72.

Participant	Actual Cost	Number of Participants	Cost borne by Participant 5 (\$72/number of participants)
1	\$72	5	\$14.40
2	\$72	4	\$18
3	\$72	3	\$24
4	\$72	2	\$36
5	\$72	1	\$72
Total Amount Borne by Participant 5			\$169.40

Thus, if the costs must be borne by the plan, participant 5 ends up paying a total of \$169.4, yet participant 1 only paid \$14.4. This unequal allocation of the costs serves no rational purpose. (Note: This question was asked last year. The response we received was, "This issue (direct assessment of charges that relate to a particular participant's account) is under examination. The Department hopes to have an answer in the form of published guidance in the not too distant future.")

DEPARTMENT OF LABOR ANSWER 8.

2000 Answer: Staff is examining this and so is not prepared to answer. We should expect guidance in the not too distant future.

2001 Answer: Staff said it is still working on the guidance. This year, however, staff offered a few clues about its position. Staff observed that the relevant issue in this situation, as in connection with PWBA's published guidance on the costs engendered in a plan's DRO/QDRO review, is whether or not an imposed plan charge to the participant "burdens a statutory right." It is that issue that impedes a positive staff approval of the proposed response.

QUESTION 9.

Pension and Welfare Benefits Administration Guidance issued in conjunction with DOL Advisory Opinion 2001-01A, at Hypothetical No. 3 appears to state that following a plan design/settlor activity (amending the plan to establish an early retirement window), the

cost of obtaining an IRS determination letter regarding the amendment would be a plan administration implementation activity. Will all requests for an IRS determination letter qualify as plan administration implementation activities regardless of whether the plan amendments that are the basis for seeking a determination letter are plan design/settlor acts or plan administration amendments required by ERISA or the Code?

PROPOSED/SUGGESTED ANSWER 9.

The implementation of a plan amendment that has been adopted is a fiduciary act chargeable against plan assets, regardless of the nature of the plan amendment. All requests for an IRS determination letter are deemed to be a plan implementation activity, regardless of the nature of the underlying plan amendment that may be the basis for the determination letter filing.

DEPARTMENT OF LABOR ANSWER 9.

Staff agreed generally with the proposed answer, saying the issued guidance said a lot about this subject. Staff sees the expenses incurred in connection with a request for an IRS determination letter as implementation expenses payable from plan assets. However, there was a caveat. A determination letter request filed for a proposed amendment (where the amendment is not required, *e.g.*, offering additional alternative forms of benefits) may raise the settlor/fiduciary issue, if the employer has not yet committed to adopting the amendment, even if it is approved by the IRS. Anything short of an employer commitment to amend leaves open the possibility that this is a plan design issue not payable from plan assets, rather than the implementation of a design issue that is payable from plan assets.

QUESTION 10.

A Company that may not qualify as an "operating company" under the DOL Plan Asset Regulation, 29 C.F.R. § 2510.3-101 (for example, a REIT) has a common stock that is publicly traded and is a "publicly-offered security" within the meaning of the Plan Asset Regulation. The Company proposes to make a private placement of a separate class of preferred stock. The Company also proposes to limit investment by benefit plan investors to less than 25% of the value of the preferred stock, so that equity participation by benefit plan investors in this non-publicly traded class of securities is not "significant" under the Plan Asset Regulation. The Company does not know, and cannot realistically know, whether benefit plan investors own 25% or more of the publicly traded common stock. If a benefit plan investor purchases any shares of the preferred stock (but less than 25% of that class), are the Company's underlying assets considered plan assets because benefit plans may own 25% or more of the common stock?

PROPOSED/SUGGESTED ANSWER 10.

No. Under the facts presented, the Company's underlying assets would not be plan assets. Assuming that the common stock is a publicly-offered security, the look-through rule of the Plan Asset Regulation does not apply with respect to the common stock, regardless of the percentage of the common stock that is actually owned by benefit plans. The look-

through rule also will not apply with respect to the separate class of preferred stock, as long as benefit plan investment in the preferred stock is not significant – *i.e.*, as long as benefit plan investors own less than 25% of this non-publicly-offered class of equity securities. Benefit plan investment in the common stock (which the Company cannot realistically measure) would not cause the look-through rule to be applied to the separate class of preferred stock.

