FMLA Violations can be costly. Can you avoid retaliation?

Employers are at risk of violating the FMLA if they, among other things, (a) deny the requested time off, (b) fail to restore the employee to his or her original or equivalent position after leave, (c) discontinue benefits during leave, or (d) deny a promotion to or demote an employee based on their requested family medical leave.

Mishandling FMLA can lead to a lawsuit that can name the employer and potentially individuals within the company. While it is possible to terminate an employee while on FMLA, the rules allowing termination are limited. If you find yourself looking at this possibility it is vital that you review your policies and be prepared to defend your decision against claims of interference and retaliation.

Violations resulting in damages:

Following are just a few cases where employees won FMLA cases for violation of FMLA against their employers:

In September 2011, the large retailer Wal-Mart was investigated by the U.S. Department of Labor’s Wage and Hour Division for terminating an employee under violation of the FMLA at one of their Georgia stores. As a result of the investigation the company was required to reinstate the employee, pay the employee $20,899 in back wages, restore all benefits and bonuses, and delete all negative references to unexcused absences from the employee’s personnel record.

In July, 2011, Alcazar-Anselmo v. City of Chicago highlights the importance of proper FMLA administration. The plaintiff, Gladys Alcazar-Anselmo, claimed interference with her rights to FMLA leave and retaliation when she was fired from her position as deputy commissioner in the Department of Consumer Services. How much did this cost The City of Chicago? The Plaintiff received $178,952.34 in compensatory damages and $237,097.46 for attorney and court costs.

In January, 2012, Bexar County Hospital District, doing business as University Health System in San Antonio, has agreed to pay a former employee $7,915 in back wages after an investigation by the U.S. Department of Labor’s Wage and Hour Division found that the hospital had placed the worker on full-time unpaid leave, in violation of the Family and Medical Leave Act. The investigation, conducted by the Wage and Hour Division’s San Antonio District Office, found that University Health System had denied an employee’s request for intermittent leave related to a serious chronic health condition. The employer instead insisted that the leave be taken continuously—even though
the worker was capable of performing the job with intermittent leave. As a result, the employee used more leave than was medically necessary, resulting in lost wages over a three-month period.

Length of time Employees can file FMLA Complaints

Employees have a two year window in which to file an FMLA complaint, or three years if the violation is deemed to be willful. An employee may register a complaint with the Wage and Hour Division of the Department of Labor (DOL), inform their union (if applicable) of any suspected violations, or file a lawsuit against their employer.

It is imperative that employers understand potential FMLA violations and the resulting risk of costly lawsuits. Add to this daunting undertaking the difficult task of correctly administering the FMLA program, along with understanding each component thereof.

TASC’s FMLAMatters provides a solution to employers. Not only do we perform all key areas of FMLA administration, we keep the employer informed about FMLA requirements and help ensure their complete compliance with the law. Proper clarification and compliance with FMLA helps employers stay out of the courtroom fighting an FMLA claim.

FMLAMatters is a giant step ahead of the competition! We work carefully with management and supervisory staff so the burden to train and educate your managers is not piled on your HR staff. When we help implement your FMLA administration we make sure the specifics and the administrative process flow as they should.

The FMLAMatters Solution

FMLAMatters ensures employees get the federal benefit they are entitled to, but not at the expense of the employer’s business. FMLA offers the following:

- Complete compliance with FMLA administrative regulations, thereby reducing legal exposure and cost to employer.
- Hold-harmless guarantee.
- Complete tracking of employee leave, thereby reducing HR responsibility—and money for such—to manage employee benefits.
- Consistent administration.
- Impartial and fair treatment of FMLA provisions.
- Complete and centralized record-keeping.
- Access to experienced employee benefits professionals.
- Thorough training of supervisors and managers regarding company procedures and FMLA regulations.
- Full review of employment policies related to FMLA.
- Toll-free customer service for management and employees.
- Access to FMLA activity reports.
ERISA Compliance is not an option. It’s the law. Can your benefit plans pass a DOL audit?

ERISA’s extensive rules address the federal income tax effects of transactions associated with employee benefits plans, with mandates that qualified plans must follow to ensure that plan fiduciaries do not misuse plan assets. ERISA has been amended repeatedly since being signed into law.

Also called the Pension Reform Act, ERISA protects the retirement assets of Americans. It is administered by the Employee Benefits Security Administration (EBSA, a division of the U.S. Department of Labor, or DOL), along with the Department of Treasury and the Pension Benefit Guaranty Corporation.

Who must abide by ERISA?

The protective laws under ERISA apply to employer-sponsored health insurance coverage and other benefits plans offered to employees by private employers (only). Corporations, partnerships, sole proprietorships, and non-profit organizations are covered, but governmental employers and churches are not, and are exempt from the application of ERISA. ERISA does not require employers to offer plans; instead it sets the rules for the plans and benefits which employers choose to offer.

