ERISA Update

PENSION & EMPLOYEE BENEFITS ISSUES

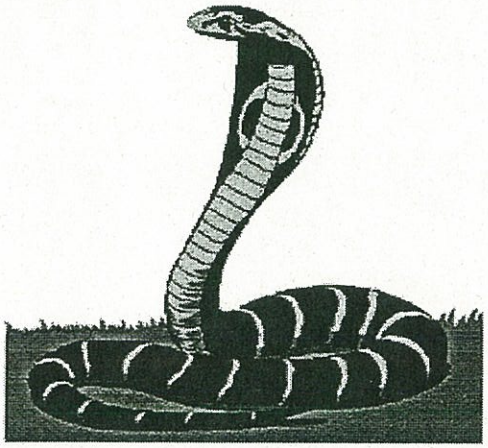
A periodic review of the latest legal developments affecting employee benefits, of interest to clients, union officials, fund administrators, trustees and attorneys.

June, 1998

Inside this Issue

SUPREME COURT RULES THAT PREVIOUS COVERAGE UNDER SPOUSE'S PLAN DOES NOT BAR ELIGIBILITY FOR COBRA COVERAGE

In our February 1998 ERISA Update, we noted that the U.S. Supreme Court had agreed to review the decision of the U.S. Court of Appeals for the Eighth Circuit in the case of Geissal v. Moore Medical Corporation about the participant's eligibility for COBRA coverage when the participant already had coverage under a health care plan sponsored by the employer of the participant's spouse. As we predicted, the June 8, 1998 decision of the U.S. Supreme Court relied on the specific terms of Federal law to conclude that such a participant may still elect COBRA continuation coverage under the plan sponsored by the participant's employer.



The case involved a participant in a health care plan whose employment was terminated and who was then offered COBRA continuation coverage under the plan. Although his election of COBRA coverage was approved by the plan, that decision was reversed when the plan discovered that the participant was already covered by a group health plan sponsored by his wife's employer. Despite the statute's specific requirement that a participant is eligible for COBRA coverage unless the participant "first becomes covered after the date of election" under another group health plan, both the Federal District Court and the U.S. Court of Appeals for the Eighth Circuit ruled that there was no "significant gap" in this participant's health care benefits and that he was not eligible for COBRA coverage.

Justice Souter's decision for a unanimous Supreme Court said that the lower courts were mistaken in rejecting the specific terms of the law. He noted the "sheer absence of any statutory support" for the "significant gap" rule adopted by the lower courts and said such a rule would require the courts to evaluate the adequacy of the coverage under the two plans.

Justice Souter's opinion also rejected the plan's argument that relying on the specific terms of the law would impose extra expenses on the plan since more participants would be able to elect

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COBRA coverage. Because participants must pay for COBRA coverage, the Court considered it unlikely that many participants with other coverage would elect COBRA coverage anyway.

This decision resolves an issue which has caused much confusion and resulted in a great deal of litigation. Whenever a health care plan rejects a participant's election of COBRA continuation coverage on the grounds that the participant has other group health coverage, the plan must be certain that the participant was not eligible for that coverage before the participant elected COBRA coverage.

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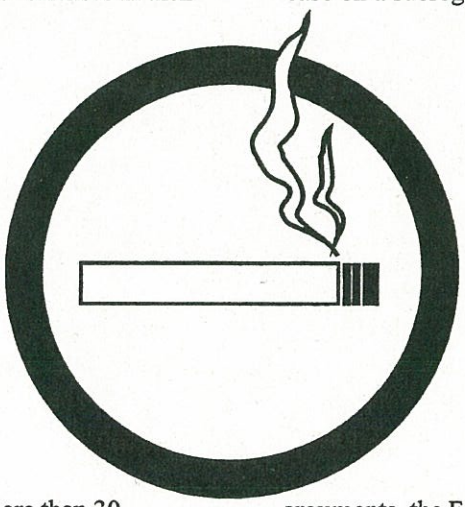
COURT REJECTS HEALTH CARE PLANS' LAWSUIT AGAINST TOBACCO COMPANIES

For nearly a year, the print and broadcast media have been filled with the debate over the liability of tobacco companies for health care expenses said to arise from tobacco related illnesses. Several states have settled lawsuits against the tobacco companies to recover for Medicaid and other health care expenses paid by the states on account of such illnesses. A more comprehensive settlement of this issue is currently being debated by Congress in its consideration of a proposal by Senator John McCain of Arizona.

