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December 11, 2000

Highlights of Revised Claims Procedure and SPD Regulations

On November 20th, the Department of Labor amended two of its regulations: (1) the regulation governing the benefit claims procedures under ERISA-governed employee benefit plans,[1] and (2) the regulation governing the summary plan descriptions ("SPDs") that ERISA-governed plans must furnish to participants and beneficiaries.[2] The amended regulations will require virtually all ERISA-governed plans to revise their claims procedures and SPDs. This memorandum summarizes the principal features of the amended regulations.

I. Claims Procedure Regulation

A. In General. The Department completely restated its prior benefit claims procedure regulation. Most of the changes made by the new regulation apply only to the handling of claims under group health plans and claims for disability benefits (including claims for disability benefits under pension plans as well as claims under disability plans). However, the new regulation also changes some of the rules governing claims under other ERISA-governed plans. For example, the regulation requires for the first time that all claims procedures contain processes and safeguards to verify that benefit determinations are consistent with both the plan documents and past administrative practice. *See* ¶ I.F, below. In addition, the regulation provides that if a plan fails to establish or follow claims procedures that comply with the regulation, a claimant will be deemed to have exhausted the plan's administrative remedies and will be entitled to bring a suit for benefits under ERISA "on the basis that the plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim." In connection with this provision, the preamble to the regulation states that the Department intends that no judicial deference be given to a claims decision made without complying with the regulation. The regulation also requires adverse appeal decisions to inform the claimant of his or

[1] 65 Fed. Reg. 70246 (Nov. 21, 2000).

[2] *Id*. at 70226.

her right to bring a lawsuit under ERISA. *See* ¶ I.O.4, below. The new regulation applies to claims filed on or after January 1, 2002.

B. New Deadlines. The regulation establishes new deadlines for actions in connection with health and disability claims. Under the regulation, claims fall into six categories:

1. Urgent health care claim: a claim for "medical care or treatment" for which applying the deadlines for non-urgent claims (a) could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or (b) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment being claimed. Whether a claim is urgent may be determined by a lay person acting on behalf of the plan. However, according to the regulation, a claim must be treated as urgent if it is so designated by a physician with knowledge of the claimant's medical condition.

2. Concurrent health care claim: a request to extend a previously-approved course of treatment beyond the previously-approved period of time or number of treatments. In addition, any reduction or termination by the plan of such a course of treatment (other than by plan amendment or termination) before the end of the previously-approved period of time or number of treatments (or a reduction in a previously-approved, indefinite course of treatment) is treated as an adverse benefit determination.

3. Pre-service health care claim: a claim for a benefit under a group health plan where the claimant's right to all or part of the benefit is conditioned by the plan on approval of the benefit before the claimant receives medical care (even if approval does not guarantee that the plan will ultimately provide the benefit).

4. Post-service health care claim: a claim for a benefit under a group health plan that is not a pre-service claim.

5. Disability claim: a claim for disability benefits.

6. Other claim: any other claim for a benefit under an ERISA-governed plan.

The deadlines for actions to be taken in connection with each type of claim are summarized in the table attached to this memorandum.

C. SPD Disclosure. All claims procedures (including any procedures for obtaining prior approval of a health care benefit, such as preauthorization or utilization review procedures) and the applicable deadlines under the plan must be described in the plan's SPD.

D. No Disincentives or Impediments. Claims procedures may not inhibit the filing of claims (*e.g.*, by requiring payment of a fee or costs or by denying a claim for failure to obtain prior approval where prior approval was impossible or inappropriate).

E. Authorized Representative. Claims procedures must not bar an authorized representative from acting for the claimant. A plan may establish reasonable procedures for determining whether an individual has been authorized to act for a claimant. In the case of an urgent care claim, however, a health care professional with knowledge of the claimant's medical condition must be permitted to represent the claimant.

F. Consistency. Claims procedures must contain administrative processes and safeguards designed to verify that benefit claim determinations are made in accordance with the plan documents and that plan provisions have been applied consistently to similarly situated claimants. The regulation does not prescribe specific requirements that such processes and safeguards must meet.

G. Collectively-Bargained Plan Exceptions. A collectively-bargained plan (other than a jointly-trusteed Taft-Hartley plan) is exempt from most of the regulation's other requirements (described below) if the collective bargaining agreement ("CBA") includes (1) provisions governing the filing of benefit claims and the initial disposition of benefit claims and (2) a grievance and arbitration procedure for adverse benefit determinations. If the CBA includes grievance and arbitration procedures for adverse benefit determinations, but not provisions governing the filing and initial disposition of benefit claims, the plan is exempt only from the provisions of the regulation governing the appeal and review of adverse benefit determinations.

