ERISA WORKSHOP:
"ERISA Claims Handling for the Nonsubscribing Employer"

By: Jerry Fazio, Esq.

Owen&Fazio P.C.
Attorneys & Counselors at Law

7557 Rambler Road, Suite 1465
Dallas, Texas 75231
(214) 891-5960 - Telephone
(214) 891-5966 – Facsimile
www.owenfazio.com

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I. ERISA OVERVIEW

A. ERISA BACKGROUND INFORMATION

- The Employee Retirement Income Security Act of 1974 (ERISA) is the law that affects employee benefit plans and sets the minimum standards for benefit plans through private sector employment.

- PURPOSE: The purpose behind ERISA was to protect participants and beneficiaries of benefit plans. In fact, in 29 U.S.C.A. § 1001(b), "Congressional Findings and Declaration of Policy," it states:

    - "It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts."

- While nonsubscription was not even a consideration when ERISA was created and passed, the definition of a "covered plan" includes nonsubscriber injury benefit plans.

    - § 1003(a): "any employee benefit plan if it is established or maintained by (1) by any employer engaged in commerce or in any industry or activity affecting commerce; or (2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or (3) both."

- <u>What kind of plans does ERISA cover?</u>

    - Pension plans that provide retirement income or defer income until termination of covered employment or beyond, and

    - Welfare plans established to provide health benefits, disability benefits, death benefits, prepaid legal services, vacation benefits, day care centers, scholarship funds, apprenticeship and training benefits, etc.

    - Definition of an "employee welfare benefit plan:"

        - "Any plan, fund or program which was heretofore or is hereafter established or maintained by an employer or by an employee, organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of

providing for its participants and its beneficiaries, through the purchase of insurance or otherwise, (a) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship, or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (b) any benefit described in section 186(c) of this title (other than pensions or retirement or death, and insurance to provide such pensions).

- Although the definitions of pension and welfare benefit plans may be broad and somewhat confusing, the general rule is that any program for the delivery of employee benefits other than wages is presumed to be subject to ERISA laws, unless there is a specific exception.

  - Plans excluded from ERISA according to §1002(36):

    - Certain governmental plans
    - Church plans
    - Plans established outside the U.S.
    - Un-funded excess benefit plans as defined in § 1002(36), and
    - Health insurers and plans that are "maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws."

      - **NOTE:** It may appear that Texas nonsubscriber plans should be excluded because they are maintained to comply with workers' compensation laws. However, they are not maintained "solely for the purpose" of complying with workers' compensation laws and are thus not excepted.

- Who Administers and Enforces the ERISA provisions?

  - The U.S. Department of Labor, through the Employee Benefits Security Administration ("EBSA"), is responsible for enforcing the fiduciary, reporting and disclosure provisions of Title I of ERISA. Title I's purpose is to protect the interests of participants and their beneficiaries.

- ERISA pre-empts state laws

  - ERISA generally preempts or supersedes any state laws insofar as they relate to an employee welfare benefit plan. State laws include "all laws, decisions, rules, regulations, or other State action having the effect of law." 29 U.S.C. § 1144.

- All state mandated insurance coverage, claims practices, claims administration and other services, relating to an employee welfare benefit plan are exempt from state laws and regulations and are governed by ERISA. This includes Texas Deceptive Trade Practices Act claims. However, actions to enforce the terms of the plan itself have concurrent jurisdiction in state court. 29 U.S.C.A. § 1132(e)(1) and (f).

- Exceptions to preemption clause: "Savings Clause," exempts laws that "regulate insurance, banking, or securities" from ERISA preemptions. But otherwise, the sweep of ERISA's preemption clause is "deliberately expansive"

- The Supreme Court instructs that a state law "relates to" an employee benefit plan if it: (1) has a connection with; or (2) reference to such a plan.[1]

    - In determining whether a claim relates to a plan, the Fifth Circuit has held that the ultimate question is whether the plaintiff's claims were stripped of their link to the pension plans, they would cease to exist.[2]

[1] *Calfornia Dip. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324 (1997).
[2] *Rokol v. Texaco, Inc.*, 77 F.3d 126, 129 (5th Cir. 1996).

