

In This Issue

- FMLA Worksite Definition Rejected
 - 401(k) Theft Growing
 - Health Insurers Curb Diagnostic Imaging
 - Survey: Women Return to Work for Less
 - Consumer Perceptions Affect Health Care Costs
 - Subrogation Agreement Signature: Ok
 - Since You Asked: An SPD in Any Language
 - Since You Asked: Coverage Decision “in Anticipation”
 - Stop-Loss Insurer: Limited Liability
-

FMLA Worksite Definition Rejected

A special FMLA rule excludes any employee who works at a facility more than 75 miles away from a location with 50 other employees. For example, a restaurant chain with 500 employees can deny FMLA requests from workers at any location outside a 75 mile radius of 50 other employees. Congress created this rule to protect employers with lean staffs who would have difficulty covering the employee’s position during FMLA leave. Employers with multiple business sites often encounter this situation.

With this in mind, the court considered the case of *Harbert v. Healthcare Services Group, Inc.*, 10th Cir., No. 03-1156, December 13, 2004. Nancy Harbert worked for Healthcare Services Group, Inc. at an office in Brush, Colorado which employed less than 50 employees within 75 miles of that worksite. The company’s regional office was in Golden, Colorado. This office was outside 75 miles from Harbert’s worksite and it retained Harbert’s employment records, provided her employee benefits, could transfer or terminate her and processed her salary. Harbert reported to individuals at the regional office and was in some ways considered an employee of the regional office.

Harbert was injured in an automobile accident and took two 30-day leaves of absence. Healthcare Services Group denied her request for FMLA leave because of where Harbert physically worked. She brought suit against her employer and won at the lower court level. The lower court determined that Harbert’s “worksite” under FMLA regulations was the regional office rather than her local office.

F

O

C

D

S

On
Benefits

At Issue

Which worksite employed Harbert? If Harbert could tie her employment to the Golden, Colorado office, she might have an argument supporting FMLA entitlement. Applying a simple, straight forward definition of worksite would likely tie Harbert to the remote facility and leave her without FMLA rights.

The lower court's decision was based upon the following regulation:

For purposes of determining [an] employee's eligibility, when an employee is jointly employed by two or more employers, the employee's worksite *is the primary employer's office from which the employee is assigned or reports.* [FMLA Reg. Sec. 825.111(3).]

Appellate Court Analysis

Harbert's employer asserted that the DOL exceeded its authority by issuing a rule defining workplace differently than Congress intended. Ultimately, the court of appeals determined that Congress intended a worksite to be construed as an employee's regular place of work. Consequently, the appeals court reversed the lower court's decision — undoing the award to Harbert of back pay, front pay, various damages, interest, attorney's fees, and court costs.

Although not binding on other jurisdictions outside of the Tenth Circuit, this decision will undoubtedly be reviewed by courts in other jurisdictions. The Tenth Circuit includes Colorado, Kansas, New Mexico, Oklahoma, Utah, and Wyoming. Interestingly, this is the second time the courts have invalidated DOL regulations governing FMLA.

401(k) Theft Growing

According to the *Wall Street Journal*, retirement plans face a growing threat from theft. In 1995 the number of 401(k) thefts identified by the Department of Labor was 34; compare that to data for fiscal year ending September 30, 2004 reporting 1,269 instances of missing money.

Only 55,195 of 683,100 defined contribution plans were audited in 1999 — the most recent year for which data is available. The DOL has about five hundred full time auditors specializing in 401(k) activity: only 38 percent more than in 1995.

The DOL is bolstering its audit capabilities but under current rules the vast majority of defined contribution programs do not require independent audits for plans with fewer than one hundred participants. Workers have little recourse because defined contribution plans are not guaranteed by protective agencies.

Establishing 401(k) programs was so easy that virtually any employer could do so. Unfortunately this appears to have led to abuses which have defrauded large numbers of unsuspecting participants. These disturbing findings may persuade Congress to enact legislation that protects 401(k) accounts.

Health Insurers Curb Diagnostic Imaging

Industry publication *BestWeek* details how health insurers are determined to curb the use of costly diagnostic imaging procedures. Experts calculate such procedures cost the insurance industry \$100 billion annually.

According to the American College of Radiology, as much as 50 percent of imaging procedures ordered by nonradiologists may be unnecessary. Other physicians performing their own imaging are two to seven times more likely to order imaging procedures than physicians with no financial interest in the radiology practice.

“The main issue,” said Dr. Lew Sandy, executive vice president of clinical strategies and policy for UnitedHealthcare, a unit of UnitedHealth Group Inc., “is there is wide variation in the quality and cost effectiveness of imaging across the country. And neither physicians nor consumers have any guidance about who is doing a good job and who isn’t.”