H. Group Health Plans. In addition to being subject to the generally applicable requirements summarized in the preceding paragraphs (¶¶ I.A-G), the claims procedures under group health plans must comply with the following requirements:

1. Failure to Follow Pre-Service Claims Procedures; Incomplete Claims. Claims procedures must provide that if a claimant fails to follow plan procedure for filing pre-service claims, the claimant will be notified of the failure and of the proper procedures. Oral notice will suffice unless the claimant requests written notice. This requirement applies only if a claimant submits a communication that is received by a person or organizational unit customarily responsible for handling benefit matters and the communication names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested. In addition, if a claimant files an incomplete claim for urgent care, the plan administrator must notify the claimant of the specific information necessary to complete the claim.

2. Mandatory Appeals: Claims procedures may not require a claimant to file more than two appeals of an adverse benefit determination before bringing a civil action under ERISA.

3. Voluntary Arbitration and Other Forms of Alternative Dispute Resolution. If a plan offers voluntary levels of appeal, including voluntary arbitration or any other form of dispute resolution, in addition to the appeals permitted by the regulation, the plan's claims procedure must provide that –

(a) the plan waives any right to assert that a claimant has failed to exhaust administrative remedies because the claimant did not elect to pursue the voluntary level of appeal;

(b) the plan agrees that any statute of limitations or other timeliness defense is tolled during the voluntary appeal;

(c) a claimant may elect to submit a claim to the voluntary level of appeal only after exhaustion of the plan’s mandatory level(s) of appeals;

(d) the plan will provide to any claimant, upon request, sufficient information relating to the voluntary levels of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to a voluntary level of appeal, including a statement that a claimant's decision to pursue (or not to pursue) a voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan, and information regarding the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and any circumstances that may affect the decisionmaker's impartiality; and

(e) no fees or costs are imposed on the claimant as part of the voluntary level of appeal.

4. Mandatory Arbitration. Claims procedures may not provide for mandatory arbitration of adverse benefit determinations, except to the extent that (a) the arbitration is conducted as one of the two mandatory levels of appeal and (b) the claimant is not precluded from challenging the decision in litigation filed under ERISA or other applicable law.

I. Disability Plans. The claims procedures of a plan providing disability benefits must comply with the requirements that apply to appeals and arbitration of adverse benefit determinations under group health plans (*see* ¶¶ I.H.2, H.3, & H.4, above), as well as with the generally applicable claims procedure requirements (*see* ¶¶ I.A-G, above).

J. Notice of Adverse Benefit Determination. In general, the plan administrator must provide a claimant with a written or electronic notice of any adverse benefit determination setting forth, in an understandable manner,

1. the specific reason(s) for the determination;

2. reference to the specific plan provisions on which the determination is based;

3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why this material or information is necessary;

4. a description of the plan's claims review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action under § 502(a) of ERISA following an adverse benefit determination on review;

5. in the case of an adverse benefit determination under a group health plan or in connection with a claim for disability benefits,

(a) if an internal rule, guideline, protocol, or other similar criterion was used to make the determination, either (i) the rule, guideline, etc. or (ii) a statement that the rule, guideline, etc. was used and will be provided to the claimant free of charge upon request; or

(b) if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (i) an explanation of the scientific or clinical basis for the determination or (ii) a statement that the explanation will be furnished free of charge upon request; and

6. in the case of an adverse determination of an urgent health care claim, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination of an urgent health care claim, the information described above may be provided orally as long as it is provided in writing or electronically within three days after the oral notification.

K. Appeal of Adverse Benefit Determination – In General. Every plan must establish and maintain a procedure that gives a claimant a reasonable opportunity to appeal an adverse benefit determination to a named fiduciary and that provides a full and fair review of the claim and the adverse benefit determination. A claims procedure does not satisfy this requirement unless the procedure --

1. complies with the deadlines summarized in the attached table;

2. provides the claimant with the opportunity to submit written comments, documents, records, and other information relating to the claim;

3. provides that the claimant shall be furnished, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information "relevant" to the claim. A document or record is considered "relevant" if it (a) was relied on in making a benefit determination, (b) was submitted, considered, or generated in the course of making the determination (regardless of whether it was relied on), (c) demonstrates compliance with the administrative processes and safeguards requirement summarized in ¶ I.F, above,[3] or (d) in the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit (regardless of whether it was relied on); and

4. provides for a review that takes into account all comments, documents, records, and other information submitted by the claimant, regardless of whether the information was submitted or considered in the initial benefit determination.