II. ERISA AND NONSUBSCRIPTION IN TEXAS

A. BACKGROUND ON NONSUBSCRIPTION IN TEXAS

- In 1913, Texas enacted workers' compensation laws, which were voluntary. Today, most private sector employers can choose to subscribe to workers' compensation or operate as a Texas nonsubscriber. It wasn't until the 1980s, when workers' compensation premiums escalated, that nonsubscription became a major issue. As nonsubscribers' businesses started providing injury benefit plans to offer occupational injury benefits to its employees.
    - As of 2008, 33 percent of Texas employers were non-subscribers. Further, 25 percent of Texas employees are employed by non-subscribers
- Because of these statistics and because ERISA governs nonsubsciber injury plans, it is important for employers to know ERISA's requirements.

B. HOW ERISA AFFECTS NONSUBSCIBERS

- Because ERISA's purpose was to protect employee benefit rights, ERISA has provided a detailed regulatory scheme with two crucial components: (1) the disclosure and reporting requirements and (2) the fiduciary duty.
- <u>The Disclosure and Reporting Requirements:</u>
    - ERISA has specific rules regarding the type of information that must be provided to participants and beneficiaries, as well as reported to certain government agencies. §§ 1021-24.
    - Of this information, the summary plan description, summary of material modification, and annual report are some of the more relevant reporting documents that ERISA requires to be available for disclosure to plan participants.
    - Summary Plan Description - §1022:
        - Summary Plan Description is a summary of the provisions of the plan, including a statement of ERISA rights. The summary should be written in language that is understandable to the average plan participant.
        - Section 1022(b) provides a detailed list of the requirements. However, some of the requirements include the following:

- Name and type of administration of the plan;
- In a group health plan, whether a health insurance issuer is responsible for financing or administration of the plan, and if so, the name and address of the issuer;
- Name and address of the person designated as agent for the service of legal process, if it is not the administrator;
- Name and address of the administrator;
- Description of relevant provisions of any applicable collective bargaining agreement;
- Plan's requirements respecting eligibility for participation and benefits;
- Circumstances which may result in disqualification, ineligibility, or denial or loss of benefits

o Publication timeframes of summary plan description to participants and beneficiaries of the plan:

  - A plan administrator is required to provide the SPD to participants, but is not required to file it with the Department of Labor.

  - The plan administrator must provide a SPD for new plans with 120 days after the plan becomes subject to ERISA.

  - ERISA requires updates every fifth year for amended plans; otherwise, the plan administrator is required to redistribute the SPD every ten years.

  - The plan administrator must provide a copy of the SPD to new participants within 90 days of participation or benefit commencement (for beneficiaries).

  - If there are any material modifications to the plan or a change in formation, the plan administrator is required to provide participants, with 210 days after the close of the plan year in which the modification was adopted, a Summary of Material Modifications (SSM), unless described in a timely distributed SPD.

o Publication timeframes of annual reports to participants and beneficiaries of the plan:

  - Plan administrator is required to provide participants a copy of the Summary of Annual Report within nine months after the close of the plan year, or within two months after the close of the extension period for filing an annual return. The plan administrator is required to file an annual return within the last day of the seventh

month after the close of the plan year and make the return available to participants upon written request.

- Liability for Failure to Meet Requirements:
  - Penalties can be severe for failing to meet the reporting and disclosure requirements under ERISA.
  - Part 1 of Title 1 of ERISA states that, upon conviction, a fiduciary may be fined up to $5,000 ($100,000 maximum if the violator is an entity other than an individual) and/or imprisoned for up to one year.

- Fiduciary Duties:
  - ERISA fiduciary duties are required by any individual or entity that exercises any discretionary control or authority over the management or administration of a plan. 29 U.S.C. A. 1002(21)(A).
  - As you will see below, fiduciaries have very strict legal requirements under ERISA. It is possible that some individuals may be acting in a fiduciary capacity without being fully aware of their responsibilities and thereby exposing themselves to liability. Fiduciaries can be held personally liable for breaching their duties, as is discussed more below.
  - Section 1104 provides for a "prudent man standard of care" and states that a fiduciary shall discharge his duties with respect to a plan:
    - Soley in the interest of participants and beneficiaries (duty of undivided loyalty);
      - **NOTE:** This is the first and most fundamental duty of an ERISA plan fiduciary. Because ERISA allows employers to act as a plan's administrator, the employer is in a difficult position of possible conflicting loyalties and must balance its duty of loyalty to the plan participants against the loyalty it owes to the company.
    - For the exclusive purpose of:
      - (1) providing benefits to participants and their beneficiaries; and
      - (2) defraying reasonable expenses of plan administration

- He shall discharge his duties "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;"

- By diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

- In accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

- Liability for Breach of Fiduciary Duty:

  - Under § 1109, "any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter:

    - shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and

    - shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

    - A fiduciary may also be removed for a violation of section 1111 of this title."