What does ERISA regulate?

ERISA is sometimes used to refer to the full body of laws regulating employee benefits plans, which are found mainly in the Internal Revenue Code and ERISA itself. ERISA does not require that employers provide a benefits plan, but it regulates the operations of such health benefits plans. In sum, while offering such plans is optional, once offered they must be managed in compliance with the various provisions mandated under ERISA, which include the following:

- Conduct: ERISA rules regulate the conduct for managed care (i.e., HMOs) and other fiduciaries (the person financially responsible for the plan’s administration).

- Reporting and Accountability: ERISA requires detailed accountability and reporting to the federal government.

Disclosures: Certain disclosures must be provided to plan participants (i.e. a written Plan Summary that clearly lists the benefits being offered, the rules for receiving or accessing those benefits, the plan’s limitations, and other guidelines for obtaining benefits such as obtaining referrals in advance for surgery or doctor visits).

Procedural Safeguards: A written policy must be established to address how claims should be filed, and must detail a written appeal process for claims that are denied. ERISA also requires that claims appeals be conducted in a fair and timely manner.

What is the ERISA annual report requirement?

Unless an exemption applies, ERISA requires the plan administrator of each separate ERISA governed plan to file an “annual report” with the DOL containing specified plan information. IRS Form 5500 is used for this purpose. ERISA authorizes the DOL to issue regulations exempting welfare plans from all or part of the Form 5500 reporting requirements, and the DOL has issued numerous exemptions for health and welfare plans. Unless an ERISA welfare plan qualifies for one of the enumerated Form 5500 exemptions, it must file Form 5500.

“Small unfunded, insured, and combination unfunded/insured welfare plans” are, as noted above, completely exempt from the Form 5500 requirement. To qualify for this exemption, a plan must cover “fewer than 100 participants at the beginning of the plan year.”
**What is the most basic ERISA rule?**

ERISA does not require an employer to provide employee benefits. Likewise, as a general rule, it does not require that plans provide a minimum level of benefits. Employers-sponsors are generally free to design their own benefits plans.

Once an employer decides to provide benefits that are subject to ERISA, the plan’s operation is regulated by ERISA, and the benefits must be detailed through a written plan document (called a Summary Plan Description). While an ERISA governed plan can exist even without a written document, such a plan is considered out of compliance (with the written document requirement imposed by ERISA).

As mentioned above, ERISA specifically requires that an employee benefits plan, including a welfare benefits plan, be established in writing. Many employers fail to consider the requirements of having a written plan document, or mistakenly assume that written insurance policies or other booklets or summaries provided by the insurance company are sufficient to meet this document requirement. In reality these documents often fall short of the ERISA requirement.

Of course insurer documents should comply with all applicable legal requirements; insurers must provide adequate disclosures and notices, and must follow federal and state compliant claims procedures and applicable HIPAA regulations. Further, insurers assume responsibility only in regards to problems with insufficiency or inconsistency, or compliance failure with state regulations, not ERISA regulations. Most policies, certificates, summaries and other documentation produced and distributed by an insurer generally specify that the employer is the plan sponsor, plan administrator, agent for service of process, and the named fiduciary. In sum, it is the employer who is held accountable for any plan failures or compliance issues.

**Who is responsible for furnishing Summary Plan Descriptions (SPDs)?**

Given that the employer-sponsor typically is the plan administrator, it follows that the employer (not the insurer) generally is responsible for furnishing Summary Plan Descriptions (SPDs), and that the employer will be held liable if adequate SPDs are lacking.

Of course insurance carriers are responsible for paying claims. Yet, as mentioned above, many employers mistakenly assume that carriers also provide SPDs. Instead, even when an insurer provides booklets describing benefits for distribution to participants, the insurer generally does not assume the statutory responsibility for SPDs.

**What are the amounts and period of statutory civil penalties?**

ERISA §502 provides civil penalties for failure or refusal to file a required IRS Form 5500; for this purpose, a Form 5500 that has been rejected by the DOL for failure to provide material information will be treated as not having been filed. The penalties for noncompliance can be heavy: under ERISA §502, the DOL may assess a civil penalty against a plan administrator of up to $1,100 per day starting from the date of the administrator’s failure or refusal to file the Form 5500.

**Excerpts from a recent DOL Audit findings of a DOL Audit:** November 30, 2011 “II. Failure to Provide a Summary Plan Description

Our investigation also revealed that the carrier Documents are the only documents governing the Plan. The Plan does not provide a summary plan description (SPD) to participants and beneficiaries of the Plan. The Documents provide descriptions of benefits and eligibility requirements furnished by the carriers of the Plan, but do not provide required Plan information and do not purport to be an SPD under ERISA.

