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Employee Benefits Update

A review and analysis of recent developments affecting employee benefits

The *Employee Benefits Bulletin* is published quarterly by the law firm of Vedder, Price, Kaufman & Kammholz. It is intended to keep our clients and interested parties generally informed on legal developments in Employee Benefits. It is not a substitute for professional advice. Reproduction of materials in this Report is permissible with credit to Vedder Price. For an electronic copy of this newsletter, please contact Mary Pennington, Marketing Coordinator, at her e-mail address: mpennington@vedderprice.com.

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.

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Pension Reform Legislation Enacted

President Bush recently signed legislation making significant changes in the laws governing 401(k) and other qualified retirement plans. Among other things, the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA) increases contribution and benefits limitations, creates new catch-up contributions for employees age 50 and older, allows the creation of "Roth" 401(k) accounts beginning in 2006, provides for faster vesting of employer matching contributions, modifies rollover, mandatory cashout and other distribution rules, and increases employer deduction limits.

These and other EGTRRA qualified retirement plan changes are summarized in further detail in a recently issued *Special Report,* which is available on our website at www.vedderprice.com.

EGTRRA changes to employer-sponsored educational assistance or tuition reimbursement programs are described later in this issue.

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GUST Restatement Deadline Looms

Employers have until the last day of the 2001 plan year to update individually designed qualified retirement plans to reflect legislative changes enacted and regulations issued since December 8, 1994, and to submit the updated plans to the IRS for a favorable determination letter (*i.e.*, by December 31, 2001, for calendar year plans).

These updates are referred to as the "GUST amendments" based upon the four principal laws that must be addressed through amendment:

- General Agreement on Tariffs and Trade ("GATT"), including the Retirement Protection Act of 1994;
- Uniformed Services Employment and Reemployment Rights Act;
- Small Business Job Protection Act of 1996; and
- Taxpayer Relief Act of 1997.

Additional legislative and regulatory changes also must be incorporated. The amendment, restatement, and IRS submission process is quite involved, and it requires the assembly of plan and employer data, as well as legal drafting. Accordingly, any plan sponsors that have not yet made plans for the GUST restatement and resubmission of their qualified retirement plans should contact their Vedder Price employee benefits attorney, or any other Vedder Price attorney with whom they have worked. If you are not sure whom to contact, call Paul Russell (312/609-7740), the firm's Employee Benefits Group Leader.

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Health Plan Contraceptive

A federal district court ruled last month that Title VII generally requires employer-sponsored group health plans to cover birth control pills and other prescription contraceptives if the plan covers other preventative prescription drugs, such as blood pressure and cholesterol-lowering drugs. The court's decision in *Erickson v. Bartell Drug Company* is binding only on employers in Western Washington State. However, combined with a recent Equal Employment Opportunity Commission (EEOC) ruling to the same effect, the decision is expected to significantly increase the number of EEOC charges and class action lawsuits nationwide challenging health plan exclusions of prescription contraceptives.

Background

As reported in the February 2001 *Employee Benefits Bulletin*, 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 proposed 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, as amended by the Pregnancy Discrimination Act of 1978. In December 2000, the EEOC issued a highly publicized determination on two charges of discrimination alleging that an employersponsored health benefits plan's failure to cover oral prescription contraceptives constituted unlawful sex discrimination. The EEOC concluded that the prescription contraceptive exclusion was unlawful and issued formal guidance to its investigators to that effect. Then last month the United States District Court for the Western District of Washington weighed in on the issue with its decision in *Erickson v. Bartell Drug Company*.

Court Decision

The plaintiff, Jennifer Erickson, filed a class action lawsuit against her employer, a family-owned chain of drug stores. She

alleged that the Bartell Drug health plan's exclusion of prescription contraceptives, such as birth control pills, Norplant, Depo-Provera, intrauterine devices, and diaphragms, violated Title VII.

The court's opinion begins by noting that the case raises an issue of first impression in the federal courts: whether the exclusion of prescription contraceptives from a health plan providing generally comprehensive prescription drug benefits constitutes unlawful sex discrimination. The court concluded that it does.

In reaching this conclusion, the court noted 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." Implicitly conceding that the exclusion was not based upon pregnancy and did not treat pregnant individuals covered by the plan any differently than other covered individuals, the court reasoned that Title VII's prohibition against discrimination requires that the "special or increased healthcare needs associated with a woman's unique sex-based characteristics must be met to the same extent, and on the same terms, as other healthcare needs." According to the court, when an employer offers broad-based prescription drug coverage, "it has a legal obligation to make sure" that the plan provides "equally comprehensive coverage for both sexes."