  - However, "no fiduciary shall be liable with respect to a breach of fiduciary duty under this subchapter if such breach was committed before he became a fiduciary or after he ceased to be a fiduciary."

III. ADVANTAGES OF ERISA GOVERNED PLANS VS. WORKERS COMP

A. STATISTICS

- Before delving into the advantages of nonsubscribing in Texas and enacting an ERISA governed plan, it is important to note the reasons many employers choose to subscribe to Texas workers' compensation.

- **Top Five Primary Reasons Why Subscribing Employers Said They Purchased Workers' Compensation Coverage[3]:**

    - Employer thought having workers' compensation was required by law – 25%
    - Employer provided WC coverage through heath care network – 24%
    - Employer was concerned about lawsuits – 14%
    - Employer needed workers' compensation coverage in order to obtain government contracts – 3%
    - Workman's Comp Insurances Rates were lower –2%

- **Top Five Primary Reasons Why Non-subscribing Employers Said They Did Not Purchase Workers' Compensation Coverage[4]:**

    - Workers' compensation insurance premiums were too high – 26%
    - Employer had too few employees – 26%
    - Employers not required to have workers' compensation insurance by law – 11%
    - Employer had few on-the-job injuries – 9%
    - Medical costs in the workers' compensation system were too high – 4%

B. ADVANTAGES TO ERISA GOVERNED PLANS

- Employee Relations

    - The State of Texas requires businesses to notify employees when they cancel their workers' compensation policy, which could clearly be perceived in a negative way by many employees. However, an ERISA plan can help employees during this transition, demonstrating that the company continues to comply with other laws relating to providing benefits.
    - ERISA was enacted to protect the interest of plan participants and beneficiaries and to provide penalties for employers that abuse the rights of their employees.

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[3] *Survey of Employer Participation in the Texas Workers' Compensation System,* Public Policy Research Institute at Texas A&M University and the Texas Department of Insurance Workers' Compensation Research Group.
[4] *Id.*

- Greater Control for the Employer

    - Benefit plans help employers manage provisions of benefits and employee care. Unlike subscribers, nonsubscribing companies can choose medical providers with a reputation for offering quality care and designate them as an authorized provider. Employers can also work with companies that provide access to a network of providers, some of which also manage claims on behalf of the nonsubscribing employer.

    - It should be noted that in a well-designed plan, it should consider issues that would typically arise following an employee injury so that the company is prepared to respond and handle the situation best. The plan provides a framework so both the employer and the employee will know in advance how to respond to the issue.

- Encourages Safety

    - Employers can require their employees to participate in safety training programs, utilize safety habits and report unsafe work conditions.
    - The plan can encourage prompt reporting of injuries.

- Mitigates Liability

    - A benefit plan can prevent frustration and misunderstanding, on both the employee and employers part, by providing a clearly articulated standard, which complies with ERISA. This can help reduce legal claims by both assuring employees that benefits are available in the event of an injury, and outlining the scope of the benefits and process.

- Arbitration

    - Creating your own plan allows you the ability to create an arbitration provision. However, it should be noted that arbitration agreements may not always be in the employee's best interest.

- Federal Law Preempts State Law

    - ERISA preemption allows ERISA-related claims to be removed to federal court. Thus, rather than a jury ruling on matters, a federal judge will be making the decision and usually require claimants to exhaust all dispute resolution procedures established according to the plan.

- Caps

- Most health care plans have limitations on the maximum allowable benefits, which can be calculated in a number of ways, such as per person, per occurrence, specific time periods, annually, etc.

- Eliminates Claims of Discrimination

  - The benefit plan should provide to all employees equally without any bias or discrimination. By complying with the terms set forth specifically by the plan, the employer can show equal access to benefits. This gives them a standard approach to handling the situation to avoid claims of bias.

- Subrogation

  - Plans can retain the right to subrogation, which permits the plan administrator to recover amounts that have been paid to or on behalf of the employee from a third party. For example, if an employee was injured during the course and scope of their employment by another person's negligence, the employer can step into the shoes of the injured employee and recover any amounts paid to and on behalf of the injured employee.