L. Appeal of Adverse Benefit Determinations – Group Health Plans. In addition to complying with the requirements summarized in ¶ I.K, above, a group health plan must --

1. provide for a review that does not give deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary who is neither the individual who made the initial determination nor the subordinate of that individual;

2. provide that, in deciding an appeal of any adverse benefit determination that is based entirely or partly on a medical judgment, the appropriate named fiduciary will consult with a health care professional with appropriate medical training and experience;

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[3] The preamble to the regulation states, however, that the Department does not intend to impose a requirement that plans artificially create new systems for the sole purpose of generating documents that can be furnished to claimants. The Department anticipates that plans will have systems for ensuring and verifying consistent decisionmaking that might or might not produce disclosable documents or information.

3. provide for the identification of medical or occupational experts whose advice was obtained in connection with the determination, regardless of whether the advice was relied upon in making the determination;

4. provide that the health care professional engaged in accordance with paragraph 2, above, was neither consulted in connection with the initial determination nor the subordinate of any person who was consulted; and

5. provide, in the case of a claim for urgent health care, for an expedited review process under which (a) a request for an expedited appeal may be submitted orally or in writing and (b) all necessary information shall be transmitted by telephone, facsimile, or other expeditious method.

M. Appeal of Adverse Benefit Determinations – Disability Claims. The claims procedures of a plan providing disability benefits must comply with all of requirements summarized in ¶¶ I.K and L, above (excluding ¶ I.L.5).

N. Furnishing of Documents. In an appeal of an adverse benefit determination, the plan administrator must provide access to and copies of documents, records, and other information described in ¶¶ I.O.3 & O.4 and ¶ I.P, below.

O. Decision on Appeal – In General. The plan administrator must give the claimant a written or electronic notice of the plan's benefit determination on review. If the determination is adverse, the notice must set forth:

1. the specific reason(s) for the adverse determination;

2. reference to the specific plan provisions on which the determination is based;

3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information "relevant" (as defined in ¶ I.K.3, above) to the claim; and

4. a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain the information about those procedures and a statement of the claimant's right to bring a lawsuit under ERISA § 502(a).

P. Decision on Appeal – Group Health Plans and Disability Claims. In the case of an adverse benefit determination under a group health plan or a plan providing disability benefits, the notice must set forth:

1. if an internal rule, guideline, protocol, or other similar criterion was relied on, either (a) the rule, guideline, etc. or (b) a statement that the rule, guideline, etc. was relied upon and that a copy will be provided free of charge upon request;

2. if the determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either (a) an explanation of the scientific or clinical basis for the determination or (b) a statement that the explanation will be furnished free of charge upon request; and

3. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Q. Preemption of State Law. ERISA's preemption provision, § 514, excludes State laws regulating insurance from the scope of ERISA preemption. However, under the Supremacy Clause of the Constitution, a State insurance law is preempted if the State law conflicts with ERISA. This raises the question whether a State insurance law regulating the handling or review of claims is preempted by the claims procedure regulation. At present, the courts are divided on this question.[4] The regulation and the accompanying preamble make the following points about the relationship between the regulation and State insurance law:

1. The Department intends the regulation's preemptive effect to be limited to the minimum required by ERISA § 514 and the Supremacy Clause.

2. The regulation should not be read to supersede State law regulating insurance (even when the State law prescribes standards for claims processes and internal review of claims) unless the State law prevents the application of the regulation's requirements, *i.e.*, unless the State law could not be read in harmony with the regulation. For example, a State law that requires insurers to allow oral claim appeals or to decide claims within shorter periods of time would not prevent application of the regulation because a plan could comply with both the regulation and State law. In other words, according to the regulation, if the State law gives the claimant greater rights than the regulation, the State law does not conflict with the regulation and is not preempted.

3. A State law regulating insurance should not be considered to prevent application of a requirement in the regulation merely because the State law establishes a review procedure to resolve disputes involving adverse benefit determinations under group health plans, provided that the review procedure is conducted by outside parties (*i.e.*, parties other than the insurer, the plan, the plan's fiduciaries, the employer, or any employee or agent of the foregoing). These types of procedures are "external reviews" and are not part of the claims procedures ERISA contemplates.

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[4] *Compare Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000) (Illinois law not preempted), *with Corporate Health Insurance, Inc. v. Texas Dep't of Insurance*, 215 F.3d 526 (5th Cir. 2000) (Texas law preempted), *petition for cert. filed*, 69 USLW 3317 (Oct. 24, 2000) (No. 00-665).