Survey: Women Return to Work for Less

The *Associated Press* reports that professional women who put careers on hold, for family or other reasons, earn 18 percent less when they return to the workforce. The penalty for putting their career on hold is even higher in the business world, where earnings drop an average of 28 percent, according to the survey by the New York-based Center for Work-Life Policy.

The drop in pay partly reflects many women’s decisions to return to work in jobs with less responsibility, or to part-time jobs. But experts believe it may also reflect women exiting the workforce during the years when men make their largest career strides.

The longer the absence the greater the loss. Reportedly, women who take less than a year off from their careers, return to the labor force at an average of 11 percent less pay — three years or more return to pay averaging 37 percent less than what they originally earned. The survey interviewed more than 2,400 women nationwide, focusing on those with a graduate, professional or undergraduate degree with high honors. The group also surveyed 653 similarly qualified men as a means of drawing comparisons.

About 44 percent of the women who exit the workforce do so to gain more family time, another 23 percent pursue a degree or additional training. In contrast, 29 percent of men cited a decision to change careers as their reason to leave the workforce. Another 25 percent said they did so to earn a degree. Only 12 percent of men surveyed said they put aside work to devote more time to family.

Consumer Perceptions Affect Health Care Costs

A survey by Destiny Health suggests a wide disparity between perceptions and reality on key health issues — a difference that may impact employer costs.

A provider of consumer-driven health plan products, Destiny Health's Chief Medical Officer Dr. Charles Schutz says, "More than anything, the study shows the need for a new definition for the word, 'healthy.' It proves that Americans tend to see themselves as well until they are actively sick. Their definition of healthy is 'I feel fine.' That is a dangerous notion that needs to be replaced by the understanding that a person is healthy only when he or she is living a healthy lifestyle and is regularly monitoring key risk factors, such as blood pressure and cholesterol levels."

Dr. Schutz described the results as "disturbing, but not surprising news" that dramatizes the urgent need for employers to offer health education programs, wellness initiatives and incentives that encourage employees to adopt better health habits. Unless harmful lifestyle behaviors are dramatically improved, a majority of employers could find themselves footing an even larger bill for medical expenses in the future.

Other interesting findings collected in the study include the following:

- Although three-quarters of the survey respondents considered themselves healthy, a research program funded by the Robert Wood Johnson Foundation found that nearly half the U.S. population (125 million) "live with at least one chronic health condition and that many live with more than one."
- Of those surveyed, 88 percent said they believed their health could be improved by eating healthy foods. Yet 43 percent acknowledged dining on fast food one or more times per week and almost 90 percent of those said they eat processed snack foods regularly.

Subrogation Agreement Signature: Ok

Subrogation rights give the plan the right to "stand in the shoes of" the injured plan participant and pursue an action against the party at fault. Subrogation helps prevent a participant from an undeserved "double recovery" (first from the plan, then later by suing and recovering damages from the negligent party).

The Supreme Court has ruled that an employer does not have the right to sit back, do nothing, and then expect full reimbursement from the plan participant when that person receives a settlement in the case. Many plans require a written promise for reimbursement for medical expenses paid while the claim was pending. This written promise is called a subrogation agreement; just such an agreement was at issue in a recent court case.

In *Kress v. Food Employers Labor Relations Association*, 391 F.3d 563 (Fourth Cir., December 10, 2004), Paul Kress was injured in an automobile accident. The plan sent him a subrogation agreement and asked both Kress and his attorney to sign the agreement. The subrogation agreement contained a provision stating that the plan would cover Kress' medical expenses, and if an award was made or a settlement was received Kress would be required to reimburse the plan in full (before others received any portion of the recovery). Kress signed the agreement, his attorney refused to sign the agreement, maintaining that the health plan should share in the attorney's fees. When the plan stopped paying medical benefits because of the attorney's refusal to sign the agreement, Kress sued his employer.

The lower court found that the plan was well within its discretionary authority. Because this requirement was well documented in the plan language, the court deferred to the plan's right to interpret its own benefits.

On appeal, Kress argued that the plan requirements were ambiguous. The court stated that ERISA allows employers to include subrogation clauses in a benefit plan and that their content is at the employer's discretion. Further, the court said a plan is permitted payment before attorney fees are paid and may condition its coverage of medical bills on that order of repayment. The court's rationale gave weight to the convenience factor of subrogation compared to an employee's right to subrogation. Subrogation, the court said, is a courtesy to tide the employee over in difficult times by advancing medical coverage that the plan is not obligated to provide.