Specifically, the Documents do not contain the following information: (1) the name of the Plan; (2) the identity, telephone number and address of the Plan sponsor, Plan administrator and other Plan fiduciaries; (3) the...
Plan tax identification number; (4) the type of plan; (5) the name of the legal agent for the Plan; (6) the name of the person to whom the service of legal process is to be made; (7) the sources of contributions and the identity of the funding medium of the Plan; (8) the nature of administration services; (9) the date of the Plan year end; and (10) a statement of ERISA rights, including the Department of Labor office to contact for information.

It is our view, your failure to furnish a SPD to participants and beneficiaries of the Plan is a violation of ERISA Sections 102(a) and (b) which state in part:

102(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries ... The summary plan description ... shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprize such participants and beneficiaries of their rights and obligations under the plan.

102(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan, ...whether a health insurance issuer...is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, ...the name and address of the administrator; names, titles, and addresses of any trustee or trustees; a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; circumstances which may result in the disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; [and] the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information.

Conclusion

In our view, for the reasons cited above, you and the Plan are in violation of ERISA and will remain so until the Plan meets the requirements [that] a summary plan description containing all required information is furnished to the Plan’s participants and beneficiaries. We invite you to discuss with us immediately plans for corrective action for these violations.

The ERISAEdge Solution

ERISAEdge provides a solution to employers by performing all key areas of ERISA administration requirements and ensuring complete compliance with the law.

ERISAEdge Administration means TASC does the following:

• Guarantees compliance to all ERISA requirements.
• Ensures ERISA Plan is current with all regulations.
• Monitors the associated employee benefits to ensure timely disclosure of plan change to employees.
• Provides resolution assistance in the event that your employee benefit plans are reviewed by the DOL.
• Provides technical and customer service assistance.
• Provides access to experienced employee benefits professionals.
• Provides instruction regarding required on-site record keeping.
• Maintains all required records for the mandated amount of time.
• Provides online storage of Plan document(s)/SPD.
• Completes the required forms accurately and in a timely manner.
• Prepares the Summary Material Modification (if necessary).
• Prepares IRS Form 5500 and associated Schedule A or C (if required).
• Prepares the SAR (if required).
• Creates and distributes a bi-annual Client newsletter.

Don’t fail a DOL audit! Don’t owe monetary penalties to an Employee! Don’t fail to provide the required legal documentation!
We have provided the foregoing statement of our views to help you evaluate your obligations under ERISA. Your failure to correct the violations may result in referral of this matter to the Office of the Solicitor of Labor for possible legal action. In addition to any possible legal action by the Department, you should also be aware that the Secretary, pursuant to section 504(a) of ERISA, is authorized to furnish information to “any person actually affected by any matter which is the subject” of an ERISA investigation. Further, even if the Secretary decided not to take any legal action in this matter, you would nonetheless remain subject to suit by other parties including Plan participants or their beneficiaries.

If you take proper corrective actions, the Department will not bring a lawsuit with regard to these issues. Further, you should understand that the Department is speaking only for itself and only with regard to the issues discussed above. The Department has no authority to restrain any third party or any other governmental agency from taking any action it may deem appropriate.

We hope this letter will be helpful to you, and that, in respect to the specific matters discussed, you will promptly discuss with us how these violations may be corrected. Please advise me, in writing, within ten (10) days of your receipt of this letter what action you propose to take to correct the violations described above.”

**October 13, 2010: Penalty owed Employee for Employer failure to provide Employee with SPD:** Plan administrator must pay maximum penalty for delay in providing requested SPD.


A medical plan participant sued her employer’s benefits committee, as plan administrator, for its failure to provide a copy of the plan’s SPD in response to her written requests. The employer had amended the plan to add a new coverage option effective January 1, 2009, in which the participant had enrolled. In a letter to the plan administrator dated March 2, 2009, the participant requested a copy of the “plan document” in order to review her coverage. The plan administrator sent several documents on April 2, 2009, including a handbook that predated the new coverage option, an announcement brochure, and an enrollment brochure.

The court interpreted the participant’s letter as a request for a copy of the SPD. Citing the handbook’s lack of any mention of the new coverage option and the other materials’ lack of specific coverage information, the court held that none of the April documents, individually or collectively, constituted the SPD. The plan administrator argued that it had 210 days after the end of the 2009 plan year to distribute an SPD that reflected the new coverage. The court strongly disagreed, distinguishing the requirement to proactively distribute an SMM or updated SPD from the separate ERISA requirement to provide certain documents (including an SPD) within 30 days after a request. The court ultimately concluded that a subsequent set of documents, sent to the participant on July 9, 2009, did contain sufficient information. However, the court chose to impose the maximum statutory penalty ($110 per day) for the period between April 3, 2009 and July 9, 2009, citing its “dismay” that the participant had to make three written requests before receiving the relevant information and even suggesting bad faith by the plan administrator in sending over 300 pages of documents that, for the most part, did not even apply to the participant’s coverage. ($10,780)