The court rejected all of the arguments offered by the employer, including the argument that prescription contraceptives are different from other prescription drugs covered by the plan, and therefore properly excluded, because all covered prescription drugs are used to treat illness, disease or injury. Contraceptives, in contrast, are not used to treat any of these conditions. The court stated that it was irrelevant that pregnancy is a natural condition, not a disease or illness, because being pregnant is not a state desired by all women or at all points in a woman's life. Prescription contraceptives, like many other drugs, the court added, "help the recipient avoid unwanted physical changes."

The court concluded that the Bartell Drug health plan discriminated against female employees in violation of Title VII by excluding prescription contraceptives because, in doing so, the plan "provides less complete coverage than that offered to male employees." Title VII, the court stated, requires employers to "provide equally comprehensive coverage, even if that means providing additional benefits to cover women-only expenses."

Implications for Employers

The *Bartell Drug* decision obviously has potentially significant implication for those employers whose health plans currently exclude prescription contraceptives. The issue is expected to be the subject of further litigation in other courts and may not be finally resolved for a number of years.

Given this uncertainty, some employers with plans excluding prescription contraceptive coverage are electing to take a wait-and-see approach. Other employers are reevaluating the potential financial costs and employee relations benefits of eliminating prescription contraceptive exclusions in light of the risks of litigation and potential adverse publicity an EEOC charge or lawsuit could generate.

If you have any questions about these developments, or would like your own health plan reviewed, please contact Bruce Alper (312/609-7890), Tom Hancuch (312/609-7824), Alan Koral (212/407-7750), or any other Vedder Price attorney with whom you have worked.

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Retiree Health Benefits Litigation

Last year's Third Circuit Court of Appeals decision in *Erie County Retirees Association v. County of Erie,* which held that the Age Discrimination in Employment Act ("ADEA") generally requires employers to provide Medicare-eligible retirees with the same level of health benefits coverage as pre-Medicare retirees, prompted many employers to begin reexamining the design of their retiree health benefits plans. The EEOC quickly embraced the Third Circuit decision, incorporating its holding into the Compliance Manual used by EEOC investigators. An April 2001 District Court decision on remand in the *Erie County* case clarified some aspects of the Third Circuit's decision but further muddied the waters with respect to others.

The most recent development comes from the EEOC. In a July 17, 2001 meeting with employer trade groups, EEOC staff reported that the EEOC was reevaluating its position on the *Erie County* decision and was temporarily deferring action on charges alleging this type of ADEA violations.

Erie County Plan Design

Erie County provided Blue Cross HMO coverage to Medicare-eligible retirees. Non-Medicare-eligible retirees, in contrast, were covered by a traditional indemnity plan, also offered by Blue Cross. The County charged non-Medicare-eligible retirees a monthly $12 premium for coverage. Medicare-eligible retirees did not pay a monthly premium to the County but were required to pay to the government the monthly Medicare Part B insurance premium.

In October 1998, the County changed the coverage for non-Medicare-eligible retirees to a Blue Cross point-of-service ("POS") plan, known as Select Blue. Under the Select Blue POS plan, retirees, for each health care incident, could utilize either an HMO arrangement or a traditional indemnity insurance coverage arrangement. The $12 per month premium charged to non-Medicare-eligible retirees remained unchanged.

A group of Medicare-eligible retirees subsequently sued, contending that the plan's design violated the ADEA.

The Court of Appeals for the Third Circuit, in a 2–1 decision, held that Medicare eligibility is not a reasonable factor other than age upon which an employer may rely in designing a retiree medical program. In doing so, the Court of Appeals rejected the employer's contention that distinguishing between retirees on the basis of Medicare eligibility is not the same as distinguishing between retirees on the basis of age. The Court reached this conclusion even though Medicare is available not only to retirees age 65 and older, but also to totally disabled retirees under 65, as well as to individuals under age 65 with end-stage renal disease.

Concluding that Medicare eligibility is a "direct proxy for age," the Court of Appeals ruled that the County could successfully defend the plan's design only if it satisfied the ADEA's equal cost/equal benefit rule. After the Supreme Court declined to hear the case, it was remanded to the District Court for further proceedings.

District Court

In the District Court, the County conceded that it could not show that its cost of providing the HMO coverage to each Medicare-eligible retiree was equal to or greater than the cost of providing either the traditional indemnity coverage option or the subsequent POS coverage option to non-Medicare-eligible retirees. In this regard, Erie County is not unique. Employer coverage for Medicare-eligible retirees is almost invariably less expensive than comparable coverage for pre-Medicare retirees because Medicare

pays a significant portion of the medical expenses incurred by Medicare-eligible retirees.

