Employee Benefits

Acknowledgments

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ERISA

The Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.,* is the federal law that governs employer-provided health and retirement benefits. Generally, ERISA pre-empts state law on retirement benefits, deferred compensation plans, group health, life and disability insurance, and other employer-provided benefits.

A full discussion of ERISA is beyond the scope of this manual.

Types of Plans Covered by ERISA

The following types of plans are subject to ERISA:

- "Employee Pension Benefit Plans," including retirement or pension plans ("defined benefit plans"), profit-sharing plans (*i.e.*, 401(k) plans), thrift and savings plans, money-purchase plans, employee stock-ownership plans, and qualified stock bonus plans. Employers are not required to offer retirement or pension benefit plans to their employees.

- "Employee Welfare Benefit Plans," including life insurance, hospital/surgical insurance, medical insurance, accident insurance, dental insurance, disability income insurance, supplemental unemployment payments, and prepaid legal services.

Plans sponsored by governmental entities and religious organizations are NOT covered by ERISA (though generally plans provided by non-profits are covered). Also excluded are: plans maintained solely for complying with workers' compensation, unemployment compensation, or disability insurance laws; plans maintained outside the U.S. primarily for the benefit of non-resident aliens; and, certain other plans that exist solely to provide benefits in excess of the limitations imposed by ERISA. This last exclusion is not likely to apply to low-wage workers. *See* 29 U.S.C. § 1003. Many plans excluded from ERISA's coverage are regulated by applicable state law or other areas of federal law.

Generally, defined contribution plans, in which contributions are withheld from an employee's paycheck and deposited, sometimes with additional employer contributions, into an account for the employee (*i.e.*, a 401(k) plan), will be the most commonly encountered type of plan. Less common today are defined benefit plans (traditional pension plans), in which an employee "accrues" pension credits through years of service, which are used to calculate benefits in the form of set periodic payments after retirement.

Requirement of Trustee to Furnish Plan Documents

Employee benefit plans are typically governed by several plan documents that set out the rules and entitlements under the plan. Employers have broad leeway in designing how benefits are earned (or "accrued") and distributed under the plan, subject to satisfying certain minimum requirements and regulations. Accordingly, specific questions regarding whether an employee is eligible to participate in the plan, how much benefit an employee has accrued (under a defined benefit plan), how and when an employee may receive benefits from the plan, and additional features that may be available will need to be resolved through examination of the plan documents.

In most cases, the most readable plan document will be the Summary Plan Description ("SPD"), sometimes labeled a pamphlet or booklet. Employees who are or may become eligible for benefits ("Participants") under a plan covered by ERISA must be furnished with an SPD, which is intended to be an understandable and reasonably comprehensive summary of the plan benefits, plus updates when significant changes are made. S*ee* 29 U.S.C. § 1024(b); 29 CFR § 2520.104b-2 (DOL regulations on disclosure of documents).

The administrator of the plan must respond to a participant's written request for the latest version of the SPD (or any other plan document). 29 U.S.C. § 1024(b)(4). If the plan fails to provide documents within 30 days of the request, a court may assess a statutory penalty of as much as $110 per day (a court would consider the length of delay, prejudice to the beneficiary, etc.). 29 U.S.C. §§ 1021-25. Upon written request, employees must also be given a report on the status of their vesting and accrued pension benefits, unless the employer has already provided, for a defined contribution plan, quarterly (or annual in some cases) statements required under the law. 29 U.S.C. § 1025(a). Failure to provide requested plan documents can be redressed through a § 502 claim. *See* Pursuing a Case, supra.

Vesting in a Pension Plan

Retirement benefits become non-forfeitable through "vesting," gradual securing of ownership through continuous employment with the employer sponsoring the benefit plan. Once benefits become vested, the employee has an unconditional right to those benefits and cannot lose them through, for example, termination of employment or amendment of the benefit plan.

1. Employee Contributions: An employee is immediately and fully vested in his or her own contributions to any retirement plan (typically contributed through amounts withheld from the employee's paycheck). 29 U.S.C. § 1053(a)(1).

2. Employer Contributions: Employer contributions must satisfy the following vesting requirements, depending on the type of retirement plan. Plan documents will include information on the vesting requirements for the particular plan. Plans may provide for vesting schedules that are more generous than the following minimum standards.

    a) Defined Contribution Plans (401(k) plans): 29 U.S.C. § 1053(a)(2)(B). If an employer makes employer contributions or provides matching contributions to a

defined contribution plan on a worker's behalf, the employee must become vested in those contributions either:

i. Entirely after three years of employment, or

ii. Six-Year Vesting, according to years of service with the employer:
20% after two years
40% after three years
60% after four years
80% after five years
100% after six years

b) Defined Benefit Plans (Pension Plans): 29 U.S.C. § 1053(a)(2)(A). If an employer makes contributions to a defined benefit plan on a worker's behalf, the employee must become fully vested in benefits derived from those contributions either:

i. Entirely after five years of employment, or

ii. Seven-Year Vesting, according to years of service with the employer:
20% after three years
40% after four years
60% after five years
80% after six years
100% after seven years

In addition, retirement plans provide that benefits become fully vested upon the employee's attainment of the plan's "normal retirement age." Consult the plan documents for a description of the plan's normal retirement age. Finally, the Uniform Services Employment and Reemployment Rights Act provides that employees out on military service cannot be treated as having incurred a "break in service" (a break in the vesting period) on account of such military service, once the employee returns to employment. 38 U.S.C. § 4318; 20 C.F.R. § 1002.259.

