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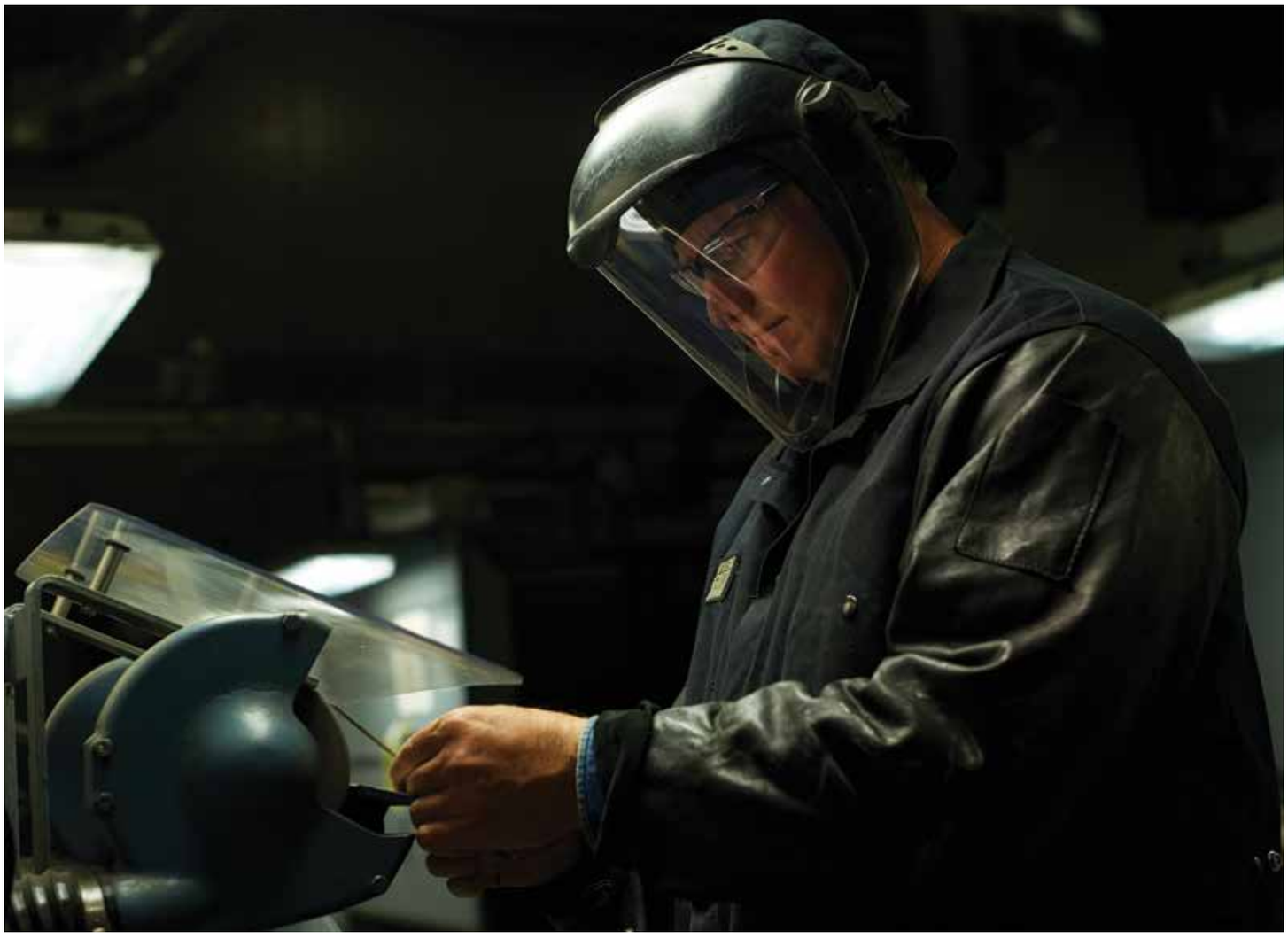
THE JOHNSON + KROL NEWSPAPER



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THE AMERICAN RESCUE PLAN ACT (ARPA)

The American Rescue Plan Act (ARPA), signed into law by President Biden on March 11, 2021, includes provisions that will significantly impact underfunded multi-employer pension plans facing critical or declining financial status.[1] This legislation comes after decades of attempts by both Democratic and Republican administrations to address the multi-employer pension plan funding crisis.

ARPA allocates funds to the PBGC in order to provide eligible, underfunded plans with special financial assistance. Most notably, ARPA will cover the payments of accrued benefits through the 2051 plan year for eligible plans, without repayment obligations.

