

Developments

March 24, 2003 to April 4, 2003

CASES

Supreme Court Upholds “Any Willing Provider” Law.

In a decision that may significantly affect the health care industry, on April 2, 2003, the United States Supreme Court unanimously upheld the validity of Kentucky’s “any willing provider” law. That 1994 law requires a managed care plan to recognize and reimburse all health care providers willing to provide services to the plan’s members and who meet the plan’s participation conditions, not simply those providers who have contracted with the managed care plan. The petitioners in the case, several health maintenance organizations and a Kentucky-based association of HMOs, argued the law was preempted by the Employee Retirement Security Act of 1974 (ERISA) because it sought to regulate employee benefit plans, would “frustrate their efforts at cost and quality control, and [would] ultimately deny consumers the benefit of their cost-reducing arrangements with providers.” In making what it called a “clean break” from prior jurisprudence, the Court held a state law (like the one at issue) regulates insurance, and therefore is not preempted by ERISA, where (1) it is specifically directed toward entities engaged in insurance and (2) it substantially affects the risk-pooling arrangement between the insurer and the insured. (*Kentucky Association of Health Plans, Inc. v. Miller*, ___ S. Ct. ___, 2003 WL 1726508 (2003).)

Employee Denied Insurance Coverage Because of Failure to Enroll.

People tend to hear what they want to hear. Take Brent Kamler. He agreed to work for PAL Telecom Group, Inc. in Brazil, but only if he received health insurance before moving. PAL told Kamler he would be insured, but PAL’s health plan required him to complete an enrollment form to receive coverage. For various reasons, Kamler never did so. Fast forward several months. Kamler is terminated and suffers a heart attack. He submits his medical bills for coverage under PAL’s health plan, and the claims are rejected; so he sues. The district court dismissed the suit, finding that Kamler never enrolled in the plan and was, therefore, not a participant with standing to sue. On appeal, the Seventh Circuit Court of Appeals specifically rejects Kamler’s claim that, had PAL not represented Kamler was

insured when he went to Brazil, he would have formally enrolled in the plan. The federal appellate court noted a promise to provide insurance was not a promise Kamler would receive insurance even if he did not enroll, and it was not reasonable for him to interpret the company representations in that manner. On March 31, 2003, the United States Supreme Court denied Kamler’s petition for writ of certiorari, thus leaving the Seventh Circuit’s holding intact. (*Kamler v. H/N Telecommunication Serv.*, ___ S.Ct. ___, 2003 WL 327450 (2003).)

Pension Plan May Exclude Hourly Employees Under ERISA.

An employee who worked all but the last few years of his employment with Summit Bancorp sued because the “salaried-only” pension plan in which he was a participant did not allow him to accrue a benefit for the time he worked as an hourly employee. The employee argued plans that exclude hourly employees violate ERISA’s minimum participation rules. The Third Circuit Court of Appeals rejected the employee’s argument, ruling there is no language in ERISA that forbids an employer from limiting plan coverage to salaried employees. Of course, for the plan to be qualified, Summit would have to be able to demonstrate the salaried-only plan satisfies the Internal Revenue Code’s minimum coverage requirements. (*Bauer v. Summit Bancorp*, ___ F.3d ___, 2003 WL 1497536 (3rd Cir. 2003).)

Employer Allowed to Recover Mistaken Overpayment of Pension Plan Benefit and Take Interest in Recipient’s House.

A plan sponsor made a mistake and paid out about \$14,000 more than the participant was entitled to receive. The plan sponsor was able to establish the overpayment was rolled by the participant into an individual retirement account (IRA) and the IRA proceeds were, in turn, used to purchase a home for the participant. Rejecting the participant’s arguments that the plan’s attempts to recover the overpayment should be time-barred or denied because the participant detrimentally relied on the plan’s determination of her benefit amount when she cashed in her IRA and incurred taxes, the federal district court ruled the plan could

seek equitable relief in the form of a constructive trust in a share of the house purchased by the participant. (*Lumenite Control Technology, Inc. v. Jarvis*, ___ F. Supp.2d ___, 2003 WL 1585091 (N.D. Ill. 2003).)

Remitting Premiums Sufficient to Maintain COBRA Even After Writing a Letter Declining Benefits.

In administering the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), an employer cannot necessarily rely on a COBRA beneficiary's initial written statement that he or she will discontinue coverage; rather, the COBRA beneficiary's actions after an election is made may dictate the rights of the COBRA beneficiary. A covered employee had a qualifying event and elected to receive COBRA coverage. Subsequently, the employer/sponsor decided to switch insurers for the plan from Dakotacare to Lincoln Mutual. Notice of the carrier change was given to Margaret Fink, who then notified the plan sponsor she was applying for benefits with her new employer and would decline coverage with the new insurer, Lincoln Mutual. Four days after Fink sent in her response, Fink's daughter was admitted to a hospital. Not wanting to have a gap in her insurance, Fink sent the COBRA premium for the next month. She sent the premium to the old insurer, Dakotacare, and not the new insurer, Lincoln Mutual. The claims for benefits were rejected by Dakotacare. While the determination of who was liable to pay the claims was remanded to the federal district court, the Eighth Circuit Court of Appeals ruled the responsible ERISA fiduciaries for the plan were obligated to apply the COBRA premium payment so that Fink's coverage was maintained. (*Fink v. Dakotacare*, ___ F.3d ___, 2003 WL 1618467 (8th Cir. 2003).)

Employer/Plan Administrator Given 44 Days to Notify Participant of COBRA Rights.

A recent federal district court case in Colorado reminds us not all courts agree when notice of a COBRA qualifying event must be delivered to a plan participant when the employer serves as the plan administrator for its group health plan. In this case, the Colorado court took a position consistent with the Department of Labor (DOL) that the notice period is 44 days when the plan sponsor has the dual

role of employer and plan administrator (i.e., the 30 days the employer has in that capacity for reporting a qualifying event to the plan administrator, plus the additional 14 days it is given as the plan administrator in which to issue notices to the beneficiaries). (*Anderson v. Royal Crest Dairy Inc.*, ___ F. Supp.2d ___, 2003 WL 1701504 (D. Colo. 2003).)

Although the position taken by the Colorado court may be the predominant view, some courts have disagreed with the DOL's position, including one federal district court in the Northern District of New York. (*Goodman v. Commercial Labor Services, Inc.*, 24 Employee Benefits Cas. 2264, 2000 WL 151997 (N.D.N.Y. 2000).) Those courts have found an employer that also serves as the plan sponsor and administrator has only 14 days after terminating an employee to notify the employee of his or her continuation rights under COBRA. For that reason, some employers are taking a conservative approach and getting the COBRA notices out within 14 days of a termination.

Participant Failed to Substantially Comply with Plan Requirements for Beneficiary Change.

Under his employer's group life insurance plan, Dr. Robert Seligman assigned his group life insurance policy to a trust. But when Seligman died, the insurer paid the proceeds to his widow, rather than to the trust. The trust sued, and the defendants moved to dismiss for failure to state a claim. In granting the defendants' motion, the federal district court held Seligman did not substantially comply with ERISA's requirements for changing the policy's beneficiary. None of his actions when effecting the policy's assignment were similar to the completion of the plan's change of beneficiary form, and Seligman had no power to change the beneficiary once the assignment was completed. (*SunTrust Bank v. Aetna Life Insurance Company*, ___ F. Supp.2d ___, 2003 WL 1452123 (E.D. Va. 2003).)



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