Potential Enforcement Issues

Employee Contributions

Employers that sponsor plans where employees make their own contributions (e.g., 401(k) plans) must withhold the elected contributions from the employee's paycheck and place them in the employee's plan account no later than the 15th day of the month following the payday. 29 C.F.R. § 2510.3-102(b). Plan participants will have a cause of action for breach of

fiduciary duty under ERISA § 502 if an employer withholds but never deposits money into the participant's account. 29 U.S.C. § 1132(a); *see* Pursuing a Case, infra. Furthermore, an officer of such an employer can be held personally liable for the breach if he or she exercised discretionary control over the contributions. A participant affected by an employer's failure to deposit contributions may wish to contact the EBSA at the Department of Labor, which also has standing to sue for breaches of duty. *See* "Administrative Complaint Options" below. If the plan is a collectively bargained plan, the participant should notify the union and the plan administrator (the Board of Trustees or its representative). Under some circumstances, failure to remit benefit contributions can result in criminal liability. 18 U.S.C. § 664. Account statements will be helpful in determining whether elected withholdings have been deposited into a client's account. Paycheck stubs will be helpful in determining what amounts have been withheld.

Discrimination and Retaliation Prohibited

It is illegal for an employer to terminate or otherwise discriminate or take adverse action against a plan participant or plan beneficiary for exercising his or her rights under ERISA (e.g., the employer cannot take adverse action against an employee because the employee has high-cost medical claims). *See* ERISA § 510. It also is illegal to retaliate against an individual who has given information or testified in any inquiry or proceeding under ERISA. *Id.* Unlawful discrimination under § 510 is enforced through § 502 claims. *See* Pursuing a Case supra. To determine whether discriminatory intent exists in § 510 cases, courts have adopted a burden-shifting analysis similar to the approach in Title VII cases.

Interference with Vesting Prohibited

Section 510 of ERISA also prohibits the employer from interfering with the participant's attainment of rights under an ERISA plan (e.g., firing the worker so that the worker's pension rights do not vest). *Id.*

Breach of Fiduciary Duty

There may be a cause of action for breach of fiduciary duty for mismanagement of a plan, such as negligent investment of plan funds. *See* ERISA § 404; see also, ERISA § 502. Whether an individual or entity will be found to be a fiduciary is based on that individual's duties and conduct. A person is a fiduciary if he or she holds or exercises discretionary authority over the management or administration of a plan or over plan assets. *See* 20 U.S.C. § 1002. Employers and boards of trustees also often hire professionals (such as investment managers and plan administrators) to manage a plan. In carrying out their fiduciary duties, the employer or trustees must show prudence in selecting these professionals; the professionals, in turn, also may be found to be fiduciaries to the plan.

The Department of Labor has extensive responsibility with regard to fiduciary duties. The DOL publishes pamphlets regarding fiduciary responsibility, which can be found on its website. The DOL regulations regarding fiduciary duties are at 29 C.F.R. § 2550.

Benefit Claims and Appeals

Unlike some other claims, beneficiaries seeking benefits due under a plan should file a claim for those benefits with the person designated by the plan to receive claims (consult the SPD to determine how and where to submit claims). Any notice of benefit denial must be provided within 90 days of the plan's receipt of the claim, although the plan may claim an extension of time upon notice to the participant. However, shorter deadlines are applicable for certain health plan claims, such as urgent care claims (72 hours) and non-urgent, pre-service claims (15 days). If a plan renders an adverse decision, the beneficiary will have an opportunity for review as set forth in the plan documents and federal regulations. *See generally* 29 C.F.R. § 2560.503-1(a)-(j) (benefit claims procedures).

Any notice of benefit denial (in part or in whole) must include a) the reason for the denial; b) reference to the particular plan section or provision upon which the denial was based; c) a description of any additional information necessary to perfect the claim, if applicable; d) a description of the plan's appeal procedures, including any applicable deadlines and including a statement of the participant's rights to bring a civil action under § 502. 29 C.F.R. § 2560.503-1(g). Additional items may be required for certain health claim denials. *Id.*

Participants in plans have the right to sue to recover benefits, enforce or clarify benefits, enjoin any act violating ERISA or the terms of a plan, and obtain other appropriate relief for violations of ERISA. Successful plaintiffs can recover lost benefits, prejudgment interest, injunctive relief, and attorneys' fees for the court proceedings (but not administrative review). However, plaintiffs cannot obtain additional compensatory or punitive damages beyond the lost benefits. Beneficiaries must exhaust their administrative remedies before going to court to pursue a claim for wrongful denial of benefits. One important exception to the exhaustion requirement, however, is where the plan fails to establish or follow claims procedures consistent with the requirements of the regulations. *See* 29 C.F.R. 2560.503-1(l).