  - This provision proves very helpful when employees assert negligence claims in state courts against third parties, after receiving benefits under a nonsubscriber benefit plan because it prevents double recovery.

- Return to Work Programs

  - Unlike workers' compensation system, nonsubscribers can have return to work programs.

  - An effective return to work program should be laid out for employees before the occurrence of an injury. Employers can work closely with healthcare providers to identify, and even design, positions that can meet the work restrictions which may be imposed on the employee by the healthcare provider. Employees can return to modified or light duty work, with the understanding that the position is temporary to accommodate their special need for a specific period of time until they can return to their regular position.

- Drug and Alcohol Screening

  - The plan can require employees to be screened immediately after an injury for drug and alcohol use, which may be a ground for denial of benefits. Additionally, the Texas Labor Code allows nonsubscribers to assert intoxication as a defense to work-related injury claims.

- Damages

- Punitive damages are typically not available to claimants in ERISA disputes.

C. CONCERNS WITH ERISA GOVERNED PLANS

- Some ERISA concerns stem from attempts to avoid state law by asserting federal preemptions. ERISA does not preempt state workers' compensation laws.

- Further, some argue that to decide whether nonsubscription should continue to have a place in the Texas Workers Compensation System, lawmakers need better data about what will actually happen to employees of nonsubscibers when they are injured.

IV. CIVIL ACTIONS BY PLAN PARTICIPANTS UNDER ERISA TO RECOVER UNPAID BENEFITS[5]

A. Overview

- Under 29 U.S.C. § 1132(a)(1)(B), a participant or beneficiary can bring a "civil action . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]." Thus, a plan participant who is denied benefits under an ERISA plan can sue to recover them.

B. Claims by Plan Participants or Beneficiaries

- Failure to Comply with ERISA Procedural Requirements:
  - STANDARD OF REVIEW.
    - This does not give rise to a substantive damage remedy unless the violations are continuous and amount to actual harm.
    - Challenges to ERISA procedures are evaluated under the "substantial compliance standard." This means that "technical noncompliance" with ERISA procedures will be excused so long as the purposes of §1133 have been fulfilled.
    - Thus, the Participant or Beneficiary MUST show that the Plan Administrator violated ERISA under the substantial compliance standard and that the violations were continuous and prejudicial.
  - Examples of Failure to Comply with Procedural Requirement:
    - Failure to Provide Notice of Denial:
      - Every employee benefit plan shall afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.
      - The plan participant must be given the reasons, easily understood by the participant, for denial of benefits. Notice of denial must comply with the following requirements:

[5] This section is based on the following cases: *Leake v. Kroger Texas, L.P.*, 2006 WL 2842024 (N.D. Tex); *Ducre v. SBC-Southwestern Bell*, 2007 WL 128900 (W.D. Tex.).

- 29 C.F.R. §2560.503-1(f) - Contents of notice: A plan administrator or the insurance company, insurance service or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

  - (1) The specific reason or reasons for denial;
  - (2) Specific reference to pertinent plan provisions on which the denial is based;
  - (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material is necessary; and
  - (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

- However, the plan administrator need not explain to the claimant "the reasoning behind the reasons." In other words, the administrator does not have to explain why it was a good reason to deny the claim.

- When the claim communications as a whole are sufficient to fulfill the purposes of §1133, the claim decision will be upheld even if a particular communication does not meet those requirements.

- Failure to Provide Documents

  - According to 29 U.S.C. §1024(b)(4)(1)), the administrator must, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description or latest annual report.

  - If the administrator fails or refused to comply with a request for any information the administrator is required to furnish by mailing to the last known address within 30 days, the administrator is liable $100 per date of the failure or refusal to provide information. The court may in its discretion order such other relief it deems appropriate.

- Failure to Consider Certain Evidence

  - In deciding a claim, a plan administrator is not obligated to rebut specifically all evidence that the claimant offers. A plan administrator is only required to state the specific reasons for denying the claim.

- <u>Administrator Abused its Discretion in Denying Claim for Benefits</u>

  - STANDARD OF REVIEW

- Four Principles:

  - 1. In determining the appropriate standard of review, a court should be guided by principles of trust law; in doing so, it should analogize a plan administrator to the trustee of a common-law turst; and it should consider the benefit determination to be a fiduciary act;

  - 2. Principles of trust law require courts to review a denial of plan benefits under a *de novo* standard unless the plan provides to the contrary.

