

JCEB-Department of Labor--June 2002
These are only unofficial individual comments.

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 8, 2002 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.

Questions for the Department of Labor for JCEB Technical Session on May 8, 2002

QUESTION 1.

The claims procedure regulation makes mandatory binding arbitration improper as a part of the claims review appeal process. Since top hat plans are not exempted from the claims review procedures of ERISA, does this mean a top hat plan cannot require that disputes be resolved through arbitration?

PROPOSED/SUGGESTED ANSWER 1.

Top hat plans would not be able to have mandatory and binding arbitration as part of the claims review appeal process. However, in light of the Supreme Court's decision in *Circuit City Stores, Inc. v. Adams*, 121 S.Ct. 1399 (2001), the Department is reconsidering the regulation's arbitration limitation.

DEPARTMENT OF LABOR ANSWER 1.

Top hat plans are not exempt from the Title I claims and appeals procedures. See FAQ A-12. The staff indicated that they have concluded their consideration of the *Circuit City* decision and do not believe the decision requires changes to the claims and appeals procedures regulation. Staff noted that the prohibition against the use of mandatory and binding arbitration as a level of the claims and appeals procedure does not preclude the use of

mandatory and binding arbitration between plans and service providers, for example, to resolve tort claims against a doctor who provides services under the plan. See FAQ B-6. Also, the provisions governing voluntary additional levels of appeals do not apply to benefits other than group health and disability. See FAQ E-3. Such plans must comply with the general requirements for a reasonable claims procedure set forth in paragraph (b), including the prohibition against requiring claimants to pay a fee or costs as a condition to making a claim or appealing an adverse benefit determination.

QUESTION 2.

Does the Department's claims review regulation override all mandatory arbitration provisions in all employee benefits plans?

PROPOSED/SUGGESTED ANSWER 2.

Yes.

DEPARTMENT OF LABOR ANSWER 2.

No. The regulation prohibits the use of mandatory, binding arbitration only with respect to group health and disability claims. See FAQ E-3. See also the answer to Question 1, above.

QUESTION 3.

Do the requirements relating to portability, access and renewability under Subchapter A of Internal Revenue Code Chapter 100 and under Part 7 of ERISA Title I (collectively the "HIPAA requirements") apply to a group health plan that only covers retirees?

PROPOSED/SUGGESTED ANSWER 3.

I.R.C. § 9831(a)(2) and ERISA § 732(a) (albeit under the heading "general exception for certain small group health plans") provide that the HIPAA requirements do not apply to a group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees. Thus, a stand-alone retiree medical plan that covers no current employees is exempt from the HIPAA requirements, regardless of the number of retirees covered thereunder.

DEPARTMENT OF LABOR ANSWER 3.

Staff generally agreed with the proposed answer that the HIPAA requirements do not apply to a retiree only plan, with one exception. ERISA § 732(a), 29 USC 1191a(a), provides that the "requirements of this part (other than section 711) shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of such plan year, such plan has less than 2 participants who are current employees." Section 711 is Standards relating to benefits for mothers and newborns.

QUESTION 4.

If a group health plan covers both current employees and retirees but dependent coverage for retirees is limited to a retiree's dependents at the time of his or her retirement (i.e., any new dependent is ineligible) while dependent coverage for current employees includes a new dependent, must the plan permit enrollment by a dependent acquired by a retiree after retirement?

PROPOSED/SUGGESTED ANSWER 4.

I.R.C. § 9801(f)(2)(A)(i) and ERISA § 701(f)(2)(A)(i) apply a special enrollment period in the event of a new dependent, if the group health plan otherwise provides dependent coverage. Where a different class of eligible dependents is permitted for covered current employees than is permitted for covered retirees, these statutory provisions and the related interim regulations

only require coverage of a new dependent if that individual qualifies as a "dependent" under the plan terms as they apply to retirees.

DEPARTMENT OF LABOR ANSWER 4.

Staff disagrees with proposed answer. The Department very carefully considered and concluded that employee means a current employee and participant means any participant, whether a current employee or a retiree. Retirees are "participants" under the special enrollment rules and as participants, the special enrollment rules allow them as participants to add dependents if they are already enrolled. However, if they have not enrolled previously, a retiree cannot use special enrollment rules to enroll. The question involves the interpretation of the phrase "otherwise eligible". ERISA § 701(f)(2)(A) ("the spouse of the individual may be enrolled as a dependent of the individual if such spouse is otherwise eligible for coverage"). Staff believes that this term refers to substantive eligibility requirements, not procedural or timing requirements. Staff indicates that clarification may be provided on this issue in the not too distant future.

QUESTION 5.

A health plan provides coverage for an employee and his dependents. The plan receives a Qualified Medical Child Support Order covering a child of the spouse of the employee, who is not also a child of the employee (and does not reside with and is not supported by the employee, although these facts may not be relevant). Must the plan provide coverage for the child?

PROPOSED/SUGGESTED ANSWER 5.

No. ERISA § 609 directs the plan of the participant (the employee in this question) to provide coverage for the child of the participant. Under the facts presented, the child is not the child of the participant, and is, therefore, not entitled to coverage. (Caveat: If under the plan's terms the child would be a "child of the participant," then the plan must provide coverage.).

DEPARTMENT OF LABOR ANSWER 5.

The Department agrees with the proposed answer with some reservation. Staff emphasizes that reference should not only be made to the plan's terms to determine whether the child is a "child of the participant." Reference should also be to ERISA § 609 and the meaning of the term "child" for purposes of qualified medical child support orders, as well as to state law to determine whether the child is a "child of the participant."

QUESTION 6.

In the case where an employee benefit plan establishes two levels of appeal in its reasonable claims procedure, is each level of appeal required to be resolved by a fiduciary?

PROPOSED/SUGGESTED ANSWER 6.

No, as long as the second level is resolved by a fiduciary. Neither the regulation, at 29 C.F.R. § 2560.503-1(h)(3)(ii), nor the preamble to the claims review regulation at 65 Fed. Reg. at 70252-54 (2000) specifies which review must be conducted by an appropriate named fiduciary. The regulation specifies with respect to group health plans that claimants must receive a reasonable opportunity for a full and fair review of a claim, which includes, *inter alia*, "a review ... that is conducted by an appropriate named fiduciary of the plan." [(h)(3)(ii)] Specifically, the regulation states that "a" review must be accomplished by a fiduciary rather than specifying whether all levels of review must be accomplished by a fiduciary. For example, a reasonable claims procedure could afford the claimant an initial level of review by a third party administrator to the plan who does not have discretionary authority or control and a second level of review by an appropriate named fiduciary of the plan. Such procedures would comply with the terms of the regulation by affording full and fair review of the claim by an appropriate named fiduciary.

DEPARTMENT OF LABOR ANSWER 6.

While the regulation does not specifically address the standards applicable at each level of review when a group health plan provides for two levels, as is permitted under the rule, the Department did provide some clarification in its *Frequently Asked Questions*, at Q-D3. In answering the

question, the Department indicated that the second level of review is subject to the same standards that apply to the first level of review. Accordingly, in the absence of further clarification, the staff believe that both levels of review would, consistent with Q-D3, require resolution of a claim by a fiduciary at each level.

QUESTION 7.

The claims procedure review affords the plan in the case of both pre- and post-service claims a one-time extension of 15 days. [(f)(2)(iii)] Does the plan receive the benefit of any unused days from the initial period to render a determination (15 and 30 days, respectively), in addition to the 15-day extension period to render a determination where the plan exercises its right to the extension?

PROPOSED/SUGGESTED ANSWER 7.

The regulation links the 15-day extension period to the initial period within which to render an adverse determination by stating “[t]his period may be extended ... for up to 15 days.” A reasonable interpretation of this language is that the 15-day extension period is added to the initial period to render a determination. Accordingly, pre-service claims could be determined within 30 days and post-service claims within 45 days so long as the plan requested the extension in compliance with the terms of the regulation.

The preamble to the regulation refers to tolling of the time period for making the determination. 65 Fed. Reg. at 70250. If the time period for making the determination is indeed “tolled” then that period is suspended or stopped temporarily. Hence, the plan would still have the benefit of any time left over from the initial period in addition to the 15-day extension period afforded by the regulation. Moreover, the language in the regulation does not state that a claim must be determined within 15 days of receiving additional information, rather the regulation specifically states that the initial determination period is extended (i.e. added to) for up to 15 days. Accordingly, if a post-service claim requires additional information and the claim is tolled at

day 15, then the plan would have the benefit of the remaining 15 days plus the 15 extension period afforded by the regulation; thus, a total of 30 days.

DEPARTMENT OF LABOR ANSWER 7.