4. Although State-mandated "external reviews" are not preempted by the regulation, a claimant cannot be required to submit a claim to external review procedures in order to bring a benefit claim suit under ERISA.

II. SPD Regulation

The amendments to the SPD regulation update and expand the requirements imposed by the current regulation. In general, the amended regulation applies as of the first day of the second plan year beginning on or after January 22, 2001; however, because some of the changes made by the amendments had previously been included in interim rules issued by the Department of Labor, some of the changes are already in effect. The changes made by the amendments include the following:

A. Health Plans. Health plan SPDs must describe:

1. any cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which the participant or beneficiary is responsible;

2. any limits on benefits, such as annual or lifetime caps;

3. the extent to which the plan covers (a) preventive services, (b) existing and new drugs, and (c) medical tests, devices, and procedures;

4. provisions regarding network providers, the composition of any provider network, and the extent of coverage for out-of-network services;

5. any conditions or limits on the selection of primary care providers or providers of specialty medical care;

6. any limits on emergency medical care;

7. any provisions requiring preauthorization or utilization review as a condition of obtaining plan benefits or services;

8. the plan's procedures governing qualified medical child support orders ("QMCSOs") (or a statement that participants and beneficiaries may obtain a copy of those procedures, free of charge, from the plan administrator);

9. an up-to-date statement of COBRA continuation rights;

10. rights under the Newborns' and Mothers' Health Protection Act of 1996 (and any rights under State law); and

11. if a health insurance issuer is responsible for the plan's financing or administration, the name and address of the issuer and the extent to which plan benefits

are guaranteed by the issuer, and the nature of any administrative services rendered by the issuer.

B. Documentation. A plan may furnish its claims procedures as a separate document that accompanies the SPD if the SPD discloses that the claims procedures are furnished, automatically and without charge, as a separate document. In addition, a plan with a provider network may furnish the listing of providers in a separate document that accompanies the SPD if the SPD includes a general description of the provider network and a statement that provider lists are furnished automatically, without charge. The SPD is not required to list each and every drug, test, device, or procedure covered by a group health plan or to disclose specific premium amounts; the SPD is required only to inform participants and beneficiaries whether and under what circumstances benefits will be provided and to direct participants and beneficiaries as to where additional information may be obtained, free of charge, about the plan's coverage of specific benefits and the circumstances and extent to which participants and beneficiaries will be liable for premiums, deductibles, copayments, etc. Deductibles, copayments, benefit caps, or limits on benefits should be set forth in sufficient detail to allow participants and beneficiaries to assess their responsibility for medical care and hospital and other costs under the plan. The preamble also confirms the Department's position that a plan will satisfy its COBRA disclosure obligation with respect to an employee and his or her spouse at the time coverage begins under the plan by furnishing to the employee and spouse, at the time coverage begins, an SPD that includes the COBRA coverage information; where the spouse's last known address is the same as the employee's, a single mailing of the required COBRA disclosure (which could be in the form of an SPD), addressed to both the employee and the spouse, will constitute good faith compliance with the COBRA notice requirement.

C. Repeal of HMO Exemption. The amendments repeal the limited exemption for the SPDs of health plans that provide benefits through federally qualified health maintenance organizations ("HMOs"). As a result, health plans providing benefits through a qualified HMO must comply with the amended SPD regulation.

D. Material Reduction in Covered Services Under a Health Plan. The administrator of a group health plan must furnish to each participant a summary of any modification to the plan, or change in the information required to be included in the SPD, that is a material reduction in covered services or benefits no later than 60 days after the date of adoption of the modification or change unless the plan sponsor or plan administrator provides summaries of plan modifications at regular intervals of 90 days or less.

E. Pension Plans. The SPD of a pension plan must describe the plan's procedures governing qualified domestic relations orders ("QDROs") or include a statement that participants and beneficiaries may obtain, free of charge, a copy of those procedures from the plan administrator. In addition, if the plan is covered by PBGC insurance, the SPD must include an updated description of the insurance. If the plan is governed by Internal Revenue Code § 401(k) or ERISA § 404(c), or if the plan is a cash balance plan, the SPD must so specify.

F. Cash Balance Plans. The preamble to the regulation states that the current regulation requires a reasonably comprehensive and clear description of the provisions of a cash

balance plan and how a prior conversion might have affected benefits that participants might have reasonably expected the plan to provide. The preamble invites comments on whether, and to what extent, changes in the SPD requirements would provide better communications about cash balance plans and cash balance plan conversions.