DEPARTMENT OF LABOR ANSWER 10.

Staff generally agreed that there is ambiguity on the issue and is uncertain as to the correct answer. Staff indicated that they would be willing to entertain requests for guidance on the issue.

QUESTION 11.

Can a plan with individually directed accounts ("IDAs") provide that participants are treated as named fiduciaries under ERISA section 402(a)(1), making section 404(c) inapplicable?

PROPOSED/SUGGESTED ANSWER 11.

Yes. Section 404(c) applies only if a plan complies with all of the requirements of 404(c). This includes the relief from fiduciary status under section 404(c)(1)(A) that is afforded a 404(c) plan participant who exercises investment discretion. If a plan does not meet the requirements of section 404(c), intentionally or unintentionally, then participants who exercise investment discretion over their accounts are fiduciaries.

DEPARTMENT OF LABOR ANSWER 11.

Staff disagreed with the proposed answer. A plan cannot side step the requirements of section 404(c) by taking the position that a participant who exercises investment discretion over his or her account is a plan "fiduciary". Section 404(c) is the only way for a plan fiduciary to avoid responsibility for the investment of a participant's account.

QUESTION 12.

The plan sponsor, as defined in ERISA section 3(16)(B)(iii), of a multiple employer plan or a multiemployer plan as defined in ERISA section 3(37)(A), is a joint board of trustees. Assume that the employers' involvement in both types of plans is limited to making contributions to the plan. In some situations, the constitution or by-laws of the sponsoring union is the document that requires employer contributions to the plan and that document can only be changed at a convention which is held every four or five years. In other situations, the document requiring employer contributions is a collective bargaining agreement, which can only be changed through collective bargaining.

If the board of trustees is engaged in settlor functions, the expenses of which may not be paid from plan assets, may the document requiring employer contributions be amended to

require the payment of an amount designated for settlor expenses? Can the board of trustees hold that amount as something other than plan assets so that it can be used to pay for settlor expenses?

PROPOSED/SUGGESTED ANSWER 12.

When a multiple employer or multiemployer plan is established pursuant to a collective bargaining agreement or otherwise, the parties to the collective bargaining agreement or other document requiring employer contributions to the plan may amend the applicable document to allow for periodic assessments of or payments by employers to pay estimated settlor expenses. Assessing contributing employers in this manner is not inconsistent with the principles Section 302 of the Labor Management Relations Act of 1947.

An amendment to the document requiring employer contributions can provide that employer payments will be held in a separate account, segregated from the plan's assets, as long as the assessments will be used only to pay settlor expenses and that they will not be used (and are not intended to be used) for any other purpose, such as offsetting benefit obligations. The amendment must provide that the payments do not belong to the plan, that the plan will not obtain a beneficial interest in the payments, and that the purpose of the separate account will be to serve as a depository arrangement for the setting aside of cash for paying for settlor expenses. In these circumstances, the plan would have no beneficial interest in the separate account and the assets in the separate account would not be considered plan assets under Title I of ERISA. *Cf. Advisory Opinion, 99-08A (May 20, 1999)*

DEPARTMENT OF LABOR ANSWER 12.

Staff stated that the Justice Department has jurisdiction over the LMRA. Staff also stated that, for ERISA purposes, the procedure described in the proposed answer would be acceptable.

QUESTION 13.

Some insurance companies have suggested that the Andrew Card Memo has effectively deferred the application date for the Claim Regulation until March 21, 2002 from the stated applicable date, that is, for "claims filed under a plan on or after January 1, 2002." Does the Department concur in this interpretation?

PROPOSED/SUGGESTED ANSWER 13.

