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Employee Benefits Bulletin

A review and analysis of recent developments affecting employee benefits

If you have any questions regarding material in this issue of the *Employee Benefits Bulletin* or suggestions for a specific topic you would like addressed in a future issue, please contact the editor, Thomas G. Hancuch at 312/609-7824 or at thancuch@vedderprice.com, or Paul F. Russell (practice leader) at 312/609-7740 or at prussell@vedderprice.com or any other Vedder Price Attorney with whom you have worked.

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Claim Procedure Rules Revised

The Department of Labor ("DOL") recently published final regulations significantly changing the claim and appeal procedure rules governing health and disability benefit plans. The regulations dramatically shorten the time periods for processing health and disability benefit claims and add a variety of new procedural requirements. The new regulations, which apply to claims filed on or after January 1, 2002, will require significant revisions to benefit plan documents and claims handling procedures.

Under existing regulations, health and disability benefit plans may take 90 days (and in some circumstances, 180 days) to respond to a claim. Critics have argued that this period is simply too long, especially in the context of medical care decisions requiring increasingly prompt action. The regulations address

those concerns by radically reducing the time frames within which claim decisions must be made. Those time frames vary, based upon the type of claim.

Health Plans

Under the new regulations, health benefit plans generally must issue a decision granting or denying a claim within the following time frames:

- 72 hours for urgent care claims
- 15 days for pre-service claims
- 30 days for post-service claims

One 15-day extension of time is permitted for each pre- or post-service claim. No extensions are allowed for urgent care claims.

The time established by the plan within which a claimant may appeal an adverse claim decision cannot be shorter than 180 days under the new regulations (as opposed to 60 days under the current regulations). Once an appeal is received, a written decision must be issued within the following time frames:

- 72 hours for urgent care claims
- 30 days for pre-service claims
- 60 days for post-service claims

Disability Benefit

Disability benefit claims ordinarily must be decided within 45 days under the new regulations. Two extensions of up to 30 days each are permitted, if needed, due to reasons beyond the plan's control. As with health benefit claims, a participant must be allowed at least 180 days to appeal a claim denial decision. Appeals must be decided within 45 days of receipt, with up to one 45-day extension permitted, if necessary. Multi-employer plans holding at least quarterly meetings of trustees may take advantage of a special "quarterly meeting" extended time period when reviewing appeals.

Other Procedural Changes

The new regulations impose a variety of requirements intended to assure that claims procedures are fair to claimants. A plan's claim procedures may not include anything that would unduly inhibit the initiation or processing of benefit claims and may not preclude a claimant's authorized representative from pursuing claims or appeals on behalf of the claimant. The procedures must include

safeguards to assure claims decisions are made in accordance with the plan's governing documents and plan provisions, and are applied consistently to similarly situated claimants.

The appeal of an initial adverse benefit decision must be decided by a named plan fiduciary who did not make the initial decision. The review on appeal must be "de novo," may not give any weight to the initial decision, and must take into account all information submitted by the claimant, regardless of whether it was submitted or considered in the initial decision. In deciding an appeal of an initial decision based wholly or partly on a medical judgment (including decisions about whether a particular item or service is experimental, investigational or not medically necessary or appropriate), the plan fiduciary must consult with a qualified health care professional who was not consulted in connection with the initial denial.

A claimant may not be required to file more than two appeals prior to filing a civil suit under ERISA § 502(a). Plans may offer claimants additional voluntary levels of appeal, such as arbitration or other forms of dispute resolution, but only after the required appeal procedure is exhausted. Election of any such voluntary appeal cannot affect the claimant's rights to any other plan benefits, and no fees or costs may be imposed on a claimant for filing or appealing any claim.

Fuller Disclosure Required

A full description of all claims procedures and applicable time frames must be included as part of the summary plan description ("SPD") required to be provided to plan participants and beneficiaries. In the case of group health plans, the SPD must include a description of any procedures for obtaining prior approval as a pre-requisite for obtaining a benefit, and prompt notice to a claimant who fails to follow the plan's procedures for filing a pre-service claim so as to permit the failure to be cured quickly, if possible.