This court decision draws attention to the steps that many employers are being forced to take in order to protect the plan when a participant refuses to honor a subrogation agreement. The Fourth Circuit includes: Maryland, North Carolina, South Carolina, Virginia, and West Virginia.

Since You Asked: An SPD in Any Language

A *FOCUS on Benefits* reader operates a factory where almost 40 percent of the workers speak Spanish: not English. Must the employer provide SPDs and other plan documents in Spanish?

The best practice would be to provide the materials in Spanish. Communications are meant to provide information; we advise employers to comply with both the letter and spirit of ERISA. The better the employer communicates the less likely it is that someone will have an issue that they can use against the employer. In addition, it is just good HR and employee relations practice to provide the information in a language that is understandable.

That said, there is no legal obligation under ERISA to provide the information to the employee in the employees' native language. In some circumstances there *IS* an obligation to provide assistance (and to communicate that availability) in their native language. The requirement arises if an employer has fewer than 100 employees, 25 percent of whom are literate only in the same language (other than English) or if an employer has 100 or more employees and the lesser of 500 or 10 percent of them are literate only the same, non-English, language. In that case, the SPD can still be provided in English, but with a notice in their native language telling them how they can get assistance in their native language.

Example:

Steel Inc. maintains a health plan which covers one thousand participants. At the beginning of a plan year, five hundred of Steel's covered employees are literate only in Spanish, 101 are literate only in Vietnamese, and the remaining 399 are literate in English. Satisfactory compliance could be achieved by preparing and distributing SPDs in each applicable foreign language. As an acceptable less expensive approach, each of the one thousand employees receives a summary plan description in English, containing an assistance notice in *both Spanish and Vietnamese* stating the following:

“This booklet contains a summary in English of your plan rights and benefits under (name of plan sponsor) group health plan. If you have difficulty understanding any part of this booklet, contact Mr. John Doe, the plan administrator, at his office in Room 123, 456 Main St., Anywhere City, State, 20001. Office hours are from 8:30 A.M. to 5:00 P.M. Monday through Friday. You may also call the plan administrator’s office at (202) 555-2345 for assistance.”

Since You Asked: Coverage Decision “in Anticipation”

Voluntarily dropping spousal coverage at open enrollment is typically not an event that would trigger COBRA. However, COBRA regulations note that reduction or elimination of coverage in anticipation of a qualifying event does have COBRA implications when a COBRA event (such as a divorce) subsequently occurs. In such a case, the “voluntary” aspect of dropping of coverage at open enrollment is disregarded. If the employee and spouse later divorce, and spousal coverage was dropped under the “in anticipation” rule COBRA must be offered to the ex-spouse. When this rule applies, the divorce is treated as the qualifying event, and COBRA coverage runs from the *date of the divorce*. This rule also extends to legal separations if the legal separation would cause a loss of coverage under the plan.

Example:

Brad uses a pre-tax salary reduction under his employer’s cafeteria plan to pay for health coverage for himself and his wife, Jennifer. At open enrollment, Brad voluntarily submits paperwork to drop Jennifer from the health plan. Brad gives no reason, but the benefits administrator suspects that Brad hopes to deny Jennifer her opportunity to elect COBRA coverage.

The benefits administrator cautiously explains to Brad that it appears that his decision to drop Jennifer’s coverage is being done in anticipation of divorcing her. If Brad subsequently divorces and properly notifies his employer of the divorce within 60 days, Jennifer will be a qualified beneficiary with a right to obtain COBRA coverage for a period of 36 months from the date of the divorce. The benefits administrator also explains that if medical claims arise during a period in which Jennifer does not have health coverage, a court could hold Brad personally responsible for those expenses.

This rule presents special challenges to plan administrators. In this example, the employer would need to provide coverage to an individual whose coverage under the plan terminated several months earlier. This may be extremely difficult for an insured plan. In addition, nothing in COBRA guidance specifies how to determine whether an employee dropped a spouse’s coverage in anticipation of a qualifying event. In most cases, the only indication that the “in anticipation rule” may apply is the fact that a divorce occurs after the employee drops the spouse’s coverage.

Because this looks so much like a COBRA triggering event, some employers find it helpful to send out a notice explaining that the individual has lost health coverage and that COBRA rights might emerge at a subsequent date. A sample cover letter that an employer might use in this situation is set out in Exhibit 2-2 of the *Willis Compliance Manual*. Providing this notice generally will trigger a response which may give the plan administrator an indication whether the coverage was dropped in anticipation of a divorce.

In that event, the plan administrator should promptly contact any insurance carrier (including a stop-loss carrier) to ensure required COBRA coverage if and when the divorce occurs.