Pursuing a Case

Enforcement of claims falls under Section 502 of ERISA. *See* 29 U.S.C. § 1132. Generally the statute provides for recovery of actual damages and reasonable attorneys' fees and costs at the judge's discretion. *See* 29 U.S.C. § 1132(g). As noted above, a claim for benefits must go through the administrative process set forth under the plan before it may be appealed to federal court. Consult the SPD to determine the plan's claims procedures.

Statute of Limitations

Except for claims for a fiduciary breach, ERISA's civil enforcement provisions do not contain a statute of limitations, and federal courts often adopt the most analogous state statute of limitations.

Many cases have found the state breach of contract statute of limitations to apply to ERISA non-fiduciary breach claims, but this is not always the case. For example, in *Watts v. Parking Management Inc.*, 2006 WL 627153 (D.D.C 3/12/06), the judge held that a former

employee was time-barred from suing his employer alleging it illegally interfered with his right to retirement benefits when it fired him four years before he would have become eligible for such benefits under section 510, the non-discrimination section of ERISA. The judge reasoned that the one-year statute of limitations found in the District of Columbia Human Rights Act (DCHRA) was the most analogous to section 510.

Claims for relief against fiduciaries for breach of their duties have a six-year statute of limitations. No such action may commence after the earlier of: 1) six years after (a) the date of the last action that constituted a part of the breach or violation, or (b) in the case of an omission, the latest date on which the fiduciary could have cured the breach or violation; or 2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation, except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation. ERISA § 413, 29 U.S.C. § 1113.

Where to File

ERISA grants exclusive jurisdiction over claims to the federal district courts, with the exception of actions to enforce the terms of the plan itself, for which state courts have concurrent jurisdiction. See 29 U.S.C. § 1132. Claims relating to employee benefits are often improperly brought in state courts and are subject to federal pre-emption and removal.

Whom to File Against

Potential defendants in an ERISA case include employers, fiduciaries, trustees, administrators, third-party service providers, and the plan itself. A person is a fiduciary if he or she holds or exercises discretionary control over the management or administration of a plan or plan assets. *See* 20 U.S.C. § 1002.

Administrative Complaint Options

If there are problems with a worker's benefit plan, contact the nearest field office for DOL's Employee Benefits Security Administration, or call 1-866-444-3272. For D.C., Maryland, and Virginia, that office is located at 1335 East-West Highway, Suite 200, Silver Spring, MD 20910. The regional telephone number is (202) 693-8700. Participants also have the right to sue in federal district court, as noted above. 29 U.S.C. § 1132.

DOL has authority to investigate complaints of fund mismanagement (*i.e.*, breach of fiduciary duty). If an investigation reveals wrongdoing, it can take action to correct the violation, including asking a court to compel plan trustees and others to put money back in the plan. Courts can also impose penalties of up to 20% of the recovered amount and bar individuals from serving as trustees and plan money managers.

COBRA Health Care Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers to provide health insurance to employees, their spouses, and dependent children, at group rates for a minimum of 18 months when that insurance is lost because of events such as the termination of the worker's employment (a "qualifying event" – see below for a definition). *See* 29 U.S.C. § 1161. Workers must pay the premiums, which generally will be higher than what the employee paid while employed, because they must pay the full premium, and the employer is permitted to add a 2% administrative cost. For a single person, those premiums are often more than $400 a month.

Coverage

Employers with 20 or More Workers Must Comply

COBRA covers all private employers, including a successor to an original employer, with 20 or more employees, foreign and domestic, that maintain a group health plan. *Id*. When determining the number of employees working for the employer, all full- and part-time common-law employees are taken into account. *See* 64 Fed. Reg. at 5163. Be sure to include related business entities when counting employees; all entities under common control are considered a single employer for purposes of COBRA.[129]

Important exception: Although employers with fewer than 20 employees are not covered by COBRA, if a small employer mistakenly represents to an employee that he or she is covered by COBRA, that employer may have a contractual obligation to provide such benefits. *See Haley v. Trees of Brookwood, Inc.*, 838 F. Supp. 1553 (N.D. Ala. 1993).

Plans subject to COBRA

Generally all group health plans are subject to COBRA. The exceptions to this rule include plans maintained by small employers; churches; and federal, state, and local governments. Similar health continuation rules covering the federal civil service can be found at 5 U.S.C. § 8905.