The case of Steamfitters Local 420 Welfare Fund v. Phillip Morris involved a group of collectively bargained health care funds in Pennsylvania which filed suit against eight major tobacco companies, four public relations firms and tobacco trade associations which provide lobbying services for the tobacco industry. In an ambitious 115 page complaint filed in Federal District Court, the funds traced the history of the marketing of cigarettes and other tobacco products in the United States from 1881 to date. It charged the defendants with a range of offenses in their efforts to promote tobacco consumption, such as misleading the public about the dangers of smoking, suppressing research which demonstrated the relationship between smoking and various illnesses and not developing safer products. Each fund sought damages back to the date it was established (which, in some cases, went back more than 30 years), arguing that the statute of limitations had not run out since the defendants' efforts to conceal the dangers of smoking had not become apparent until "quite recently".



In its decision on April 22, 1998, the Court dismissed the funds' complaint for several reasons. First, the Court rejected the funds' argument they could properly bring a lawsuit against the parties alleged to have caused injuries to the funds' participants. The Court said that this could be done only by way of subrogation and would have required the funds to prove the facts of the thousands of individual cases involved. The funds had deliberately avoided bringing the case on a subrogation theory for that reason. The funds conceded that their complaint was not based on mere negligence by the defendants since the damages sustained by the funds would not be regarded as having been "proximately caused" by the defendants' conduct.

In addition to rejecting the funds' more technical legal arguments, the Federal District Court concluded that the funds had, in fact, not suffered any damages. The Court agreed with the defendants that the funds (all of which were tax exempt entities) served only to collect contributions from employers under collective bargaining agreements and use those monies to pay their participants' medical expenses. According to the Court, any increased medical expenses paid by the funds were covered by increased levels of employer

contributions negotiated by the unions sponsoring the funds. Also rejected was the funds' argument that this lawsuit was analogous to the pending lawsuits brought against the tobacco companies by the various states to recover Medicaid and other similar disbursements. The Court rejected this contention on the grounds that the states were actually paying the increased medical costs from their own assets while the funds were merely handling the payments with monies provided by others pursuant to the collective bargaining agreements.

The funds' final claim was based on alleged fraud, misrepresentation and concealment by the defendants. The Court rejected the funds' argument that they had been lulled into inaction by the defendants' misrepresentation and concealment and would have taken action had the funds known the full danger of tobacco related illnesses. The Court found that this argument was "too speculative" to be taken seriously.

Historically, claims by smokers against tobacco companies have been unsuccessful. This trend, however, seems to be changing and the tobacco companies continue to seek protection against lawsuits brought by smokers in federal legislation. This decision has been appealed and a more favorabledecision from the Court of Appeals is very possible.

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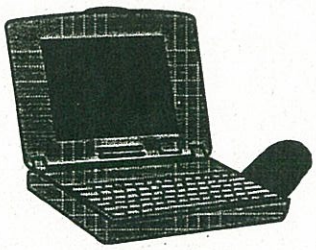
PROPOSAL WOULD REQUIRE PLANS TO CONSIDER YEAR 2000 PROBLEMS WHEN MAKING INVESTMENTS

Almost everyone working with a computer is aware of the problems which may occur in the year 2000. Senator Robert Bennett of Utah has introduced a proposal to require fiduciaries of employee benefit plans to consider the Year 2000 problem when making investment decisions. Under this bill, fiduciaries would need to determine that the issuer of a security is taking steps to avoid the problem and that the market in which the security is traded can continue to operate without problems during the Year 2000.



Senator Bennett has said that his bill is intended to incorporate into federal law actions taken by President Clinton in creating his Council on Year 2000 conversion. If enacted, it would greatly increase the disclosure requirements for publicly traded corporations and require extensive review by investment manager.