No. The Card Memo delayed for 60 days the effective date for any regulation which had been published in the Federal Register but had not yet become effective. The Claim Regulation were published in the Federal Register on November 21, 2000, and became effective as of 12:01 a.m. January 20, 2001. The Card Memo could not have become effective until after President Bush was inaugurated at Noon on that same day, so by its terms the Card Memo does not apply to the Claim Regulation. Even assuming that the Card Memo did delay the effective date of the Claim Regulations to March 21, 2001, the

Claim Regulation by its terms applies to claims filed on or after January 1, 2002, and this provision would have become effective on March 21, 2001. There is, therefore, no basis for delaying the application date of the Claim Regulation. The Claim Regulation applies to all claims filed on or after January 1, 2002.

DEPARTMENT OF LABOR ANSWER 13.

Staff stated that it does not read the Card memo as self effectuating. It directed the agencies to postpone the effective dates of certain regulations. The staff is not in a position to say why the effective date of the claims procedure regulation was not postponed pursuant to the Card memo, but the proposed explanation regarding the regulation's effective date is plausible. **Note:** Since the meeting on May 9, 2001, the Department published in the Federal Register a notice extending the compliance date of the Claims Regulation for group health plans. 66 FR 35886, July 9, 2001.

QUESTION 14.

What is the meaning of the phrase "claims filed" in the regulation's language quoted in the question above?

PROPOSED/SUGGESTED ANSWER 14.

If "claims filed" has the same meaning as "claim for benefits"¹, then one looks to the Plan's "reasonable procedures for filing benefit claims" in order to determine when a claim has been filed and, therefore, whether the new Claim Regulation applies. If "claims filed" does not have the same meaning as "claim for benefits", then there is no regulatory or statutory standard for determining when a claim has been filed for purposes of determining the applicability of the Claim Regulation. (Note: This issue also arises in connection with "claims involving urgent care," "pre-service claims," and "post-service claims." Each of these use the terms "claim for medical care or treatment" or "claim for a benefit," but do not use the term "claim for benefits."

DEPARTMENT OF LABOR ANSWER 14.

Staff stated that a "claim for benefits" is the equivalent of a "claim filed," and that they are both the equivalent of "claim" as it is used in the list of terms in the last sentence of the proposed answer.

QUESTION 15.

Are contracts between healthcare providers and HMOs or PPOs (which, in turn, have agreements with insured and self-insured ERISA medical plans) —

- a. "instruments under which the plan is established or operated" within the meaning of ERISA §104(b)?²

- b. "relevant" within the meaning of §2560.503-1(m)(8)?
- c. "a written instrument" or "plan instrument" within the meaning of ERISA §§402(a)(1) and (2)?
- d. "documents and instruments governing the plan" within the meaning of ERISA §404(a)(1)(D)?

PROPOSED/SUGGESTED ANSWER 15.

- a. Yes.
- b. Yes.
- c. Maybe.
- d. Probably.

The purpose of ERISA's written instrument requirement and disclosure requirements are to provide participants and beneficiaries with adequate information to understand their benefits and legal rights to benefits. Inasmuch as the benefits available under a medical benefit plan are dependent upon the financial arrangements between healthcare providers and HMOs/PPOs (the benefit of which the plan sponsor has contracted for), participants and beneficiaries may not be able to understand how their plan functions and what benefits they are entitled to if they are denied access to all the agreements forming the contractual links between themselves and their medical providers.³ Also, these documents are relevant under section 2560.503-1(m)(8) for much the same reasons.

If in practice, HMOs and PPOs make claim determinations or appeal decisions based in part on their contracts with healthcare providers, then in effect, the HMOs and PPOs are performing an ERISA § 503 Named Fiduciary function, partially based on those provider contracts. If those contracts do not constitute "plan instruments" under ERISA section 402(a)(2), the Claim Regulation may not be satisfied, because the HMOs and PPOs are exercising Named Fiduciary authority without being properly appointed.