Written or electronic notice of any adverse benefit determination must be provided to claimants describing, in a manner calculated to be understood by the claimant, (i) the specific reason(s) for the determination with reference to the specific plan provision(s) on which it is based; (ii) any additional information needed for the claimant to perfect the claim and an explanation of why it is needed; (iii) the plan's review procedures and applicable time limits, including the right to sue under ERISA § 502(a) following an adverse benefit determination on review; (iv) any internal rule, guideline, protocol or similar criterion relied on in making the

adverse determination; and (v) an explanation of the scientific or clinical judgment for any determination based on medical necessity or experimental treatment or a similar exclusion or limitation. In addition, the claimant must be given the name of any medical expert whose advice was obtained on behalf of the plan, regardless of whether the advice was relied on in making the determination.

Action Required

The new regulations will require employers to make changes to their plan documents and summary plan descriptions prior to the January 1, 2002 effective date. Changes will also be required in the claims handling procedures utilized by claim and plan administrators.

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New SPD Content Rules

In addition to significantly changing the claims procedure rules governing health and disability benefit plans, the Department of Labor ("DOL") also recently published final regulations on the required content of summary plan descriptions ("SPDs"). The SPD content regulations apply to both pension and welfare benefit plans.

SPDs must be updated to reflect the new regulations no later than the first day of the second plan year beginning on or after January 22, 2001. Thus, for calendar plans, SPDs must be updated by January 1, 2003, to reflect the new content requirements.

Highlights of the new SPD content regulations are described below.

Fee Disclosures

Under the new regulations, SPDs must describe any plan provisions that may result in the imposition of a fee or charge to a participant or beneficiary, or to his or her individual account under the plan, the payment of which is a condition to the receipt of plan benefits. For example, a 401(k) plan SPD must describe any loan fees and annual account maintenance fees charged to

participants.

QDPROs and PMCSOs

The new regulations require SPDs of pension plans, including 401 (k) plans, to either (a) describe the plan's procedures for handling quali-fied domestic relations order ("QDRO") determinations or (b) state that a copy of those procedures may be obtained without charge from the plan administrator upon request. Similarly, group health plan SPDs must either (a) describe the plan's procedures for handling qualified medical child support order ("QMCSO") determinations or (b) state that a copy of those procedures may be obtained without charge from the plan administrator upon request.

COBRA Rights

The new SPD content regulations contain specific rules for group health plans subject to the COBRA continuation coverage rules. The SPD must include a description of the COBRA rights and obligations of plan participants and beneficiaries including, among other things, information about what constitutes a qualifying event and who qualifies as a qualified beneficiary. The SPD also must include notice and election requirements and procedures, premium payment rules, and a duration of continuation coverage explanation. SPDs which currently provide a comprehensive description of COBRA rights and obligations may need only minor revisions to comply with this portion of the new regulations.

Other Health Plan Requirements

The new regulations also require group health plan SPDs to include a description of the following:

- any cost-sharing provisions, including premiums, deductibles, coinsurance and co-payment amounts for which the participant or beneficiary will be responsible;
- any annual or lifetime caps or other limits on benefits under the plan;
- the extent to which preventive services are covered;
- criteria utilized by the plan for determining whether prescriptions for existing and new drugs are covered;
- rules governing the use of network providers and the circumstances under which coverage is provided for out-of-network services;
- any conditions or limits on the selection of primary care physicians or providers of specialty medical care;
- any conditions or limitations on obtaining emergency

medical care;
- any provisions requiring pre-authorizations or utilization review as a condition to obtaining a benefit or service under the plan; and
- any circumstances which may result in an offset, reduction or recovery of benefits, such as the plan's exercise of subrogation or reimbursement rights in connection with the treatment of injuries caused by a third party.