The Year 2000 problem arises because some software programs which were written in the past allow for the use of only the last two digits in a year. This limitation can have adverse consequences in any computer program which uses the year (such as the year of a participant's birth) for any type calculation, sorting, data sequencing or determination of eligibility for benefits. If the year is not used for such purposes, it is less likely to cause problems.

Although this proposal is given little chance of being enacted, it serves to make fiduciaries more aware of the Year 2000 problem and ensure that appropriate remedial actions are taken. It is particularly important that fund offices which rely on computers in benefit administration identify the types of programs which will be affected and retain a knowledgeable computer professional to make the necessary changes in programming and take other appropriate steps

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The question of which documents govern the plan's operations will always be difficult. The best approach is to consolidate all operational rules in the plan document in order to provide the plan with a degree of certainty as to which documents must be disclosed.

DEPARTMENT OF LABOR CLARIFIES WHICH DOCUMENTS MUST BE PROVIDED UPON PARTICIPANT'S REQUEST

Section 104(b) of ERISA provides that certain documents, such as summary plan descriptions and summary annual reports, must be provided to participants and beneficiaries of employee benefit plans automatically. The section identifies other documents, such as the most recent Form 5500, any collective bargaining agreement and the plan's trust agreement, which must be provided in response to a written request from a participant or beneficiary. The law also provides that "other instruments under which the plan is established or operated" must also be provided in response to such a request.

This ambiguous statutory provision has given rise to considerable litigation. The U.S. Courts of Appeals are divided as to whether this provision requires a pension plan to provide a copy of its actuarial valuation if the participant requests it. The U.S. Court of Appeals for the Second Circuit (which has jurisdiction over the State of New York) has determined that such reports need not be provided.

Many employee benefit plans receive requests from participants for copies of contracts between the plan and a service provider. In Advisory Opinion 97-11A, the U.S. Department of Labor reviewed the question of whether an employee benefit plan is obligated to provide a copy of its contract with a third party administrator. The Department concluded that the contract had to be provided only if the contract's provisions were part of the plan or governed the plan's operations. For instance, if the contract contained provisions governing the plan's benefits or specified procedures or formulas to be applied when determining a participant's benefit, would disclosure be mandated.

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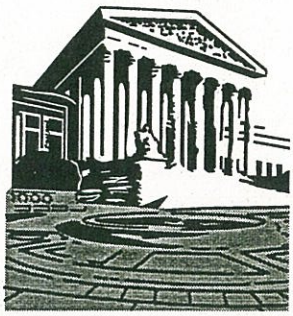
COURTS RELY ON PLAN PROVISIONS EVEN WHEN INCONSISTENT WITH SUMMARY PLAN DESCRIPTION

Several recent cases have involved inconsistencies between the terms of a plan document and the plan's summary plan description. Over the years, most courts have relied on the terms of the summary plan description when there is a contradiction between the terms of the SPD and the plan. The courts have reasoned that because the SPD is intended to be the participant's primary source of information about the plan, its provisions should prevail in such cases. However, two recent cases indicate that courts will, instead, rely on the terms of the plan when they consider it to be appropriate.

The case of Mers v. Marriott International Group Accidental Death and Dismemberment Plan involved a participant in two accidental death plans sponsored by his employer. The insurance policies provided that death benefits were payable in the event the participant's death was caused by an accident. Death due to an "accident" was described in both policies as resulting "directly and independently of all other causes", such as a physical condition. However, only one of the plans included this description in its SPD. When a participant died while performing volunteer work for Habitat for Humanity as part of his job, his wife's claims for benefits under both policies were denied on the grounds that an accident had not caused the participant's death. This conclusion was reached principally on the basis of the participant's medical records which showed that he suffered from arteriosclerosis and his death might have been caused by an aneurysm. The U.S. Court of Appeals for the Seventh Circuit upheld the right of the plan to rely on the plan's description even though it was not reflected in the SPD. Since the SPD in this case satisfied ERISA's disclosure requirements, the Court said that only in the event of an actual contradiction between the terms of the SPD and the terms of a plan would the SPD prevail.