Definition of a Group Health Plan

A group health plan is one maintained by an employer or employee organization (e.g., a union) to provide health care to individuals who have an employment-related connection to the employer or employee organization. A group health plan can include health coverage provided through "cafeteria plans" and, in certain circumstances, flexible spending accounts. *See* 29 U.S.C. § 1167.

[129] "Common control" is a complicated analysis under the tax regulations, relating to stock ownership and control over a business, among other factors. Workers with claims under COBRA who are endeavoring to engage in this inquiry should consult a professional.

Worker & Other Eligibility

Individuals Eligible for COBRA Coverage

COBRA coverage extends to the worker, the worker's spouse, and any dependent child of the covered employee (including a child who is born to or adopted by a covered employee during the period of COBRA continuation). It also extends to any "individual who is (or was) provided coverage under a group health plan by virtue of the performance of services by the individual for one or more persons maintaining the plan." *See* 29 U.S.C. § 1167.

If a qualified beneficiary does not choose COBRA continuation coverage by the time the election period ends, the individual ceases to be a qualified beneficiary. § 1165.

Note: Non-resident aliens with no source of income from sources within the United States are not qualified beneficiaries.

Individuals Not Eligible for COBRA Coverage

Federal, state, and local government employees are not covered by COBRA. *See* instead 5 U.S.C. § 8905(a), D.C. Code §§ 1-621.01 & 1-621.14 for continuation of coverage rules for governmental employees.

Qualifying Events

Generally, qualifying events are those that result in the loss of employer-provided group health coverage for employees, their spouses, and dependents. Specifically, those events include:

- the worker's termination of employment, voluntarily or involuntarily, for reasons other than gross misconduct;
- a reduction in the worker's work hours that causes the loss of group health coverage (not including employees who are presently out on FMLA leave for whom health insurance coverage must continue at employer's expense);
- death of a covered employee;
- divorce or legal separation from the covered employee;
- loss of dependent status by the child of the covered employee under the provisions of the group health plan;
- the worker's entitlement to Medicare benefits (for this qualifying event, the qualified beneficiaries are the spouse and dependent children of the covered employee, not the covered employee); or
- the employer's bankruptcy proceeding under Title 11 of the U.S. Code that results in the substantial elimination of coverage for a retiree with employer-provided health insurance.

See 29 U.S.C. §1163. The qualifying event must cause loss of coverage. Such loss of coverage is not just termination of coverage; it includes any change in the terms and conditions of such coverage, such as an increase in premiums or a reduction of benefits. *Id.*

Notice to Employees and Election of Coverage

Upon the occurrence of a **qualifying event**, the employer is required to notify the employee of his or her rights to elect and pay for health insurance coverage. The *employer* has a duty to notify the *plan administrator* of the qualifying event within **30 days** of that event. 29 U.S.C. § 1166. If the qualifying event is either (1) divorce or legal separation; or (2) a child's ceasing to be a dependent, then the covered employee must notify the plan administrator of such event within 60 days after the later of 1) the qualifying event; (2) the date on which the beneficiary loses (or would lose) coverage as a result of the qualifying event; or (3) the date on which the beneficiary received notification of the responsibility to notify the plan and the procedures for doing so. Id. at § 1166(a)(3).

After receiving notice of the qualifying event, the *plan administrator* has **14 days** to notify the *employee* of their continuation rights. 29 U.S.C. § 1166; 29 C.F.R. § 2590.606-4(b).

Note: If the employer is the plan administrator, in there is no clear rule as to the amount of time the employer has to notify the employee. Some courts have held that the employer has 14 days, and some have held that the employer has 44 days. The DOL's 2003 proposed regulations set the time at 44 days. The proposed regulations also require that the plan administrator notify the employee if the employee is not entitled to COBRA continuing coverage.

Time for Worker to Claim COBRA Coverage

The period of time a qualified beneficiary has to elect COBRA health-care continuation is **60 days** after the later of:

- The date the qualified beneficiary would lose coverage on account of the qualifying event; OR
- The date notice is provided to the qualified beneficiary of the right to elect COBRA continuation coverage.

Each qualified beneficiary must be offered the opportunity to make an independent election to receive COBRA. Thus, if a covered employee with a spouse and children leaves a job, the worker, spouse, and each of the children must be provided the opportunity to elect COBRA coverage independently. Parents and legal guardians can make elections on behalf of their minor children. A legal representative or the estate of a qualified beneficiary who is incapacitated can make a COBRA election for that beneficiary. § 1165.

When a qualified beneficiary elects the coverage, the coverage is retroactive to the date of the loss of coverage. The beneficiary will therefore have to pay the premiums retroactively.

If a qualified beneficiary waives COBRA health-care continuation coverage during the election period, that choice to opt out of benefits does not end the right to elect COBRA coverage. The qualified beneficiary can revoke the waiver any time before the end of the election period.