The District Court's opinion then focused on the "equal benefit" aspect of the equal cost/equal benefit exception. Under the equal benefit rule, an employer must provide the same health benefits to older workers (Medicare-eligible retirees, in the Third Circuit's view) as to younger workers. For this purpose, it is permissible to take Medicare into account. Under the EEOC regulations implementing the equal cost/equal benefit rule, if the employer-provided health benefits, combined with Medicare, provide older workers with "a lesser benefit of any type (including coverage for…dependents)," the rule is not satisfied.

The District Court held that the Blue Cross Medicare HMO was a lesser benefit than either the traditional indemnity option or the later POS option offered to non-Medicare-eligible retirees because Medicare-eligible retirees were required to pay a higher monthly premium for such coverage. That is, although Medicare-eligible retirees paid no monthly premium to Erie County, they were required to pay to the government the Medicare Part B premium, which was $43.50 per month in 1998 and currently is $50 per month. Non-Medicare-eligible retirees, in contrast, paid only the $12 per month Erie County charged for their retiree health benefits coverage. The District Court's decision thereby calls into question the lawfulness of any retiree health benefits premium structure in which the monthly premium paid by Medicare-eligible retirees, including the premium paid for Medicare Part B, exceeds that paid by non-Medicare-eligible retirees.

The District Court also considered the plaintiffs' argument that the HMO coverage provided to Medicare-eligible retirees was inferior to the traditional indemnity and later POS options available to non-Medicare-eligible retirees. Surprisingly, the District Court concluded that the HMO was not a lesser benefit than the traditional indemnity option but was inferior to the POS option subsequently offered. In reaching this conclusion, the District Court held that the coverage offered to Medicare-eligible retirees must be "objectively" a lesser benefit. Comparing the Medicare HMO to the traditional indemnity option, the District Court observed that the limited choice of providers available through the Medicare HMO was accompanied by a greater level of coverage for authorized services provided, including the absence of deductibles and generally lower co-payments. The traditional indemnity option, while offering retirees a greater choice of providers, required payment of an initial deductible and thereafter paid only a percentage of covered expenses. The

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District Court concluded that "the relative benefit of either [the HMO or traditional indemnity] plan is largely in the eye of the beholder."

Not so, however, with respect to the HMO versus the POS option. This is because, the District Court stated, non-Medicare-eligible retirees covered under the POS plan could elect either HMO or traditional indemnity-type coverage for each health care incident. Medicare-eligible retirees, in contrast, were restricted to an HMO form of coverage. This distinction, the District Court held, rendered the POS plan objectively superior to the Medicare HMO and, therefore, made the latter a "lesser benefit" not satisfying the equal cost/equal benefit rule.

EEOC Reconsiders Its Position

The latest development comes from the EEOC. In a July 17, 2001 meeting with employer trade groups, EEOC staff reported that the EEOC:

- is reviewing its position on the *Erie County* decision;
- has suspended application of its recently revised Compliance Manual interpretation of how the ADEA applies to retiree health benefit plans;
- is temporarily deferring action on pending and new charges alleging *Erie County*-type ADEA violations; and
- is considering how to clarify or modify its current policy on retiree health benefits under the ADEA, including the possible issuance of proposed new regulations.

Implications for Employers

The EEOC's informal announcement is a welcome development for employers that have taken a "wait and see" approach following the Third Circuit's *Erie County* decision. Unfortunately, the EEOC's reconsideration of its position does not eliminate the uncertainty generated by *Erie County.* The Third Circuit's decision technically is binding only in Delaware, Pennsylvania, and New Jersey. However, that decision is expected to generate similar litigation across the country. And while *Erie County* may have been wrongly decided, and another court may reach a contrary result, the *Erie County* decision gives plaintiffs a leg up.

That being the case, employers offering different, and arguably lesser, benefits to Medicare-eligible retirees must engage in a risk

largest employee benefits practices, with ongoing responsibility for the design, administration and legal compliance of pension, profit sharing and welfare benefit plans with aggregate assets of several billion dollars. Our employee benefits lawyers also have been involved in major litigation on behalf of benefit plans and their sponsors. Our clients include large national corporations, smaller professional and business corporations, multi-employer trust funds, investment managers and other plan fiduciaries.

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assessment. This includes employers whose Medicare-eligible retirees pay a larger monthly premium for coverage, taking into account Medicare Part B premium payments.

In conducting a risk analysis, an employer will need to examine the likelihood that it could be subject to suit in the Third Circuit. An employer also typically will want to explore potential alternatives that are consistent with the *Erie County* decision. This process, unfortunately, may well be complicated by a variety of factors, including the absence of identical managed care options for Medicare-eligible and pre-Medicare-eligible retirees in many areas, uncertainty over the viability and application of the District Court's "objectively" lesser benefit analysis, retiree resistance to benefit changes, collective bargaining agreement or other contractual restrictions, and cost considerations. In the absence of any easy choices among potential alternatives, many employers may elect to continue to wait for more definitive guidance.

