

Employee Benefits DEVELOPMENTS

March 2006



RULINGS, OPINIONS, ETC.

The DOL issues two new FMLA opinion letters.

The Department of Labor (DOL) issued two opinion letters reiterating its position that employers may not reduce or discontinue contributions to health care plans when an employee takes an unpaid Family and Medical Leave Act (FMLA) qualifying leave. The opinion letters confirmed the DOL's position on this matter in the context of continuing contributions made to multiemployer and cafeteria health plans.

The facts of the first opinion letter involve an employer who made contributions to a cafeteria plan. Employees could elect to allot the contribution to a variety of benefits, including group health insurance. The DOL states, "Employees taking unpaid FMLA leave must have that portion of their cafeteria plan allotment to group health insurance (including dental) premiums paid by the [employer] in the same amount as paid prior to the start of FMLA leave." An employee's entitlement to other types of benefits, such as holiday pay, are limited by the employer's established policy for providing such benefits when an employee is on other forms of leave.

The DOL further states that even though the FMLA does not mandate the continuation of contributions for other benefits such as disability/life insurance, the FMLA does require that an employee must be able to resume benefits in the same manner and at the same levels as were provided when leave began. Therefore, an employee covered under disability/life insurance must be able to resume coverage immediately following FMLA without having to, for example, submit to a physical or other qualifying procedure. The practical result may be that the only way for an employer to restore these types of benefits to the employee would be to pay for the benefit during the employee's FMLA leave and then recover the employee's share of those payments when the employee returns from leave.

In the opinion letter pertaining to multiemployer plans, the DOL noted FMLA regulations require an employer to continue contributing to a multiemployer health plan on behalf of an employee on FMLA leave, "unless the plan contains an explicit FMLA provision for maintaining coverage such as through pooled contributions by all employers party to the plan." The DOL cited legislative history in commenting that Congress intended that employers continue contributing to multiemployer health plans for the duration of FMLA leave, unless the plan provides for some other method of maintaining coverage. (Wage and Hour Opinion Letter FMLA2006-2; Wage and Hour Opinion Letter FMLA2006-3-A).

CASES

New York City's Equal Benefits Law found invalid. In a recent 4-3 decision, New York State's highest court struck down a New York City law that prohibits city agencies from entering into contracts with firms that fail to provide domestic partner benefits, finding the law is preempted by both the Employee Retirement Income Security Act (ERISA) and a state competitive bidding law. New York City's Equal Benefits Law required contractors to provide to employees' domestic partners health, pension, disability, parental leave, adoption assistance, and other employee benefits that are equal to the benefits provided to spouses. Shortly after the law's effective date, the mayor unsuccessfully sought a temporary restraining order against the law's enforcement, asserting that the law was inconsistent with, and therefore preempted by, provisions of the General Municipal Law and the City Charter, and that it was preempted by ERISA. Agreeing with the appellate division's reversal of a lower court decision, the Court of Appeals found the mayor was correct in refusing to enforce the law because the law is invalid. The court held the Equal Benefits Law conflicts with a Municipal Law requiring contracts for public work to be awarded to the lowest responsible bidder. The court also rejected the argument that the law does not violate ERISA because it does not regulate benefit plans, but reflects a decision by the city, as a market participant, to choose the firms it deals with based on the benefits provided to its employees. On the contrary, the court found the Equal Benefits Law is preempted by ERISA because it seeks to prescribe the terms of benefit plans governed by ERISA. (*Council of the City of New York v. Bloomberg*, N.Y. Ct. App., 2006).

Wal-Mart can't "wrap." When this case arose, Wal-Mart's medical plan was self-insured. The medical plan was part of a single welfare plan known as the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan. The plan was maintained in the form of a "wrap" plan document that incorporated by reference the various documents governing Wal-Mart's welfare benefit arrangements. The operative document with respect to the plan's medical benefits was the medical plan SPD. However, the "wrap" plan document did not expressly incorporate the SPD. Importantly, the SPD contained a subrogation provision entitling Wal-Mart to recover medical expenses paid on behalf of a covered person injured in an accident if the covered person subsequently obtained a money judgment or settlement against another. The "wrap" document did not contain a subrogation provision.

Nancy Gamboa, an employee of Wal-Mart, and her husband, Jose Gamboa, were covered under Wal-Mart's medical plan when they were injured in an accident caused by a drunk driver. Wal-Mart paid approximately \$178,000 in medical expenses for care received by Mr. Gamboa, who had been seriously injured.

Later the Gamboa family settled the suit against the negligent party receiving almost \$1 million in money damages. In an attempt to exercise the subrogation rights in the SPD, Wal-Mart pursued the Gamboas for reimbursement of the amounts it had paid on Mr. Gamboa's behalf. The Gamboas disputed Wal-Mart's reimbursement claim, arguing that the official plan document (i.e., the "wrap" plan document and the documents incorporated into it by reference) did not authorize reimbursement. The court agreed with the Gamboas and dismissed Wal-Mart's claim. The court reasoned that because the SPD was the only document authorizing a right of recovery and because the SPD was not a part of the official plan document, the subrogation right could not be enforced.