What Health Insurance Coverage Must Be Offered & Cost of Insurance

The kind of health continuation coverage that is available to qualified beneficiaries is ordinarily the same coverage they had the day before the qualifying event, including the same deductibles and plan limits. The coverage must be the same coverage that is provided to similarly situated individuals under the employer's plan. If the coverage is not the same coverage that other employees and their families have, then the group health plan is not in compliance with COBRA. An exception to this last rule is if there is other coverage offered to the qualified beneficiaries that does constitute COBRA coverage. *See* 29 U.S.C. § 1162.

Note: If an employer has eliminated or reduced health coverage in anticipation of a qualifying event, that elimination or reduction of that coverage is disregarded when looking at the coverage in effect before the qualifying event occurs.

In general, an employer only has to provide the coverage the qualified beneficiary was receiving immediately before the qualifying event. However, if an employer provides an open-enrollment period for selection of another plan or benefit package, or to add/eliminate family members to similarly situated active employees, then that employer must make the open-enrollment period available to the qualified beneficiaries receiving COBRA continuation coverage.

In some cases, a qualified beneficiary will be covered by a health plan that is specific to the region where he/she works and does not extend to the area to which the qualified beneficiary is relocating. The employer is not required to provide health coverage if the only plan the employer has is the one that is specific only to the region the qualified beneficiary is leaving. If the employer provides different health coverage to employees that can be extended to the area where the qualified beneficiary is moving, then that health coverage must be made available to the qualified beneficiary in his or her new location.

Cost

Under COBRA, a qualified beneficiary may be required to pay a premium or cost for continuation of coverage. *See* 29 U.S.C. § 1164. The cost of coverage cannot exceed 102% of the cost paid for active beneficiaries. The extra 2% is allowed to try to compensate the employer for the added costs of administering COBRA. As a practical matter, this means that qualified beneficiaries will often have to pay in excess of $400 per month for health insurance, and more if there are additional beneficiaries. The reality is that COBRA is not a viable option or solution for low-wage earners. In the event that a worker becomes entitled to an additional 11 months of COBRA due to disability (see Duration of Coverage), the health plan can charge 150% of the cost instead of 102% for the additional 11 months. 29 U.S.C. § 1162(3).

Duration of Coverage

When the qualifying event is the termination of employment or the reduction in hours, qualified beneficiaries can purchase up to **18 months** of coverage beginning at the date of the termination or reduction of hours. This period can be extended to **29 months** if the worker

whose employment was terminated or whose hours were reduced is determined to be disabled under Title II or XVI of the Social Security Act within the first 60 days of COBRA continuation coverage. The extension also applies to a spouse and any children of the worker who are qualified beneficiaries.

The qualified beneficiaries can purchase up to **36 months** of coverage if the qualifying event is:

- the death of the covered employee;
- a spouse's divorce or separation from the covered employee;
- a dependent child ceasing to be considered as such under the terms of the group health plan; or
- the covered employee's becoming entitled to Medicare.

If the applicable period is 18 months, that period can be extended to 36 months if, during the 18-month period, any of the following occur:

- the covered employee dies;
- the covered employee becomes eligible for Medicare;
- the covered employee divorces or legally separates; or
- the covered employee's child ceases to be a dependent.

See 29 U.S.C. § 1162.

Early Termination of Coverage by Employer

Employers can terminate COBRA coverage before the statutory period expires in the following circumstances:

- on the date the employer stops providing any group health plan to its employees;
- the first day that timely payment of the COBRA premium is not made to the health plan as determined under its provisions;
- after electing COBRA coverage, the date when the qualified beneficiary becomes covered under another group health plan;
- in the case of coverage for a former spouse, when the spouse remarries and becomes covered under another group health plan as the new spouse's dependent;
- for cause (such as submitting fraudulent medical claims) as long as it is on the same basis as similarly situated non-COBRA beneficiaries; or
- after COBRA continuation is elected, the date when the qualified beneficiary becomes entitled to Medicare benefits.

If an individual is receiving coverage under a group health plan because of his/her relationship to a qualified beneficiary and the obligation to provide COBRA coverage to the qualified beneficiary ends, then the obligation to provide group health coverage to the individual ends as well.

Remedies for Violations of COBRA

There are several remedies available depending on the nature of the COBRA violation:

- The IRS can impose excise tax penalties of up to $200/day for failure to comply with the Act;
- Beneficiaries can recover a penalty of up to $110/day for failure to provide election notice;
- Qualified beneficiaries can sue to recover health insurance coverage;
- Failure to provide election notice can be the grounds for a suit for other damages, such as worsening of a medical condition; and
- Attorneys' fees can be awarded to the prevailing party.

See 29 C.F.R. Pt. 5 § 1131-1136.

Continuation Benefits for Employees in the Military

The Uniform Services Employment and Reemployment Rights Act (USERRA) requires health plans to offer COBRA-like continuation benefits for up to 24 months for employees called to serve in military service. 38 U.S.C. § 4317(a); 20 C.F.R. §§ 1002.1 et seq. USERRA applies to employer-sponsored health plans regardless of the size of the employer. The employer and health plan may provide that USERRA and COBRA continuation coverage periods run concurrently, so long as the requirements of both laws are satisfied. 26 C.F.R. § 54.4980B-7, Q&A 7. Consult the plan's SPD or other plan documents to determine procedures for electing USERRA coverage. Violations of USERRA should be reported to the Department of Labor's Veterans' Employment and Training Services (VETS).