If you have any questions about these developments, please contact Tom Hancuch (312/609-7824), Alan Koral (212/407-7750), Phil Mowery (312/609-7642), Chuck Wolf (312/609-7888), or any other Vedder Price attorney with whom you have worked.

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Health Plan Claim Procedure Rules Postponed

The Department of Labor ("DOL") earlier this month extended the effective date of the new claim procedure rules applicable to group health plans. The DOL's action delays the effective date for at least six months and brings welcome relief for insurers, third-party administrators, and plan sponsors.

Late last year, the DOL issued final regulations changing the claim and appeal procedure rules governing all employee benefit plans. The most significant changes involved the health and disability benefit plans, while the rules governing other benefit plans remained largely unchanged. As reported in the February 2001 edition of the *Employee Benefits Bulletin*, those regulations dramatically shorten the time periods for processing health benefit claims and will require significant revisions to health benefit plan documents and claims handling procedures.

The new regulations originally were scheduled to apply to all claims filed on or after January 1, 2002. The extension for health benefits claims is to the first day of the first plan year beginning on or after July 1, 2002, but in no event later than January 1, 2003. Thus, the extended effective date will vary from plan to plan based upon the date the plan year begins, as follows:

- Plan Year Beginning July 1: New claim procedures apply to health benefits claims filed on or after July 1, 2002.
- Plan Year Beginning July 2 – December 31: New claims procedures apply to claims filed on or after the first day of the 2002 plan year (*e.g.*, October 1, 2002, for a plan with an October 1 plan year).
- January 1 – June 30: New claims procedures apply to claims filed on or after January 1, 2003.

If you have any questions about these developments, please contact Tom Hancuch (312/609-7824) or any other Vedder Price attorney with whom you have worked.

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Educational Assistance Changes

Most of the employee benefits changes made by the Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA") involve qualified retirement plans. However, EGTRRA also amended the rules governing employer-sponsored educational assistance programs. For classes beginning on or after January 1, 2002, the favorable tax treatment afforded employer reimbursements of undergraduate level expenses will once again be available for graduate coursework.

Internal Revenue Code Section 127 enables an employee who receives tuition reimbursement or other educational assistance under an educational assistance program to exclude up to $5,250 of that assistance from his or her gross income. Without Section 127, these payments from an employer would be treated as income to the employee and as wages for employment tax purposes unless a limited "job-related" standard in Code Section 162 applied.

For purposes of Code Section 127, the term "educational assistance" includes the payment of educational expenses incurred by an employee, such as tuition, fees, books and supplies. The Small Business Job Protection Act of 1996 limited the definition of "educational assistance" by specifically excluding the payment of expenses for any graduate-level courses, including law, business, medical and other advanced academic or professional degree courses.

EGTRRA modified Section 127, by expanding its applicability to again include graduate-level coursework. Therefore, the reimbursement of graduate-level education expenses will be excludable from an employee's gross income up to the $5,250 limit for courses beginning on or after January 1, 2002, the effective date of the EGTRRA changes. Reimbursements of undergraduate level courses will continue to receive favorable Section 127 tax treatment up to the annual $5,250 maximum.

If you have any questions about these developments, please contact Tom Hancuch (312/609-7824) or any other Vedder Price attorney with whom you have worked.

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Prototype & Volume Submitter Plans

In July the IRS announced significant changes to the determination letter process for nonstandardized prototype and volume submitter plans (as distinguished from individually designed plans and standardized prototypes). Previously, employers that adopted a nonstandardized prototype or volume submitter plan could not rely on an opinion letter issued by the IRS to the plan provider, such as Vanguard, Fidelity, or John Hancock. Rather, the employer needed to submit a separate IRS application for a determination of the plan's qualified status.

IRS Announcement 2001-77 changes these rules, allowing many employers to rely on the plan provider's IRS opinion letter when the employer adopts or updates a nonstandardized prototype or volume submitter plan, thereby eliminating the need for the employer to request a separate employer IRS determination letter. Generally, to qualify for this relief, the employer may not modify the provider's adoption agreement that accompanies the plan, and the provider must have obtained

an IRS opinion letter in light of all GUST changes. To assist employers, the IRS will post a list of all GUST-approved prototype and volume submitter plans on the Internet.

Significantly, a number of exceptions apply. Therefore, employers with nonstandardized prototype or volume submitter plans should review those plans with the provider and with their employee benefits counsel to determine if the employer can rely on the provider's IRS opinion letter or whether the employer should apply for a separate determination letter. For additional information, contact Robert Simon (312/609-7550) or any other Vedder Price attorney with whom you have worked.

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