HMOs and PPOs that make final benefit determinations are acting as fiduciaries and must discharge their duties "in accordance with documents and instruments governing the plan..." ERISA § 404(a)(1)(D). To the extent these claim decisions are governed by provider contracts, those contracts should be such "documents and instruments."

DEPARTMENT OF LABOR ANSWER 15.

Staff stated that the question was framed too broadly and failed to focus on the contents of the particular document involved. Staff suggested that footnote 8 in *Pegram v. Herdrich*, 530 U.S. ___, 120 S.Ct. 2143 (2000) may provide some support for the argument that these kinds of contracts are "documents and instruments governing the plan" within the meaning of ERISA § 404(a)(1)(D). However, to date, the Department has taken the position that they are not such "documents and instruments." Staff stated that the question was framed too broadly and failed to focus on the contents of the particular document involved. Staff suggested that footnote 8 in *Pegram v. Herdrich*, 530

U.S. ___, 120 S.Ct. 2143 (2000) may provide some support for the argument that these kinds of contracts are "documents and instruments governing the plan" within the meaning of ERISA § 404(a)(1)(D). However, to date, the Department has taken the position that they are not such "documents and instruments."

QUESTION 16.

The Claim Regulation appears to prohibit any mandatory arbitration that would preclude a claimant from seeking judicial review under ERISA §502(a) or under "other applicable law."⁴ Is the Department of Labor reconsidering this position in light of the Supreme Court's recent *Circuit City* decision?

PROPOSED/SUGGESTED ANSWER 16.

The Department of Labor is reconsidering this position on mandatory arbitration and will publish a request for information from the public on this issue in the near future.

DEPARTMENT OF LABOR ANSWER 16.

Staff stated that the *Circuit City* decision is still under review and no conclusion has been reached concerning the decision's impact on the regulation. The staff does not anticipate that the Department will be publishing a request for information from the public.

QUESTION 17.

The definition of "adverse benefit determination"⁵ includes both (a) the failure to provide a benefit (*e.g.*, pre-service approval) and (b) the failure to provide payment (in whole or in part). The Claim Regulation's provision regarding notification of initial decisions on claims for urgent care states that "the plan administrator shall notify the claimant...of the plans benefit determination (whether adverse or not)..."⁶ This language suggests that a claim for payment must be decided within a 72-hour period or an expedited appeal must be permitted, even if the medical services were, in fact, performed and the only remaining question is whether and how much to pay. If so, must insurers and TPAs be prepared to make determinations about payments, as well as verification of eligibility for "claims involving urgent care" within 72 hours?

PROPOSED/SUGGESTED ANSWER 17.

No. When a claim for urgent care is also a pre-service claim, (*i.e.*, when the benefit is conditioned on pre-service approval within the meaning of Section 2560.503(m)(2)), it is necessary to have an interaction with the plan to determine eligibility and coverage within the Claim Regulation's accelerated time frames for initial determination and review. However, if the provision of a benefit is not so conditioned, the plan need not make a payment determination on an accelerated basis, even in cases where the physician considers the medical needs of the patient to be "urgent" within the meaning of §2560.503(m)(1). The plan must, however, provide the participant or healthcare provider

with information as to the patient's eligibility for benefits within the Claim Regulation's time frames for urgent care claims, subject to further investigation.

The current definition of a "claim for urgent care" implies that should the plan not render a decision in the accelerated time frame provided under the Claim Regulation, medical care or treatment will be delayed, with potential harm to the patient. But where the provision of the benefit is not conditioned on pre-service approval, there is no justification for such a delay in medical care or treatment. Therefore, requiring payment determinations on an accelerated basis in such circumstances serves no useful purpose. Since the definition of "adverse benefit determination" includes both (a) the failure to provide a benefit (*i.e.*, pre-service approval) and (b) the failure to provide payment (in whole or in part), and the provision in the Claim Regulation regarding notification of initial decisions for urgent care implies that payment must be determined within the 72 hour period or an expedited appeal must be permitted (even if the medical services have already been performed and the only issue was whether and how much the plan would pay), this clarification is necessary and the Department will issue this clarification in the very near future.