Basic Questions to Ask a Client

- Where do/did you work? (If the answer indicates federal civil service or a religious organization, then COBRA likely does not apply. Check for similar rules under those systems.)
- How many people does your company have working for it? (If the answer is fewer than 20, check to see whether this includes part-time employees, whether there were more employees during the year, or whether this is a branch of a larger employer. If the answer is no, then it is unlikely that COBRA applies.)
- Were you covered by health insurance by your employer? (If not, COBRA health-care continuation probably does not apply.)
- Who else in your family is under the employer's health plan? (Spouse? Dependents?)
- When you left work, did your employer inform you about the right to continue your health insurance coverage? (If the worker left employment and has not received notice that he/she had a right to COBRA coverage, the former employee still has 60 days to elect COBRA coverage, even though he/she may have lost health coverage.)

D.C. Government Employees' COBRA Rights

If a claimant loses his or her job, the D.C. Code provides that the D.C. government is required to offer the employee the opportunity to purchase health insurance. *See* D.C. Code § 1-621.14. Federal COBRA rights are not applicable to D.C. government employees.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) amended COBRA to add protections for individuals with pre-existing medical conditions. Specifically, HIPAA seeks to (1) limit the exclusion of employees from health plans due to pre-existing conditions; (2) prohibit discrimination against employees and their dependents based on their health status; (3) require employers to make coverage available or renewable to certain employees; and (4) provide workers who lose coverage with better access to individual insurance coverage. *See* 29 U.S.C. § 1181 *et seq*. However, effective Jan. 1, 2014, all group health plans will be prohibited from imposing pre-existing condition exclusions.

HIPAA also provides protections against the unauthorized disclosure of personal health information by certain covered entities, including entities that provide services for employer-sponsored health plans. The privacy provisions of HIPAA apply to health information created or maintained by **health-care providers** who engage in certain electronic transactions, health plans, and health-care clearinghouses. However, employers are *not* covered entities directly regulated by the privacy rules of HIPAA. The Department of Health and Human Services (HHS) has issued the regulation "Standards for Privacy of Individually Identifiable Health Information," applicable to entities covered by HIPAA. The Office for Civil Rights (OCR) is the Departmental component responsible for implementing and enforcing the privacy regulation. *See* 45 C.F.R. § 164.500 *et seq*.

To file a complaint for a privacy violation under HIPAA, the worker must do so in writing and within 180 days of when the violation became known to the worker. In D.C., Maryland, or Virginia, the complaint must be filed at the following regional office:

Office for Civil Rights
U.S. Department of Health & Human Services
Region III
150 S. Independence Mall West – Suite 372, Public Ledger Building
Philadelphia, PA 19106-9111

The telephone numbers for the office are (800) 368-1019 and (215) 537-7697 (TDD), and forms and additional information on how to file a complaint can be found at www.hhs.gov.

Prompt Pay Act of 2002

D.C. Code § 31-3132(a) requires health benefits plans to compensate any person entitled to reimbursement for a covered service within 30 days after receipt of a claim that is accompanied by all reasonable and necessary documentation. If a health insurer fails to comply with this requirement, the health insurer shall pay interest beginning on the 31st day after the receipt of the claim if the claim remains unpaid after 30 days. A formal claim by the person filing the original claim is not required. § 31-3132(b). The statute states the interest payable if the health insurer fails to compensate the person within 30 days. § 31-3132(c)(1)-(3).

The statute stipulates that there shall be a rebuttable presumption that a claim has been received by a health insurer:

- within five business days from the date the provider or person entitled to reimbursement placed the claim in the U.S. mail;
- within 24 hours if the claim was submitted by the provider or provider's agent electronically and was not returned to the provider by a claims clearinghouse or returned to the provider by the insurer if submitted directly to the health insurer; or
- on the date recorded by the courier if the claim was delivered by courier.

§ 31-3132(h)(1)-(3).

A health insurer shall provide a manual or other document that sets forth the claim submission procedures to all contracting providers at the time of contracting and 30 days prior to any changes in the procedure. § 31-3132(j). Furthermore, a health insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including electronic or facsimile confirmation of receipt of a claim. § 31-3132(j).

Exceptions

"Prompt payment" is not required under this law if the payer:

- notifies the person submitting the claim within 30 days after the receipt of the claim that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute;
- states, in writing, to the person the specific reasons why the legitimacy of the claim, a portion of the claim, or the appropriate amount of reimbursement is in dispute; and
- pays any undisputed portion of the claim within 30 days of the receipt of the claim.

§ 31-3132(d)(1)-(3).

Additionally, the health insurer will not be held in violation of the statute if its failure to pay a claim is caused:

- in material part by the person submitting the claim; or
- by impossibility due to matters beyond the health insurer's reasonable control, such as an act of God, insurrection, strike, fire, or power outages.

§ 31-3132(k)(1)-(2).

If any portion of the claim is disputed, the health insurer must process the undisputed portion within 30 days after receipt of all reasonable and necessary documentation. § 31-3132(e). If the insurer fails to comply with this requirement, it must pay interest at the statutory rates.

Federal Disability Retirement

If a federal worker is unable to render **useful and efficient service**, s/he may apply for disability retirement, through which s/he can collect a portion of his or her salary from the contributions made to her or his retirement fund. If a worker cannot perform **any single critical element** of his or her current job on account of illness or injury, then s/he is unable to render useful and efficient service, and is deemed disabled. *See* 5 U.S.C. § 8451 *et seq*. (FERS); 5 C.F.R. § 844.103 *et seq*. (FERS); 5 U.S.C. § 8337 (CSRS) ; 5 C.F.R. §§ 831.101, .1201 *et seq.* (CSRS).

A worker need not be totally disabled in order to collect federal disability retirement benefits. If the disabling **medical condition is likely to last more than one year**, then a worker is eligible to collect disability retirement benefits. The disability need not be because of an on-the-job injury, and can be the result of the exacerbation or flare-up of a pre-existing condition.

Enrollment Requirement

There are two federal employment systems: Federal Employee Retirement System (FERS) and Civil Service Retirement System (CSRS). Make sure you know which system an employee is in before you advise them about disability retirement.

FERS employees must be enrolled in their retirement system for 18 months in order to be eligible for disability retirement. CSRS employees must be enrolled for a minimum of five years in order to be eligible.

Note: A federal employee who is injured on the job cannot collect both workers' compensation and disability retirement. Although an employee can apply for both workers' compensation and disability retirement, the employee must elect one or the other.

Accommodation and Reassignment

Because disability retirement is supposed to be a last resort, federal agencies are required to make reasonable attempts to reassign and accommodate disabled workers. Accommodations must allow the worker to perform all the critical aspects of her job in order to be valid. Reassignments must be to another position in the agency with the same grade, pay, and tenure,

and within the same commuting area. Only after attempts to accommodate and reassign have been exhausted can a federal employee apply for disability retirement.

Federal workers **must** cooperate with these attempts at reassignment and accommodation; if they fail to do so, or turn down reasonable accommodations or reassignments, they can be denied disability retirement.

Checklist

Make sure your client meets all these qualifications in order to successfully apply for disability retirement:

_____ Enrolled in FERS for at least 18 months, or enrolled in CSRS for at least 5 years
_____ Suffer from a disease or injury
_____ This disease or injury became disabling only **after** you entered federal service
_____ Unable to perform any **one** of the critical elements of your job in a satisfactory manner
_____ Likely to be unable to perform that critical element for at least one year
_____ Currently in government service, or have been separated from service for less than one year
_____ Agency cannot accommodate the disability or find a suitable reassignment to a comparable position

Application Procedure

Employees may submit an application for disability retirement **within one year** after the date of their separation. If the application is submitted before separation or within 31 days of separation, it may be sent to the personnel department of the worker's agency, but it is generally better to send it directly to the Office of Personnel Management (OPM). After 31 days, the application should be sent directly to FERS at Office of Personnel Management, Federal Employees' Retirement System, Employee Records and Service Center, P.O. Box 200, Boyers, PA 16020. For information, request Standard Forms 3105 (A through E) and 3107 from the agency or OPM.

Note: Termination from a job does not preclude a federal employee from applying for disability retirement. In fact, termination because a person cannot perform the functions of a job due to a medical condition may help bolster a claim for disability retirement.

If a worker is denied disability retirement by OPM, the worker can usually request reconsideration and file a letter brief in support, as a part of which new evidence (e.g., new medical records) can be submitted. The right to request reconsideration is stated in the CSRS regulations at 5 C.F.R. § 831.109. The FERS regulations do not contain this provision.

If the reconsideration is denied, the worker can appeal to the Merit Systems Protection Board (MSPB) and request a hearing before an administrative law judge (ALJ). Appeals from the ALJ are taken to the MSPB (an actual board that is like an appellate court). Appeals from the

MSPB are taken to the Federal Circuit court.

Benefits Received

If a worker successfully applies for disability retirement under FERS, he will receive 60% of his average pay during the first year of disability and 40% of the average pay during all other years. Average pay is the average amount earned during each year of the three highest consecutive paid years of federal civil service. **FERS employees on disability are also required to apply for Social Security**, even if they believe they are not eligible to receive it. If a person is eligible for Social Security, during the first year, for every dollar the worker receives from Social Security, the same amount will be deducted from his disability payment. This will most likely reduce the worker's entitlement to his disability payment to nothing, or almost nothing. During subsequent years, for each dollar a person receives from Social Security, FERS will deduct 60 cents from the disability payment.

CSRS employees do not have to apply for Social Security, and if they do apply and receive it, their disability payment will not be reduced. Like FERS, CSRS disability is also predicated on the same average pay definition as FERS, but the formula for computing benefits is a bit more complex:

- If a worker has 22 or more years of "creditable service,"[130] but less than 22 years of actual service, she will collect 40% of average pay.
- If a worker has 22 or more years of actual service, the annuity will be computed under the general formula for regular retirement and will be higher than 40% of average pay.
- If a worker has fewer than 22 years of creditable service, she will receive less than 40% of average pay, ranging from 7.5% for 5 years of service to 38.25% for 21 years of service. (The percentage increases by 1.75% through year 10, and then increases by 2% each year.)

The benefits are taxable income, but recipients are eligible for the Earned Income Tax Credit. *See The Earned Income Credit 2012 Outreach Kit*, Center on Budget and Policy Priorities. The kit can be found on the Center's EITC website at http://eitcoutreach.org.

Disability retirement benefits continue until the worker (1) dies; (2) returns to work for the federal government; (3) voluntarily gives up the benefits; (4) recovers from the disability; or (5) is "restored to earning capacity."[131] For more detail, *see* 5 C.F.R. § 831.1209. Workers who successfully received disability are eligible to maintain government health insurance, but they must pay the same monthly premiums as they did when they were employed.

A person can work in another non-government job while on disability retirement.

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130 To compute creditable service, add the number of years until a worker reaches 60 to the number of years s/he worked in the federal civil service.

131 A person is restored to earning capacity when his or her income from wages or self-employment or both equals at least 80% of the current rate of pay of the position occupied immediately before retirement. *See* 5 U.S.C. § 8337(d).

However, if in doing so, she is "restored to earning capacity," disability retirement benefits will cease, including group health insurance coverage.

Retirement for D.C. Public School Teachers

Disability Retirement

The worker must meet the following conditions to be eligible for disability retirement in D.C.:

- be physically or mentally disabled ("not due to vicious habits, intemperance or willful misconduct");
- be incapable of satisfactorily performing the duties of the teacher's position;[132]
- have completed five years of eligible service; and
- apply for disability or be ordered to apply for disability before leaving DCPS or within six months of leaving.

See D.C. Code § 38-2021.04(a)

The teacher must be examined under the direction of a health officer of D.C. and be found disabled by the health officer. Alternatively, a two-thirds majority of the members of the Board of Education can qualify a teacher for disability retirement. *Id.* Every worker who retires because of a disability must be examined every year under the direction of the Director of the Department of Human Services to assess the disability. If the worker recovers before reaching retirement age, s/he shall be reinstated in accord with the rules applicable (similar or equal position). Payment shall continue until the worker is reinstated. The Board of Education may direct or order medical or other examinations to assess the level of disability of the worker. § 38-2021.04(b).

If, before reaching the age of retirement but after retiring due to a disability, the worker earns income of not less than 80% of the current rate of pay for the position that the worker occupied before retirement, the retirement income shall be terminated. § 38-2021.04(c). The retired worker can have his or her payments reinstated if s/he shows that s/he is earning less than the 80%; however, the worker must show that this reduction in wage is not due to normal income fluctuations. § 38-2021.04(c).

Regular Retirement for D.C. Public School Teachers

D.C. Public School teachers hired before Oct. 29, 1996, are entitled to an annuity if they have five years of eligible service, retire, and either:

(1) reach 55 years of age and have completed 30 years of service;

[132] This is exact language from the statute, so advocates can resist an attempt by the D.C.P.S. to suggest other suitable employment or arguments that the person is not disabled from <u>all</u> employment.

(2) reach 60 years of age and have completed 20 years of service; or
(3) reach 62 years of age.

D.C. Code § 38-2021.03(a).

If the worker was employed on or after Oct. 29, 1996, s/he must complete 30 years of service and five years of eligible service to acquire her annuity. *Id.*

A worker involuntarily separated from service is entitled to an annuity reduced by one-sixth of 1% for each full month the teacher is younger than 55 on the date of separation *if* the worker completed 25 years of service or completed 20 years of service and is older than 50. However, if the worker was removed for "cause on charges of misconduct or delinquency," s/he is not eligible for an annuity. § 38-2021.03(b).

If there is a major reorganization, reduction in force, or transfer of functions where a large percentage of workers are separated or placed on furlough or receive a reduction in pay, the Board of Education can offer voluntary retirement as follows:

(1) workers who have completed 25 years of service; or
(2) workers who are 50 years or older and completed 20 years of service.

Those who opt for early retirement shall receive an annuity reduced by one-sixth of 1% for each full month the worker is younger than 55 at the date of her separation and be eligible for the early-out retirement incentive program established under D.C. Code § 38-2021.03. § 38-2021.03(f).