Stop-Loss Insurer: Limited Liability

What happens when a claim to cover medical expenses is brought *directly* against a stop-loss carrier? Does the carrier have liability or is it only required to reimburse the plan sponsor *after* the plan pays?

Such a situation took place in Indiana when a health plan sponsor went bankrupt and was unable to pay for participant medical claims. Ordinarily, the plan sponsor would have paid the claim and then filed for reimbursement under its stop-loss policy. Due to the bankruptcy, the plan sponsor did not have the money to pay the medical claims, and asked the stop-loss carrier to directly pay claims.

The U.S. Court of Appeals for the Seventh Circuit ruled that a stop-loss insurer has no liability in this instance because the stop-loss policy limited the carrier to liability for reimbursement — and no evidence of paid claims was ever submitted. *Indiana Funeral Directors Insurance Trust v. Trustmark Insurance Corp.*, Seventh Cir., No. 03-1868 (October 21, 2003). The Seventh Circuit includes: Illinois, Indiana, and Wisconsin.

The appeals court found that the stop-loss insurance policy only provided coverage if the plan “actually paid” for medical expenses that exceeded the policy’s \$60,000 threshold — and in this case the health plan provided no evidence that it paid for the participants’ medical expenses.

With stop-loss carrier coverage becoming increasingly expensive and liability aggressively resisted, policy provisions are getting more stringent. Some other trends to watch for include stop-loss carriers carefully scrutinizing signed disclosure forms. Employers are told that they must disclose any pending claims and certify their knowledge by signature. Additionally, stop-loss carriers are demanding to see phone logs, e-mail, and other evidence substantiating that the employer actively investigated the possibility that more pending claims might exist by contacting satellite facilities, and actively pressing for information that might reveal hidden claims.

U.S. Benefit Office Locations

Anchorage, AK (907) 562-2266	Eugene, OR (541) 687-2222	Miami, FL (305) 373-8460	Portland, OR (503) 224-4155
Atlanta, GA (404) 224-5000	Florham Park, NJ (973) 410-1022	Milwaukee, WI (414) 271-9800	Raleigh, NC (919) 459-3000
Austin, TX (800) 861-9851	Ft. Worth, TX (817) 335-2115	Minneapolis, MN (763) 302-7100	Rochester, NH (603) 332-5800
Baltimore, MD (410) 527-1200	Grand Rapids, MI (616) 954-7829	Mobile, AL (251) 433-0441	Roswell, NM (505) 317-3397
Bethesda, MD (301) 530-5050	Greenville, SC (864) 232-9999	Montgomery, AL (334) 264-8282	St. Louis, MO (314) 721-8400
Birmingham, AL (205) 871-3871	Houston, TX (713) 625-1023	Mountain View, CA (650) 944-7000	San Diego, CA (858) 455-4888
Boston, MA (617) 437-6900	Jacksonville, FL (904) 355-4600	Naples, FL (239) 514-2542	San Francisco, CA (415) 981-0600
Cary, NC (919) 459-3000	Knoxville, TN (865) 588-8101	Nashville, TN (615) 872-3700	San Juan, PR (787) 756-5880
Charlotte, NC (704) 376-9161	Lake Mary, FL (407) 805-3005	New Orleans, LA (504) 581-6151	Seattle, WA (206) 386-7400
Chicago, IL (312) 621-4700	Lexington, KY (859) 223-1925	New York, NY (212) 344-8888	Tampa, FL (813) 281-2095
Cleveland, OH (216) 861-9100	Long Island, NY (516) 941-0260	Orange County, CA (714) 953-9521	Washington, DC (301) 530-5050
Columbus, OH (614) 766-8900	Los Angeles, CA (213) 607-6300	Philadelphia, PA (610) 964-8700	Wilmington, DE (302) 477-9640
Dallas, TX (972) 385-9800	Louisville, KY (502) 499-1891	Phoenix, AZ (602) 787-6000	
Denver, CO (720) 932-8137	Malvern, PA (610) 889-9100	Pittsburgh, PA (412) 928-8000	
Detroit, MI (248) 735-7580	Memphis, TN (901) 818-3263	Plainview, NY (516) 941-0260	

Other Willis Locations:

Willis has offices in more than 20 other U.S. cities and in 73 countries around the world, with a total of 260 offices worldwide.

FOCUS is produced by Legal & Research Group of Willis: willis.focusonbenefits@willis.com or 877-4WILLIS (toll-free). *FOCUS* is not intended to provide legal advice. Please consult your attorney regarding issues raised in this publication. Willis publications appear on the internet at: www.focusonbenefits.com.

Copyright © 2005 Willis