This case instructs plan sponsors to exercise care in preparing "wrap" documents to ensure that the "wrap" document clearly identifies all documents intended to constitute a part of the official plan document. If all or some of an SPD is intended to constitute a part of the official plan document, the "wrap" plan document should specifically say so. In addition, whenever the constituent documents are amended, the "wrap" document should be amended as well in accordance with the plan's amendment procedures. (*Wal-Mart Stores, Inc. Associates' Health and Welfare Plan v. Gamboa*, W.D. Ark., 2006).

Participants not bound by arbitration clause between investment manager and plan. A participant in the Micor, Inc. pension plan filed a suit against Saloman Smith Barney, Inc. (SSB), the plan's investment manager, for breach of fiduciary responsibility in handling the plan's investments. SSB tried and failed to have the suit dismissed in favor of an arbitration clause that broadly covered any disputes between SSB and the plan arising from the handling of the plan's accounts under the investment management agreement. The rejection of SSB's attempt to compel arbitration was upheld by the U.S. Court of Appeals for the Ninth Circuit. Many arrangements and agreements with investment managers and financial institutions require arbitration as a means to resolve disputes, and the SSB investment management agreement contained a typical arbitration clause. The breach of fiduciary responsibility lawsuit, however, was not brought by the plan's sponsor or trustees who entered into the agreement with SBB. As authorized by ERISA, the plaintiffs sued a fiduciary (SBB) for breach of responsibility in an effort to recover funds for the plan as a whole. And while the court acknowledged that had the suit been brought by the plan sponsor, arbitration would be required, the court found no authority to bind the individual participants to the arbitration clause to which they were not parties. This decision is not on the merits of SBB's performance as a fiduciary, so the plaintiffs

still must show a breach of responsibility to achieve a recovery. If the plaintiffs are successful, one might wonder why the plan did not take action first to seek recovery. Investment managers, however, should take note that arbitration clauses with employee benefit plans will not necessarily preclude lawsuits with participants. (*Comer v. Micor Inc. and Salomon Smith Barney, Inc.*, 9th Cir., 2006).

Error-prone COBRA notice procedures costly to employer.

COBRA litigation frequently involves claims of failed delivery of COBRA notices. That is exactly the type of claim Robert Tufano brought against Riegel Transportation, Inc. (RTI). Tufano was terminated by RTI in June 2002 and his coverage under RTI's group medical insurance program ended in October 2002. Believing he still had medical insurance in effect, Tufano incurred medical expenses for a surgical procedure in December 2002. The health insurance carrier did not cover all of Tufano's surgical expenses and advised him that his insurance coverage actually had ended three months earlier. The carrier, however, offered Tufano an opportunity to purchase COBRA coverage retroactive to the termination of his prior coverage. Tufano declined the COBRA coverage due to ongoing litigation concerning his employment termination. Nonetheless, Tufano filed a subsequent lawsuit against RTI in which he alleged he never received from RTI notice of his COBRA rights. The court ruled RTI had the exclusive duty of providing Tufano with notice of his COBRA rights and that RTI had not met its legal obligation to provide that notice. Because RTI could neither provide testimony of a person who actually mailed the notice, nor could they offer sufficient proof that the notice was sent pursuant to RTI's internal office procedures, the court ruled the evidence put forth by RTI failed to establish a presumption that Tufano received his COBRA notice. Based on evidence that RTI's system of providing notice is prone to error, the court also found Tufano was able to prove that he had not received the COBRA notice. Accordingly, the court awarded Tufano damages equal to the amount of his unpaid medical bills (\$10,232.90). The moral of this story is that protection against claims for failure to properly deliver COBRA notices, at the very least, must include a documented set of COBRA notice procedures and an ability to demonstrate those procedures are consistently followed. (*Tufano v. Riegel Transportation, Inc.*, E.D.N.Y., 2006).

This newsletter is a periodic publication of Hodgson Russ LLP. Its contents are intended for general informational purposes only and should not be construed as legal advice or legal opinion on any specific facts or circumstances. Information contained in the newsletter may be inappropriate to your particular facts or situation. Please consult an attorney for specific advice applicable to your situation. Hodgson Russ is not responsible for inadvertent errors in this publication.

Employee Benefits Practice Group

Peter K. Bradley
716.848.1446
pbradley@hodgsonruss.com

Richard W. Kaiser
716.848.1494
rkaiser@hodgsonruss.com

Dianne Bennett*
716.848.1406
dianne_bennett@hodgsonruss.com

Anita Coles Costello
716.848.1532
anita_costello@hodgsonruss.com

Arthur A. Marrapese III
716.848.1751
Art_Marrapese@hodgsonruss.com

David A. Pratt**
518.465.2333
dpratt@hodgsonruss.com

Michael J. Flanagan
716.848.1480
mflanaga@hodgsonruss.com

Daniel R. Sharpe
716.848.1402
dsharpe@hodgsonruss.com

* Of Counsel
** Independent Counsel