  - 3. If the plan provides to the contrary by granting "the administrator or fiduciary discretionary authority to determine the eligibility for benefits, trust principles made a deferential standard of review appropriate.

    - Majority of ERISA plans provide for this.

  - 4. if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a factor in determining whether there is an abuse of discretion.

    - However, the existence of a conflict of interest will modify the standard of review in an ERISA case. When a plan administrator's decision is tainted by a conflict of interest, the court employs a "sliding scale" to evaluate whether there was an abuse of discretion. The greater the evidence of conflict on the part of the administrator, the less deferential the abuse of discretion standard will be.

    - When the insurer and the administrator are the same entity, an "inherent conflict of interest" exists.

    - A conflicted administrator merits less deference. If the plan fiduciary is both the insurer and the administrator of the ERISA plan at issue, under the *Vega* "sliding-scale approach," both the Administrator's legal interpretation of the Plan and its factual findings must be supported by "some concrete evidence in the administrative record."

    - New Supreme Court Case:

      - *Metropolitan Life Ins. Co. v. Glenn*, 2008 WL 2444796 (U.S.): The Supreme Court reconfirmed that the dual role creates a conflict of interest and a reviewing court

should consider the conflict as a factor in determining whether the administrator abused its discretion in denying benefits.

- Such a conflict exists in the following circumstances:
  - 1. an insurance company makes all benefit decisions on claims it pays; or
  - 2. the employer makes all benefit decisions on claims it pays (as with employers who administer their own claims in-house); or
  - 3. a third party administrator makes some benefit decisions and defers to the employer to make tougher decisions (such as those to deny certain benefit claims).
- However, this conflict of interest is only one of the several factors to consider. Further, where the administrator has taken active steps to reduce potential bias, the conflict is less important.

- ANALYSIS OF WHETHER ADMINISTRATOR ABUSED ITS DISCRETION
  - **TWO-PRONG APPROACH:** First, the court must determine whether the Plan Administrator's interpretation of the Plan is legally correct; if it is not, the court must determine whether the decision was an abuse of discretion.
  - **Is the interpretation legally correct?**
    - Three factors to determine whether the interpretation is legally correct:
      - (1) Whether the Plan Administrator has given the Plan a uniform construction;
      - (2) Whether the interpretation is consistent with a fair reading of the Plan; and
      - (3) Any unanticipated costs resulting from different interpretations of the Plan.
  - **Did the administrator abuse its discretion?**
    - After you determine whether the interpretation is legally correct, then the Court determines whether the Plan Administrator abused his or her discretion. The decision must prevail if it is supported by "substantial evidence" and is not "arbitrary and capricious."

- In many of the ERISA plans, they grant the administrator the discretionary authority to determine the eligibility of benefits; thus, courts view a plan administrator's factual determinations for abuse of discretion. If the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail.

- For the factual findings to be supported by substantial evidence, there need only be a rational connection between the known facts and the decision or between the found facts and the evidence.

    - Review of the administrator's decision need not be particularly complex or technical; it need only assure that the administrator's decision fall somewhere on a continuum of reasonableness, even if on the low end.

    - Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.

    - If the Plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail. However, courts will not "countenance a denial of a claim solely because an administrator suspects something may be awry. Although we owe deference to an administrator's reasoned decision, we owe no deference to the administrator's unsupported suspicions."

- What happens if the Administrator abused his discretion?

    - The court can award damages, which would include the amount due on the claim plus interest.[6]

    - Attorneys fees may be awarded:

        - To determine whether to award attorney's fees, the court can look to the following factors[7]:

            - (1) the degree of the opposing party's culpability or bad faith;
            - (2) the ability of the opposing party to satisfy an award;

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[6] *Vega v. Nat. Life Ins. Servs., Inc.*, 188 F.3d 287 (5th Cir. 1999)

[7] *Kennedy v. Plan Adm'r for DuPont Sav & Inv. Plan*, 497 F.3d 426, 431-32 (5th Cir. 2007).

        - (3) whether an award would deter others acting under similar circumstances;
        - (4) whether the requesting party sought to benefit all participants and beneficiaries of an ERISA plan, or to resolve a significant question regarding ERISA; and
        - (5) the relative merits of the parties' positions.

- The Plan Participant or Beneficiary may also bring a retaliation claim if they are terminated:
    - According to 29 U.S.C. § 1140:
        - "It shall be unlawful for any person to discharge, fine, suspend, expel, discipline or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provision of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . . ."