

## ***NEW REGULATIONS AFFECT EMPLOYEE BENEFIT PLANS***

In the waning days of the Clinton administration, federal regulators have issued three separate sets of final regulations affecting employee benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA), especially health plans. The regulations are of tremendous importance to sponsors and administrators of such plans and address:

- The content of summary plan descriptions (SPDs);
- Processing benefit claims; and
- Privacy of confidential medical information.

The U.S. Department of Labor (DOL) issued the regulations relating to SPD content and benefit claims procedures on November 21, 2000, to address changes in the design and administration of employee benefit plans since the initial regulations were adopted some 20 years ago. The Department of Health and Human Services (HHS) issued the privacy regulations in response to a legislative mandate in the Health Insurance Portability and Accountability Act of 1996.

### **SPD Content Regulations**

Under ERISA, employee benefit plans must communicate information regarding eligibility, benefits and other plan rights and features through an SPD. The recent changes enacted by the DOL regulations are effective on the first day of the second plan year beginning on or after January 22, 2001 (i.e., January 1, 2003, for calendar year plans).

The most significant changes apply to health plans, which must disclose detailed information regarding common restrictions and limitations imposed by managed care organizations (e.g., network providers; whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of specialty medical care; and any provisions requiring pre-authorization or utilization review).

Other disclosures include a requirement that SPDs include a description of its procedures governing qualified domestic relations orders or qualified medical child support orders, or a statement that participants and beneficiaries can obtain, without charge, a copy of such procedures; disclosure of Pension Benefit Guaranty Corporation coverage for defined benefit plans, with separate model statements for single employer plans and multi-employer plans; disclosure of COBRA rights in group health plan SPDs; and model language for the required disclosure under the Newborns' and Mothers' Health Protection Act.

### **Final Claims Procedures Regulations**

ERISA also requires plans to have written, reasonable procedures for reviewing and deciding participant claims. The new regulations, again issued by DOL, apply to claims filed on and after January 1, 2002.

Mandates include faster decisions on initial claims for medical and disability benefits (30 days for most medical claims and 45 days for disability claims, versus 90 days under current regulations). The regulations also require expedited review for urgent care claims (72 hours) and pre-authorizations (15 days). Appeals of denied claims for medical and disability benefits will also have to be decided more quickly than under current regulations. These new timeframes do not affect claims under retirement plans.

The procedures also give more power to claimants. Claimants have more time to file appeals-180 days, rather than current 60 days. Plans cannot impose fees or costs as a condition to filing or appealing a claim and may not require more than two levels of review of denied claims. A plan may require a claimant to submit to arbitration as part of the claims process, but only with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if claimant has right to challenge decision through an ERISA 502 action. The decision maker on appealed claims must be different than the person deciding initial claim.

More complete disclosure is also required. Plans must provide specific reasons for denials, including, for health and disability plans, identification of and access to any guidelines, rules, or protocols relied upon in making the adverse determination. Plans must also provide participants access to all documents, records and other information relevant to the benefit determination, without regard to whether the plan relied on the material, including the names of medical professionals consulted as part of the claims process.

### **Medical Privacy**

The final privacy regulations were published by HHS on December 28, 2000. They generally apply beginning February 26, 2003.

The regulations govern disclosure of “protected information”: confidential health information that identifies (or could be used to identify) a specific individual and relates to a physical or mental medical condition or payment of health care for that individual. They directly regulate “covered entities”: health plans with at least 50 participants, health care providers, and health care “clearinghouses” (entities that process health data). The regulations indirectly regulate any entity that contracts with a covered entity. Covered entities must obtain general consents from participants before routine disclosures for health care treatment, payment and operations. Specific authorizations are required for non-routine disclosures (e.g., employment decisions and non-health purposes).

A health plan (including any insurer or HMO) cannot disclose protected information to a plan sponsor until the plan document is amended to restrict the uses and further disclosures of the information. The plan document must describe which of the plan sponsor’s employees can have access to the protected information, restrict their use of the information to plan administrative functions, and provide a mechanism for resolving any employee’s noncompliance with the privacy policy.

## **Action Steps**

We recommend that plan sponsors and administrators act now to review SPDs and plan documents (including contracts with third parties) for compliance with these new regulations. Although there is time to make any necessary amendments, sometimes substantial lead time is needed to coordinate any plan changes with individuals responsible for plan documents and communications. Please contact a member of our Employee Benefits Department if you would like more information.

*Because of the changing nature of this area of the law and the importance of individual facts, this information is not meant to provide legal opinions and is not a substitute for the advice of legal counsel.*

*If you have questions regarding this topic, please contact:*

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