A Federal District Court in the case of Swaback v. American Information Technologies reviewed facts involving just such a contradiction but enforced the terms of the plan anyway. According to the Court, a decision made by the plan administrator that a beneficiary could not receive a lump sum retirement benefit due to her husband's death was based on an SPD provision directly contradicted by the terms of the plan. The Court relied on the statement in the SPD which said that in the event of such a contradiction, the plan provisions would be controlling. The Court also awarded the beneficiary attorneys' fees on the grounds that the plan administrator's decision was not "substantially justified".

In our February 1998 ERISA Update, we reviewed the case of Williams v. Midwest Operating Engineers Welfare Fund. The case involved a health care plan which had refused to cover a participant's medical expenses arising out of injuries sustained when he was shot by a policeman after trying to breakdown the door of an apartment where his girlfriend was staying. The plan document stated that it covered expenses caused by non-occupational injuries or illnesses. Although the SPD did not define the term "injury", the plan document stated that the expenses were covered if they resulted from bodily harm due to an "accident". The U.S. Court of Appeals for the Seventh Circuit said that the SPD provision must prevail and that the failure to more fully describe covered expenses in the SPD meant that the administrator's denial must be overturned.

Finally, a recent Second Circuit case serves as a reminder of the importance of having accurate plan amendments drafted to reflect the trustees' decisions. In Gallo v. Madera, a participant was entitled to an early retirement benefit under a plan provision providing such benefits for employees over age 55 with 25 years of service. Several years before the participant's retirement, however, a different plan provision which provided for "any age" early retirement was amended to incorporate an exclusion for participants who had incurred a break in service of two consecutive years. Such a rule was, however, not specifically added to the provision governing this participant's early retirement. When the plan denied the participant's application because he had incurred a break in service of more than two consecutive years, the participant brought suit in Federal Court based on the literal terms of the plan provision. The Second Circuit ruled that the trustees could not apply the break in service amendment to this participant since the amendment made no reference to this plan provision.

Most of the time, courts will be receptive to participants' claims for benefits when those claims are clearly supported by the terms of EITHER the plan or the SPD. Because plan documents are longer than SPDs, they almost always contain provisions and technical requirements not reflected in SPDs. Consequently, plans should make every effort to avoid inconsistencies between the documents even if doing so requires the use of longer SPDs.

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COURTS DETERMINE THAT PLAN FIDUCIARIES NOT LIABLE FOR MISTAKES MADE BY PLAN EMPLOYEES

Three recent cases have determined that a breach of fiduciary responsibility did not occur when an employee of the plan made a mistake. Two of these cases, Schmidt v. Sheet Metal Workers National Pension Fund and Whalen v. Wyman-Gordon Company, involved clerical errors by plan employees. In the first case, a plan employee mistakenly sent a participant the wrong form for naming a beneficiary to receive the participant's death benefit. The U.S. Court of Appeals for the Seventh Circuit found that the plan was not liable for the mistake because the plan document and summary plan description provided detailed information on the procedure to be followed by this participant when designating a beneficiary.

In the second case, a Federal District Court in Massachusetts ruled that the plan was not liable for misplacing a participant's beneficiary designation form when the plan treated the designation as in effect even though the form was missing. The matter resulted in litigation because the designation was challenged by another party. In both cases, the Courts ruled that the plans' fiduciaries had done everything required by Federal law.

The third case, Easa v. Florists' Transworld Delivery Association, arose when a benefits administrator mistakenly told a participant in a pension plan that his early retirement option would provide greater benefits than it actually did. The mistake occurred because the administrator used the wrong figures from a report prepared by the plan's actuary. In rejecting the participant's claim that the plan should be required to give him the larger benefit, the Federal District Court held that imposing such a liability on pension plans would be improper since the funding of pension plans is based on precise actuarial calculations. Imposing unexpected liabilities on a pension plan could endanger its financial status. The Court also found that the correct formula for determining the participant's early retirement benefit was clearly specified in the documents which he had been given. It determined that the duties of this administrator involved only clerical functions so that the administrator would not be considered to be a fiduciary. The plan's actual fiduciaries were found to have played no role in this miscommunication.