For health plans with a provider network, the new regulations state that a listing of providers may be furnished as a separate document that accompanies the plan's SPD as long as the SPD contains a general description of the provider network and a statement that provider lists are furnished automatically, without charge, as a separate document.

Plan Termination Information

The regulations require (i) additional information about the plan sponsor's right to terminate the plan or to modify or eliminate the benefits provided; (ii) a summary of plan provisions governing the benefits, rights and obligations of participants and beneficiaries upon the plan's termination or amendment; and (iii) an explanation of plan provisions governing the allocation and disposition of plan assets upon termination. In the case of a pension plan, the SPD also must include a description of any provisions governing the accrual and vesting of benefits upon termination of the plan.

PBGC Insurance

All pension plan SPDs must include a statement indicating whether benefits of the plan are insured under Title IV of ERISA and, if insured, a description of the insurance provided by the Pension Benefit Guaranty Corporation ("PBGC"). The new regulations contain two versions of a revised and updated PBGC model statement, one for single-employer plans and one for multi-employer plans.

ERISA Rights Statement

The model statement of ERISA rights provided in the existing regulations, and found in many existing SPDs, has been substantially revised and updated.

HMO Exemption

Existing regulations exempt the benefits being provided through a

federally qualified HMO from various SPD disclosure requirements, as long as certain conditions are met. Under the new regulations, this limited exemption for qualifying HMOs is eliminated.

Action Required

As noted above, SPDs do not have to be updated to comply with the new content requirements until the beginning of the second plan year beginning on or after January 22, 2001. However, due to the costs associated with the preparation and distribution of updated SPDs, plan sponsors generally should plan to incorporate the newly required changes into the next version of the SPD for each of their plans, even if that SPD is being issued this year.

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New Required Minimum Distribution Regulations

On January 12, 2001, the Internal Revenue Service ("IRS") published proposed regulations significantly modifying the Internal Revenue Code's required minimum distribution rules for qualified retirement plans, including IRAs. Code § 401(a)(9) generally requires qualified plan participants to begin taking distributions at the later of age 70½ or termination of employment. The proposed regulations simplify and substantially liberalize the rules for calculating the amount of a participant's required annual distribution and for designating beneficiaries, and allow considerable flexibility in planning for minimum distributions after the participant's death.

Plans that do not offer one or more distribution options permitting a benefit to be paid in installments over an extended period generally will not be affected by these new rules. However, sponsors of plans that do offer ex-tended distribution options (other than, or in addition to, annuities) should give serious consideration to amending their plans now to enable plan participants to take advantage of the flexibility offered by the new rules. IRA owners and IRA custodians also can apply the new rules immediately, even though the formal effective date is January 1, 2002.

The principal changes relate to defined contribution plans, as does

the discussion below. The rules governing annuity payments from defined benefit plans are largely unchanged.

Uniform Lifetime Distribution Method

In most cases, lifetime distributions to participants are governed by a single table of actuarial factors. These factors correspond to the former minimum distribution incidental benefit ("MDIB") table applicable under prior rules, and generally allow a greater income deferral than previously allowed. The MDIB factor is based on the joint life expectancy of the participant and an assumed beneficiary who is 10 years younger than the participant (determined under the tables published in Treasury Regulation § 1.72-9). Thus, a participant who designates his estate or an organization (e.g., a charity) as his or her beneficiary could still take lifetime minimum distributions based on a more favorable joint life MDIB factor. However, if the participant's designated beneficiary is his or her spouse, and that spouse is more than 10 years younger than the participant, the participant may apply an even more favorable joint life expectancy factor, as determined under Treasury Regulation § 1.72-9.

Designated Beneficiary

Generally, a participant can designate the beneficiary of his account at any time before death. In a departure from prior rules, the beneficiary determined at death, and possibly for a period after the participant's death, will govern the applicable minimum distribution factor thereafter. For example, for minimum distribution planning, a primary beneficiary could disclaim his or her interest in the plan at the participant's death in favor of a younger contingent beneficiary, allowing a longer income deferral and distribution period. Under the new rules, it no longer is necessary for the participant to fix his or her plan beneficiary, for this purpose, at age 70½ (as long as the plan does not require the lump sum distribution of benefits). Special rules apply to a surviving spouse, including a rollover of a participant's benefit to an IRA.

Default Rule for Post-Death Distributions

Under the new rules, the designated beneficiary may receive the remaining payments over the beneficiary's remaining life expectancy, unlike prior rules in which the participant's elections governed post-death distributions. The beneficiary's life expectancy is based on the beneficiary's age in the year following the participant's death and is reduced by a factor of 1 in each succeeding year. Moreover, if allowed under the employer's plan

or IRA, a beneficiary now may designate his or her own beneficiary. If the initial beneficiary dies before the account is fully paid, the succeeding beneficiary could receive payments over the remaining life expectancy period of the initial beneficiary.

If the participant does not have a designated beneficiary, a similar rule applies except by reference to the participant's actuarial life expectancy. In contrast, under the old rules, the account would be distributable by December 31 of the year after the participant's death if the participant had elected to recalculate his or her life expectancy for minimum distributions and died leaving no individual designated as beneficiary.

Qualified Domestic Relations Orders

The proposed regulations allow delays of required minimum distributions during the time the qualified status of a domestic relations order is being determined.

Effective Date

The proposed regulations are effective for distributions for calendar years beginning on or after January 1, 2002. However, until final regulations are issued, employers and IRA owners may rely on either the prior proposed regulations (issued in 1987) or amend their plans and rely on these new proposed regulations. Given this choice, the employer's circumstances and the plan's design, qualified plan sponsors should review their plans to consider whether to amend their plans and apply the new rules immediately, or to postpone action and rely on the prior regulations until the new regulations are finalized.

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EEOC and Contraceptives Coverage

The Equal Employment Opportunity Commission ("EEOC") recently ruled that the Title VII of the Civil Rights Act of 1964 requires employer sponsored health benefit plans to cover prescription contraceptives if they also cover preventive care services for other medical conditions, such as hypertension. The EEOC's position, if adopted by the courts, has significant implications for employers.

Background

Surveys indicate that slightly less than half of all employer sponsored group health plans cover prescription contraceptives. For years, Planned Parenthood, the National Organization for Women, and other groups have been urging Congress to enact legislation requiring all employer group health plans to cover the cost of prescription contraceptives. However, the pro-posed legislation has found only limited support among members of Congress.

Recently, proponents of the legislation have adopted a new tactic – convincing the EEOC and the courts that coverage of contraceptives already is required by existing law, namely Title VII of the Civil Rights Act of 1964. At least one Planned Parenthood-funded lawsuit is pending in federal court in Seattle, Washington. That law-suit, and others which are expected to be filed against employers across the country, received a boost from a recent EEOC decision finding merit to charges that an employer health plan violated Title VII by excluding coverage for prescription contraceptives.

EEOC Decision

The EEOC decision was issued in connection with charges of discrimination filed by two women against their employers. Each charge alleged that the employer's failure to cover oral prescription contraceptives under its health benefits plan constituted unlawful sex discrimination. The EEOC agreed.

The EEOC began its analysis by observing that Title VII, as amended by the Pregnancy Discrimination Act of 1978, provides that discrimination "on the basis of sex" includes discrimination "on the basis of pregnancy, childbirth and related medical conditions." Under EEOC guidelines, pregnancy-related medical conditions generally must be treated the same as non-pregnancy-related medical conditions.

The EEOC then pointed out that contraception is a means to prevent, and to control the timing of, the medical condition of pregnancy. If employer health plans cover services, drugs and devices to prevent the occurrence of other medical conditions, then those plans must also cover services, drugs and devices that prevent the occurrence of pregnancy, the EEOC reasoned. The EEOC then cited the following covered services and drugs under the two employer health plans at issue which, in the EEOC's view, necessitated coverage of prescription contraceptives:

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- vaccinations;
- drugs to control blood pressure and cholesterol levels; and
- preventive care for children and adults, including physical examinations and related laboratory services.

Under the EEOC's analysis, Title VII requires the employer health plans to cover the expenses of prescription contraceptives to the same extent, and on the same terms, that the plans cover the expenses identified above.

Much of the media coverage, and the very first paragraph of the EEOC's press release announcing its decision, has focused on the coverage of the prescription drug Viagra. However, the plans' coverage of Viagra was irrelevant to the EEOC's analysis and was mentioned only in a footnote to the EEOC's decision. The EEOC's position, if adopted by the courts, is expected to require employer health plans to cover prescription contraceptives even if the plan excludes Viagra and similar prescription medications used to treat sexual dysfunction.

Significantly, unlike a statute or regulation, the EEOC's decision does not have the force and effect of law. The courts, in addressing individual lawsuits challenging plan exclusions of contraceptives, are likely to consider, but will not be bound by, the EEOC's interpretation of Title VII articulated in the recent EEOC decision.

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2001 Cost-of-Living Adjustments

Most of the dollar limitations applicable to qualified retirement plans have gone unchanged for 2001, as shown in the table below. The principal exceptions are $5,000 increases in both the defined contribution plan annual addition maximum (to $35,000) and the defined benefit plan annual benefit maximum (to $140,000).

Limitation	2000	2001
Defined Contribution Plan Maximum Annual Addition	$30,000	$35,000

Defined Benefit Plan Maximum Annual Benefit at Social Security Retirement Age	$135,000	$140,000
Maximum Salary Deferral to 401(k) and 403(b) Plans	$10,500	$10,500
Highly Compensated Employee Threshold	$85,000	$85,000
Maximum Considered Compensation	$170,000	$170,000
SIMPLE Plan Contribution Maximum Annual Deferral	$6,000	$6,500
Social Security Taxable Wage Base	$76,200	$80,400

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DOL Limits Small Plan Audit Exemption

Under Section 103 of ERISA, plan administrators are required to engage an independent qualified public accountant to examine the plan's financial statements and to file an opinion along with the Form 5500 annual report for the plan. Under existing regulations, plans with less than 100 participants at the start of the plan year were considered "small plans" and were exempt from this audit requirement.

The Department of Labor recently issued revised regulations. The new regulations still permit small plans to avoid the audit requirement. However, under the new regulations, the exemption is not automatic and small plans, with the exception of small welfare plans, must satisfy certain conditions to qualify for the exemption.

Under the new regulations, the plan administrator of a small pension plan is not required to engage an independent auditor if two conditions are satisfied. First either (a) 95% or more of the plan assets must be "qualifying plan assets" or (b) the assets which are not qualifying plan assets must be covered by a bond which is not less than the value of those assets and which meets the requirements of ERISA § 412. Second, the plan administrator must issue an expanded summary annual report, including additional information about plan assets and the surety company issuing any required bond.

The following are considered "qualifying plan assets" for purposes of the audit exemption:

1. qualifying employer securities as defined in § 407(d)(5) of ERISA;
2. loans meeting the prohibited transaction exemption requirements of § 408(b)(1) of ERISA;
3. assets held by a regulated financial institution, such as a bank, an insurance company qualified under state law to do business, or a broker-dealer organization registered under the Securities Act of 1934;
4. shares issued by an investment company registered under the Investment Company Act of 1940 (e.g., a registered mutual fund);
5. investment and annuity contracts issued by an insurance company qualified to do business under state law; and
6. in the case of an individual account plan, any assets over which the participant (or beneficiary) has the opportunity to exercise control and is furnished, at least annually, with a statement from a regulated financial institution describing the assets held (or issued) by the institution and the amounts of those assets.

The new regulations are applicable as of the first plan year beginning after April 17, 2001. Accordingly, for calendar year plans, the revised regulations are effective for the plan year beginning January 1, 2002.

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