Staff presumed that this question related to a group health plan. The answer differs depending upon why the extension is necessary. If the plan takes an extension (other than for a need for additional information from the claimant), there is no tolling; the initial time period continues to run, followed immediately by the extension period for a total period of time equal to the initial time period plus the extension period. On the other hand, if the plan takes an extension to obtain additional information from the claimant, the time period is tolled, meaning that once notice requesting additional information goes out to the claimant, the initial time period ends; the extension period begins to run when the information is received or the time given the claimant to respond expires, whichever comes first. Staff referred to the FAQs and in particular C-3:

If the period within which a group health claim must be decided is ending and the claimant has yet to furnish all the information necessary to decide the claim, may the plan extend the time period for deciding the claim and, if so, for how long?

In general, a group health plan may unilaterally extend the decision making on both pre-service and post-service claims for 15 days after the expiration of the initial period, if the administrator determines that such an extension is necessary for reasons beyond the control of the plan. There is no provision for extensions in the case of claims involving urgent care.

If the reason for taking the extension is the failure of the claimant to provide information necessary to decide the claim, and the claimant is so notified of this fact, the time period for making the decision is suspended (“tolled”) from the date of the notification to the claimant to the earlier of:

- The date on which a response from the claimant is received by the plan or
- The date established by the plan for the furnishing of the requested information (at least 45 days).

The extension period (15 days) – within which a decision must be made by the plan – will begin to run from the date on which the claimant’s response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days). See §§ 2560.503-1(f)(2)(iii) (A) and (B); 2560.503-1(f)(4); 2560.503-1(i)(4). Also see 65 FR at 70250, n.21.

QUESTION 8.

Sections 2560.503-1(f)(4) and (i)(4) of the claims review regulation allow the period of time for making a benefit determination on review to be tolled due to a claimant’s failure to submit information necessary to decide a claim. How are the timeframes and tolling rule applied when it is not the claimant, but a third party (such as the Social Security Administration or a contributing employer in the case of a multiemployer plan) who must submit the information needed to process benefit claims.

PROPOSED/SUGGESTED ANSWER 8.

Where a pension plan is dependant on the Social Security Administration or another third party to supply information necessary to decide a claim for pension benefits, the period of time for making a benefit determination on review is tolled until the plan receives the necessary information.

DEPARTMENT OF LABOR ANSWER 8.

In the case of a group health or disability benefit claim, if the reason for taking the extension is the failure of the claimant to provide information necessary to decide the claim, and the claimant is so notified of this fact, the time period for making the decision is tolled from the date of the notification to the claimant to the earlier of: (1) the date on which a response from the claimant is received by the plan or (2) the date established by the plan for furnishing the requested information (at least 45 days). The tolling rule in paragraphs (f)(4) and (i)(4) of the regulation is not available outside of this limited context, such as where the plan determines that it would be useful or necessary to obtain information from a party other than the claimant. Nor is

tolling available with respect to initial claims for pension benefits. In this regard, however, nothing precludes a plan from obtaining a claimant's consent to an extension of the period for making a decision.

QUESTION 9.

Will the Department of Labor continue to apply the principles of DOL Opinion Letter 92-02A, that a stop loss insurance policy issued to an employer sponsoring a welfare benefit plan that provides benefits exclusively out of the employer's general assets is not a "plan asset", notwithstanding the Court of Appeals decision in *Patelco Credit Union v. Sahni*, 262 F.3d 897 (9th Cir. 2001)? That case held that the stop loss insurance carrier's checks payable to the employer were "plan assets".

PROPOSED/SUGGESTED ANSWER 9.

The DOL continues to apply the principles of DOL Opinion Letter 92-02A.

DEPARTMENT OF LABOR ANSWER 9.

Staff agreed with the proposed answer. The Department will continue to apply the principles of DOL Opinion Letter 92.02A in determining whether amounts paid by the insurer under a stop loss policy are "plan assets." The Department reaffirmed the 92.02A analysis in DOL Opinion Letter 2001-02A. Staff emphasized that traditional notions of property rights will continue to apply and, therefore, in some instances stop loss policy proceeds may be plan assets.

QUESTION 10.

An employer closed operations and proceeded to effect distributions of all accounts under its defined contribution plan to its former employees, all of whom had a termination of employment. The distribution election forms

clearly stated that account balances would be credited with interest through June 30 and any earnings thereafter would be prorated among any accounts remaining under the plan. Election forms were returned and all accounts under the plan were paid out with earnings through June 30. The actual distribution of all accounts occurred August 31. The trustee placed the assets in an interest-bearing account as of June 30. The plan stated that administration costs could be assessed to the plan, but the employer paid those costs. Can the plan reimburse the employer from the post-June 30 earnings for the administrative costs associated with plan termination paid by the employer before distributing the post-June 30 earnings to the participants?

PROPOSED/SUGGESTED ANSWER 10.

Yes. It should be permissible for the plan to reimburse the employer for its payment of the plan termination-related plan expenses, assuming the expenses were necessary and reasonable for the administration of the plan. Reimbursement of the employer should be allowed under ERISA 408(b)(2).

DEPARTMENT OF LABOR ANSWER 10.

Staff agreed with the answer with certain reservations. Staff would want to see evidence of a “meeting of the minds” that the expenses would be reimbursed at or before the time the services were performed. With the plan language being permissive, the fundamental question is whether there is an obligation on the part of the plan to reimburse the expenses. The staff believe that where there is a clear understanding or agreement on or before the time the services are performed that the plan will reimburse the employer, a fiduciary could justify reimbursing the expenses. The staff did not believe that a written understanding or agreement is necessarily required.

QUESTION 11.

(Same facts as Question 10). Separate and apart from the termination costs referred to in the prior Question, can the plan reimburse the employer for administrative costs paid by the employer for prior years?

PROPOSED/SUGGESTED ANSWER 11.

No. The reimbursements would be impermissible under ERISA 406(a)(1)(B).

DEPARTMENT OF LABOR ANSWER 11.

Staff generally agreed with the proposed answer. As in the prior question, because the plan language is permissive (that is, allowing the plan to pay expenses), the fundamental question again is what circumstances would compel a fiduciary to reimburse the employer for paying those expenses. Again, reimbursement could be appropriate if there was a clear understanding or agreement on or before the time the services were performed that the plan would reimburse the expenses. Without such understanding or agreement, the staff felt there would be no basis for the fiduciary to reimburse the expenses. Staff felt that under the facts presented, a significant delay in reimbursement may stretch the “expectation” of reimbursement theory. Rather than a reimbursement theory, it might be possible to argue that reimbursement is consistent with Prohibited Transaction Class Exemption 80-26. However, the meeting of the minds about the arrangement (i.e., that there was an interest free loan) must be supported by evidence. Under the circumstances presented, the permissive plan provision would not, in and of itself, be sufficient evidence.

QUESTION 12.

Individual AB, who was a participant in the X Company Profit Sharing Plan terminated from the employment of Company X in 1980. In 1981, AB received a Form SSA advising her that she was entitled to a distribution from the Plan. In the 1990’s, Company Y acquired Company X. In 2002, individual AB contacts Company Y, advises it that she was a participant in the Company X profit sharing plan, but did not receive (or does not recall receiving) a distribution from the plan. Company Y conducts appropriate diligence with respect to the X Company Profit Sharing Plan, but can find no record of individual AB.

In what manner is the burden of proof allocated? Does the production of a Form SSA [Schedule SSA (Form 5500) - annual registration statement identifying separated participants with deferred vested benefits, required to be filed by all plans that had separated participants during the plan year] by the participant transfer the burden to the plan sponsor? Can the plan sponsor require the Plan participant to produce his or her prior federal income tax returns? If it is determined that either the Plan participant has satisfied his or her burden or the plan sponsor has not satisfied its burden, what benefit should the participant receive? Is the general rule under ERISA § 107 that records be retained not less than six years after the filing date of the document based on the information they contain a defense?

PROPOSED/SUGGESTED ANSWER 12.

Regardless of whether or not participant can produce a Form SSA or any other documentation indicating that at some previous time he or she was entitled to a benefit from a tax-qualified plan, if his or her request for benefits is submitted at a time when the plan would not be obligated to retain records under ERISA Section 107, he or she should have the burden of proof, even though that effectively requires a plan participant to establish a negative.

DEPARTMENT OF LABOR ANSWER 12.

Staff did not agree with the proposed answer.

Staff cautioned that questions relating to procedural rights and remedies in individual benefit claims proceedings and/or actions for breach of fiduciary duties generally depend on the facts and circumstances involved.

Staff noted that, under ERISA § 209, employers (and, in some cases, plan administrators) must “maintain records with respect to each of his employees sufficient to determine the benefits due or which may become due to such employees.” Unlike the “not less than six years” requirement for keeping annual reporting records under ERISA § 107, the recordkeeping requirement under § 209 is not similarly limited. See Information Letter to Mr. Gregg M. Goodman (Aug. 23, 1983). If the absence of records regarding a participant’s benefit entitlement resulted from a violation of ERISA § 209, staff thought it would not be an appropriate response to the recordkeeping violation to require the employee to prove that he or she had not been paid all the benefits due him or her under the plan.

Staff also noted that employers and plan administrators could take steps to avoid or minimize these types of situations. For example, the Form SSA specifically provides employers and plan administrators with the option of updating deferred vested benefit information once distributions have been made to participants. Staff also suggested that plan fiduciaries and/or employers should establish and periodically review recordkeeping procedures as a way of ensuring adequate records are maintained regarding benefit entitlements. Fiduciaries and employers should consider including procedures on recordkeeping problems in mergers and/or acquisitions where issues may arise due to a lack of continuity in persons responsible for maintaining plan and employer records.

QUESTION 13.

Can a plan administrator include in its QDRO procedures for a defined contribution plan a requirement that once the participant has terminated employment and received a distribution, the alternate payee must also receive a distribution?

PROPOSED/SUGGESTED ANSWER 13.

Yes. Although it may be characterized as boot strapping, once such a provision is included in the procedures, a proposed order that was inconsistent with the procedure would fail to satisfy Code ERISA § 414(p) and 404(a)(1)(D).

DEPARTMENT OF LABOR ANSWER 13.

Staff does not agree with the proposed answer. A QDRO gives the alternate payee the rights of a participant; if the participant's rights are not limited, the alternate payee's rights cannot be limited; (see Inman-Campbell Advisory Opinion 2000-09A). If a participant can delay distribution, the right to delay distribution should be assignable to the alternate payee as well. Thus, the participant cannot indirectly cause a forced distribution to the alternate payee.

QUESTION 14.

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 14.

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

DEPARTMENT OF LABOR ANSWER 14.

Staff agreed that a literal reading of the regulation would support the proposed answer. On the other hand, the staff believed that the intent of the regulation could be satisfied through the furnishing of a profile prospectus. A fund profile is not a “prospectus.” However, the profile provides much useful information in a usable format and is generally easier to understand than the prospectus. The Department currently is reviewing this issue (that is, providing a profile, rather than a prospectus, but making the prospectus available upon request by the participant) in the context of an advisory opinion request.

QUESTION 15.

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

PROPOSED/SUGGESTED ANSWER 15.

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 whose 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
4	\$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 \$169.40, yet participant 1 only paid \$14.40. This unequal allocation of the costs serves no rational purpose.

DEPARTMENT OF LABOR ANSWER 15.

The issues raised by this example continue to be under active review by the Department. The Department indicated that, while there was internal agreement regarding many of the issues, a final decision has not been reached.

QUESTION 16.

Do participants have standing to sue an employer/fiduciary for plan investment losses resulting from the employer/fiduciary's breaches of the duty to monitor investment managers, if the plan is an overfunded, defined benefit plan?

PROPOSED/SUGGESTED ANSWER 16.

No. The participants do not have standing to sue under Article III of the Constitution, because (under the circumstances) they have suffered no cognizable harm. *See Harley v. Minnesota Mining & Manufacturing Co.*, No. 00-2214 (8th Cir. 3/26/02).

DEPARTMENT OF LABOR ANSWER 16.

The case, *Harley v. Minnesota Mining & Manufacturing Co.*, raises two issues: (1) whether the participants' had standing to bring the claim, and (2) whether the amounts paid to the investment advisor constituted a prohibited transaction for self-dealing under ERISA § 406(b) or whether ERISA § 408(c)(2) provides an exemption for ERISA § 406(b), because the fees were reasonable. According to staff, there is now a split in the circuits on the exemption issue. The Department disagrees with the rulings on both issues in *Harley v. Minnesota Mining & Manufacturing Co.* The Department plans to file an amicus brief with respect to the pending motion for a rehearing en banc, pending before the 8th Circuit, however the filing of the amicus brief must be approved by the Solicitor General's office. Approval has not yet been given. Until the amicus brief is filed (or not), staff could elaborate on these issues.

QUESTION 17.

Does the Department continue to maintain that multiemployer plan trustees always act in a fiduciary capacity?

PROPOSED/SUGGESTED ANSWER 17.

No. In light of recent court decisions, the Department has determined that in certain situations, multiemployer plan trustees can act as plan sponsor/settlers and not as fiduciaries. *See, e.g., Gard v. Blankenburg*, No. 00-1234 (6th Cir. 2/21/01).

DEPARTMENT OF LABOR ANSWER 17.

The staff indicated that this issue is currently under consideration.