G. Subrogation or Reimbursement Provisions. The SPD of any pension or welfare benefit plan must disclose subrogation, reimbursement, and other provisions that might eliminate or offset plan benefits.

H. Fees or Charges. The SPD of any pension or welfare benefit plan must include a summary of any fee or charge that must be paid to receive benefits under the plan.

I. Authority To Terminate or Amend Plan. The SPD of any pension or welfare benefit plan must describe the plan sponsor's authority to terminate the plan or to eliminate benefits under the plan, plan provisions governing the rights and obligations of participants and beneficiaries upon termination of the plan (or amendment or elimination of benefits under the plan), and any provisions governing the allocation and disposition of assets upon termination of the plan.

J. Statement of ERISA Rights. The regulation expands and updates the prior regulation's model ERISA rights statement.

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Claims Procedure Deadlines

Event	Urgent Health Claims	Concurrent Health Claims	Pre-Service Health Claims	Post-Service Health Claims	Disability Claims	Other Claims
Notice of Failure to Follow Claims Procedure for Filing a Pre-Service Claim	ASAP, but not later than 24 hours following the failure	If claimant asks to extend course of treatment, same as for urgent, pre-service, or post-service claims, as appropriate	ASAP, but not later than 5 days following the failure	NA	NA	NA
Notice of Incomplete Claim	ASAP, but not less than 24 hours after receipt of claim	If claimant asks to extend course of treatment, same as for urgent, pre-service, or post-service claims, as appropriate	NA, but may extend deadline for initial claim decision by 15 days	NA, but may extend deadline for initial claim decision by 15 days	NA, but may extend deadline for initial claim decision twice, for periods of up to 30 days each	NA, but may extend deadline for initial claims decision by 90 days
Claimant Furnishes Missing Information	A reasonable amount of time, but not less than 48 hours	If claimant asks to extend course of treatment, same as for urgent, pre-service, or post-service claims, as appropriate	At least 45 days	At least 45 days	At least 45 days	NA
Initial Claim Decision	ASAP, but not later than 72 hours (or, if additional information requested, not less than 48 hours after the earlier of (a) plan's receipt of the additional requested information or (b) the end of the period given to claimant to provide the additional information); must be provided even if decision is not adverse	Notice of any reduction or termination of a course of treatment must be given sufficiently in advance to allow claimant to appeal and obtain a determination before benefit is reduced or terminated. If claimant asks to extend course of treatment involving urgent care, ASAP with notice to be given within 24 hours after receipt of claim (provided claim made at least 24 hours before end of treatment period); must be provided even if decision is not adverse	WRPT, but not later than 15 days after receipt of claim, plus one 15-day extension (if extension due to matters beyond plan's control); must be provided even if decision is not adverse	WRPT, but not later than 30 days after receipt of claim, plus one 15-day extension (if extension due to matters beyond plan's control)	WRPT, but not later than 45 days after receipt of claim, plus two 30-day extensions (if each extension due to matters beyond plan's control)	WRPT, but not later than 90 days plus one 90-day extension
Oral Notification	Notice of adverse determination may be given orally by deadline for initial decision, with written notice within 3 days after oral notice	If urgent care involved, urgent care deadline applies	NA	NA	NA	NA
Claimant Files Appeal	At least 180 days after receipt of notice of adverse benefit determination	At least 180 days after receipt of notice of adverse benefit determination	At least 180 days after receipt of notice of adverse benefit determination	At least 180 days after receipt of notice of adverse benefit determination	At least 180 days after receipt of notice of adverse benefit determination	At least 60 days after receipt of notice of adverse benefit determination
Claim Appeal Decision	ASAP, but not later than 72 hours after receipt of request for review	Same as for urgent health claims, pre-service health claims, or post-service health claims, as appropriate	WRPT, but not later than 30 days after receipt of appeal (15 days if 2 levels of appeal)	WRPT, but not later than 60 days after receipt of appeal (30 days if 2 levels of appeal) (subject to exception for regularly-scheduled multi-employer plan trustee or committee meetings held at least quarterly)	WRPT, but not later than 45 days after receipt of appeal plus one 45-day extension (subject to exception for regularly-scheduled multiemployer plan trustee or committee meetings held at least quarterly)	WRPT, 60 days plus one 60-day extension (subject to exception for regularly-scheduled trustee or committee meetings held at least quarterly)

Key: ASAP – as soon as possible; **NA –** not applicable; **WRPT –** within a reasonable period of time.