Although these decisions serve to protect plan fiduciaries from mistakes made by plan employees, other Courts have been willing to impose liability on the plan under these circumstances. In Estate of Becker v. Eastman Kodak Company, the U.S. Court of Appeals for the Second Circuit found that a participant's beneficiary could bring a lawsuit to recover benefits which were lost when a benefits counselor failed to explain that the participant's death benefit would be greatly reduced if a participant did not convert from a disability benefit to a retirement benefit before her death. However, the Second Circuit found that the documentation which had been given to this participant was ambiguous about the time for making such an election. Had the written information given to this participant been clearer, the Court might have reached a different result despite the mistaken advice from the benefits counselor.

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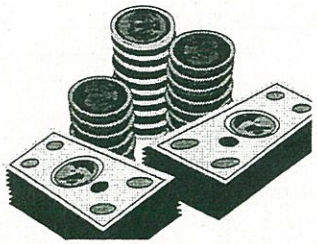
It is important that the fund office employees be given the training necessary to ensure that their responses to participants' questions are accurate. We recommend that plans establish written procedures for processing questions from participants so that an accurate written response can be provided.

Although participants do not have "vested" rights to receive health care benefits under most welfare plans, the courts have generally ruled that amendments limiting or decreasing benefits cannot be applied to medical expenses incurred before the date the amendment is adopted. Although the Court of Appeals which decided this case does not have jurisdiction over the State of New York, it is very likely that New York courts would come to the same conclusion.

WELFARE PLAN AMENDMENT CANNOT BE APPLIED TO EXPENSES INCURRED BEFORE AMENDMENT WAS ADOPTED

A frequent problem concerns the ability of welfare plans to retroactively apply plan amendments. Although Federal law requires that all types of retirement benefits "vest" over a period of time, those rules do not apply to welfare plans. For various reasons, welfare plans will often attempt to apply plan amendments retroactively in an attempt to limit or otherwise modify the plan of benefits.



The U.S. Court of Appeals for the Tenth Circuit recently addressed the issue of whether a plan amendment establishing the plan's subrogation rights could be applied to expenses incurred before the amendment was adopted. In the case of Member Services Life Insurance Company v. American National Bank and Trust, a participant's dependent children were injured in a fire caused by a defective cigarette lighter. The participant's health care plan paid the medical expenses which the children incurred because of their injuries. The plan was then modified to include a standard subrogation provision which gave the plan the right to be reimbursed for its payments from damages an injured party may receive on account of the injuries. The Court rejected the plan's contention that it should be permitted to apply the amendment retroactively on the grounds that the injuries were incurred and the expenses paid before the amendment was adopted.

Consequently, the plan was not able to recover any portion of the damages which the children obtained in a product liability lawsuit against the maker of the cigarette lighter.

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COURT RULES THAT SPOUSE OF "OWNER/OPERATOR" IS NOT COVERED BY BARGAINING AGREEMENT

The case of Dugan v. Smerwick Sewage Company, involved a collective bargaining agreement between a local union and a company requiring contributions to various welfare funds for the company's employees. When the bargaining agreement was executed, the former sole shareholder of the company was an employee and his wife had become the company's sole shareholder. To cover such cases, the bargaining agreement specifically said that contributions were to be made on behalf of any employee who was a "relative (father, mother, son, daughter, brother, sister) of a company shareholder, officer or director". When the company did not contribute on behalf of the former sole shareholder, the funds brought suit to recover what they regarded as the contributions due based on the former shareholder's work. The U.S. Court of Appeals for the Seventh Circuit determined that the former sole shareholder was not a "relative" for purposes of this provision, since the terms in parenthesis did not include spouses. In support of its conclusion, the Court of Appeals noted that the bargaining agreement provisions was subsequently modified to specifically include the husband or wife of any shareholder, officer or director.

The coverage of "owner/operators" and relatives of corporate owners working for a corporation has always been a difficult problem. This case emphasizes the importance of clearly specifying in the bargaining agreement the class of individuals who are covered.

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The information contained in this newsletter is only a summary of recent developments affecting employee benefit plans. It is not intended to take the place of specific legal advice. If you have any questions concerning how these developments affect your plan, please contact Blitman & King LLP at either our Syracuse or Rochester offices. You may also reach us at our internet address or web site:

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