DEPARTMENT OF LABOR ANSWER 17.

The accelerated time frame would only apply where the plan terms require that a plan decision be made prior to the provision of medical services. In that circumstance—that is where a plan requires a payment decision to be made in advance of treatment--and the payment decision is adverse to the participant, the participant would have encountered a failure to provide payment of the claim within the meaning of the "adverse benefit determination" definition.

QUESTION 18.

Must ERISA plans or their fiduciaries comply with the Disclosure Provisions of the Gramm-Leach-Bliley Financial Services Modernization Act ("GLB Act") or any state law authorized by that Act?

PROPOSED/SUGGESTED ANSWER 18.

No. While ERISA plans may be "financial institutions" under the GLB Act, neither the plans nor their fiduciaries have to comply with the Disclosure Provisions. Any state law authorized by the Act that attempts to regulate an ERISA plan or its fiduciaries would be preempted by ERISA. The FTC has stated in the context of determining whether a beneficiary of a trust for which a financial institution (such as a bank) is a trustee, that neither the grantor nor a beneficiary of the trust is a "consumer" or "customer" of the financial institution. The rationale being that because the financial institution assumes fiduciary obligations (including the duty to protect the confidentiality of the beneficiaries' information) that are enforceable under state law, no additional protections are needed. Rather, says the FTC, the trust itself is the "customer."

Similarly, the FTC has excluded from the definition of "customer" or "consumer" any participant in an employee benefit plan. Since ERISA imposes independent disclosure obligations on benefit plans and imposes on plan sponsors and fiduciaries obligations enforceable under federal law, similar logic should also find that while an ERISA plan might be a "financial institution", it does not deal with "consumers" or "customers" and therefore has no additional disclosure obligations under the GLB Act.

Finally, fiduciaries of ERISA plans and other plan service providers (other than state regulated insurers) should have no greater duties under the GLB Act than do the ERISA plans for which they work.

DEPARTMENT OF LABOR ANSWER 18.

The FTC (and not the Department) has interpretive authority with respect to the Gramm-Leach-Bliley Financial Services Modernization Act. The Department has not discussed with the FTC the issue presented in the question.

QUESTION 19.

Section 104(b)(4) of ERISA requires a plan administrator to provide a copy of an annual report to a participant within 30 days of a written request for the document. The annual report for a pension fund includes the Schedule SSA, which shows the social security numbers and vested pension amounts of terminated vested participants. Can the plan exclude the Schedule SSA from the copy of the Form 5500 delivered to a participant if the participant does not submit releases signed by all of the deferred vested participants whose personal information is disclosed on the form?

PROPOSED/SUGGESTED ANSWER 19.

Yes. The deferred vested participant's social security number and vested pension entitlement may not be disclosed to someone other than the participant without a release signed by the participant.

DEPARTMENT OF LABOR ANSWER 19.

Staff agreed that the Schedule SSA is not required to be disclosed under section 104(b)(4) of ERISA (as the proposed answer concludes), but stated that the proposed answer is based on an incorrect premise. The Form 5500 annual Return/Report is a multi-agency form. The Schedule SSA is part of the "annual return" required by the Internal Revenue Code but is not part of the annual report to the Department of Labor. *See* 29 C.F.R. § 2520.103-1(b) and (c), which list the schedules that are part of the annual report to DOL. Certain schedules filed solely to satisfy reporting obligations under the Code (such as Schedule SSA) are not part of the Title I annual report and are not required to be disclosed under section 104(b)(4). The Schedule SSA itself reflects this, with a legend in the upper right hand corner that says "This Form is NOT Open to Public Inspection."

QUESTION 20.

The Mental Health Parity Act states that a group health plan cannot impose aggregate or annual limits on mental health benefits that differ from those applied to other benefits.

- a. If a plan does not have a specific "aggregate lifetime limit" or "annual limit" on mental health benefits (*i.e.*, \$1,200 per year) but limits payments on mental health benefits to a certain number of visits at a capped dollar amount per visit (*i.e.*, 20 visits at up to \$60 per visit), does this violate the Act?
- b. Would the answer change if the plan imposed capped dollar amounts per visit on other services, such as chiropractic services?

PROPOSED/SUGGESTED ANSWER 20.

- a. No. This is not an "aggregate lifetime limit" or "annual limit" on mental health benefits.
- b. No. This is not an "aggregate lifetime limit" or "annual limit" on mental health benefits.

DEPARTMENT OF LABOR ANSWER 20.

- a. Staff views this as an impermissible constructive annual limit under MHPA. It is permissible to have a limit on the number of visits that will be covered per year, but not to couple such a limit with a dollar limit that has the effect of capping the maximum amount covered each year. This answer is consistent with Q&A 8 in a DOL publication on HIPAA, MHPA, NMHPA and WHCRA – available at <http://www.dol.gov/dol/pwba/public/pubs/compasst.htm> – which has been coordinated with the IRS and HCFA (now CMS).
- b. Whether the answer would change where the plan imposes limits on other services depends on the benefits on which those other limits are imposed. Under MHPA, any dollar limit must be coordinated with a dollar limit on medical/surgical benefits generally. Under 29 C.F.R. § 2590.712(b), if a limit applies to at least 2/3 of the medical/surgical benefits, the limit may also be applied to mental health benefits "in a manner that does not distinguish between the medical/surgical and mental health benefits." If the limit only applies to chiropractic benefits, as stated in the example, it is not likely to hit 2/3, or even 1/3. As the regulations specify, if a limit applies to less than 1/3 of medical/surgical benefits, the limit cannot be imposed on mental health benefits. Finally, if the limit applies to between 1/3 and 2/3 of the medical/surgical benefits, a formula in the regulations describes the manner in which the limit may be applied to mental health benefits.

A follow-up question was asked as to whether it would be permissible to have an annual limit on mental health benefits of 50 visits that would be covered at, for example, 80% of

"usual and customary" cost (UCR). Staff responded that the Department enforcement efforts have not targeted this plan practice, but staff cannot predict how courts would view such a limit.

A second follow-up question was asked about the likelihood that MHPA, which is currently scheduled to sunset for services furnished on or after September 30, 2001, will be extended. Staff said that an extension has been proposed every year. As of the date of the meeting (May 9, 2001), staff was not able to predict whether an extension would be enacted.

QUESTION 21.

Section 701(f)(1) of ERISA gives "employee[s]" and their dependents special enrollment rights in connection with the loss of coverage under another plan. Section 701(f)(2) of ERISA gives "individual[s]" who are "participant[s] under the plan" and their dependents special enrollment rights with respect to the acquisition of a new dependent. Do either or both of these rules apply to retirees who participate in the plan?

PROPOSED/SUGGESTED ANSWER 21.

Section 701(f)(2) of ERISA applies to retirees who are or may become eligible to receive a benefit from the plan, since they fall within the definition of the term "participant" set forth in section 3(7) of ERISA. Section 701(f)(1) does not apply to retirees since they are not employed by an employer and therefore do not fall within the definition of "employee" as set forth in section 3(6) of ERISA.

DEPARTMENT OF LABOR ANSWER 21.

Section 701(f)(1) of ERISA applies to employees. Section 701(f)(2) applies to retirees. A retiree may add a dependent if the retiree gains a dependent (such as by marriage) during the coverage period. However, if the retiree declined coverage and subsequently gains a dependent, the retiree may not then elect coverage.

QUESTION 22.

Can a summary plan description that is provided on an employer's intranet satisfy the electronic delivery requirements of proposed regulation 29 C.F.R. § 2520.104b-1(c)?

PROPOSED/SUGGESTED ANSWER 22.

Yes. Proposed Regulation 29 C.F.R. § 2520.104b-1(c) establishes a safe harbor under which pension and welfare benefit plan administrators can satisfy the obligation to furnish summary plan descriptions, summaries of material modifications, and summary annual reports using electronic media. The safe harbor contemplates electronic delivery to participants of plan documents. However, the regulation does not address steps to be taken by a plan administrator to satisfy its obligation to provide documents by providing

participants access to an intranet system under which participants can access summary plan descriptions, summaries of material modifications, and summary annual reports.

Documents furnished through electronic media must satisfy the following requirements, among others, under the proposed regulation's safe harbor:

- The plan administrator must take appropriate and necessary measures to ensure that the system for furnishing documents results in actual receipt of the transmitted documents by the participants.
- Each participant must be provided notice, through an electronic means or in writing, apprising the participant of the documents to be furnished electronically, the significance of the documents, and the participant's right to request and receive, free of charge, a paper copy of each document sent electronically.

In the case of intranet access:

- If the Plan Administrator conducts periodic reviews to confirm that participants are in fact accessing plan documents through the intranet, the first criterion is satisfied.
- If a Plan Administrator sends an electronic message to all participants advising participants of the ability to access plan documents on the intranet, the second criterion is satisfied.

DEPARTMENT OF LABOR ANSWER 22.

Yes. A summary plan description that is provided on an employer's intranet may satisfy the electronic delivery requirements of the proposed regulations as long as each participant has effective access to the intranet at his or her worksite.

Staff explained that the regulations were drafted to avoid including or excluding particular types of technology especially in light of the continuing changes in technology. As a result, the failure to specifically refer to an "intranet" in the regulations is not fatal to the analysis. Providing information via an intranet is acceptable as long as all of the applicable, safe harbor requirements are met.

In commenting on the proposed answer, staff noted that the conclusions at the end of the proposed answer were too narrow. For example, staff took the position that the notice referred to in the last bullet of the proposed answer is inadequate, unless it includes all of the information referred to in the second bullet of the prior paragraph.

QUESTION 23.

Is a discount eyewear program an ERISA benefit?

PROPOSED/SUGGESTED ANSWER 23.

ERISA defines the term "welfare plan" as "any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment." ERISA § 3(1). Eyewear and vision care services come within the scope of benefits allowable under a welfare plan. Therefore, a plan that offers employees the ability to receive eyewear and vision care services is a welfare plan within the definition of ERISA § 3(1). Nothing in ERISA provides that these products or services cannot be offered to participants at a discount. Therefore, a plan that offers the employees the ability to purchase discount eyewear and vision care services is an ERISA welfare benefit plan.

DEPARTMENT OF LABOR ANSWER 23.

Staff cautioned that discount eyewear may be a welfare benefit, but the arrangement described in the question is not necessarily a welfare benefit plan. Staff stated that, among other requirements, a discount eyewear program needs to be established and maintained by an employer, employee organization, or both, before it can be considered a plan. There are not enough facts presented in the question to make a determination as to whether this is a welfare benefit plan established and maintained by an employer or simply an employer allowing a separate eyewear provider to make its discount program available to the employer's employees. *See* 29 C.F.R. 2510.3-1(j).

¹ §2560.503-1(e).

² See also footnote 24 to the Preamble to the Claim Regulation.

³ The best example of this interrelationship is the ban on balance billing typically found in a healthcare provider's contract with an HMO or PPO.

⁴ §2560.503-1(c)(4)(ii).

⁵ §2560.503-1(m)(4).

⁶ §2560.503-1(i)(2)(i).

The preceding questions and answers are based on informal discussions between private sector representatives of the JCEB and Department of Labor officials. The questions were submitted by ABA members and the responses were given at a May 9, 2001 meeting of JCEB and government representatives. The responses reflect the unofficial, individual views of the government participants as of the time of the discussions, and do not necessarily represent agency policy. This report on the discussions was prepared by designated JCEB representatives, based on the notes and recollections of the JCEB representatives at the meeting, and has been reviewed by Labor Department staff who were present at the meeting. The questions were submitted in advance to the agency, and it was understood that this report would be made available to the public.