This provision does not appropriate a specific amount to the PBGC, but projections estimate the expenditures to qualifying plans to be close to $86 billion. As a result, the multi-employer pension industry has been bracing itself for significant increases in premiums and PBGC dues. While ARPA does increase the flat-rate premium paid to the PBGC to $52 per participant starting in 2031 and remains indexed to inflation, this is only about a $7–$12 increase from what the flat-rate premium was projected to be in 2031 under current law. This increase is much smaller than previously proposed.

In order to be eligible for special financial assistance, multi-employer pension plans must fall into one of the following categories:

- Plans in critical and declining status;
- Plans in critical status if they have a modified funded percentage of less than 40% and a ratio of less than two active participants to three inactive participants;
- Plans that had benefit suspensions approved prior to the date of enactment; or
- Plans that became insolvent after December 16, 2014.

In determining the amount of special financial assistance needed, the PBGC will use the interest rate used in the plan's most recent zone certification. The special financial assistance will be paid to plans in a single, lump-sum payment and must be segregated from other plan assets. Furthermore, in order to receive the special financial assistance, plans that had previously suspended benefits must reinstate those benefits.

The PBGC has 120 days from the date of enactment to issue guidance detailing the application requirements. The legislation also grants the PBGC the authority to limit applications in the first two years of the program to those plans in most financial need. Qualifying plans have until December 31, 2025, to submit an application for special financial assistance.

In addition to the special assistance program, ARPA also provides COVID-19 relief for multi-employer pension plans. For plan years beginning in 2020 or 2021, the legislation allows a plan to retain its 2019 zone status, to extend its funding improvement plan or rehabilitation period by five additional years, and to amortize losses over a 30-year period.

It comes as a relief to multi-employer pension plans that several previously considered provisions were excluded from the final version of ARPA. First, other than the changes discussed above (special financial assistance, increase in PBGC premiums, and temporary COVID-19 relief), ARPA does not significantly change multi-employer funding rules. Furthermore, the legislation as passed does not include any limitation on the actuarial discount rate used to calculate plan liabilities.

At this point, multi-employer pension plans are waiting for additional guidance and clarity from the PBGC. The PBGC has until July 10, 2021 to issue guidance regarding the financial assistance application process. Plan professionals should continue to closely monitor developments at the PBGC and Treasury.

[1] American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. (2021–2022).

THE AMERICAN RESCUE PLAN INCLUDES COBRA SUBSIDIES

On March 11, 2021, President Biden signed into law the American Rescue Plan Act of 2021 (ARPA), which includes several provisions relating to group health plans, notably a new COBRA subsidy. The Act creates a federal subsidy that will cover 100% of COBRA premiums for certain eligible individuals where the qualifying event was an involuntary termination of employment (for reasons other than gross misconduct) or a reduction in hours. COBRA subsidies are not available for other qualified beneficiaries who experience a qualifying event such as divorce, death or loss of dependency status.

The COBRA subsidies will be available from April 1, 2021 through September 30, 2021. The subsidy will end earlier if an individual becomes eligible for other group health plan coverage or Medicare or reaches the end of his or her 18-month COBRA continuation period. Individuals are required to notify the group health plan if they become eligible for another group health plan or Medicare.

The COBRA subsidy is a refundable tax credit against quarterly payroll taxes. Multi-employer plans are eligible to receive the credit. If the tax credit exceeds the amount of payroll taxes due for a particular period, the credit is refundable. The credit may also be advanced pursuant to instructions by the Secretary of the Treasury.

The Act also creates a special election period for individuals who previously experienced an involuntary termination or reduction in hours but did not elect COBRA or dropped COBRA coverage, and who are still within their COBRA maximum coverage period. These individuals may elect COBRA coverage within 60 days of receiving the required COBRA notice explained here. The coverage will be effective with the first period of coverage beginning on or after April 1, 2021. During this period, the COBRA election notice must include "clear and understandable language" of the availability of the COBRA subsidies, and if permitted by the plan, the ability for the individual to enroll in a different coverage option under the group health plan. This notice must also be provided to individuals who are eligible for the subsidy due to an involuntary termination or reduction of hours followed by a loss of coverage before April 1, 2021.

The Department of Labor provided guidance and model notices on April 8, 2021. Plan administrators are required to give notices to eligible qualified beneficiaries by no later than May 30, 2021. Plan administrators must also notify individuals no more than 45 days and no less than 15 days before the date the COBRA subsidy will expire for the individual. The notice must include information regarding the expiration of the subsidy and the expiration date. This notice is not required if the individual becomes eligible for coverage under another group health plan or Medicare.

If you have any questions about the COBRA subsidy, please contact our office.

CHANGES AT THE NLRB

Acting GC Ohr intends to robustly enforce the National Labor Relations Act's provisions that protect employees' Section 7 rights.

After President Biden took office, he bucked tradition and asked for the resignation of President Trump's appointed General Counsel, Peter Robb, rather than allowing him to serve out the remainder of his term. Robb declined, and so Biden fired Robb and installed Region 13 Regional Director Peter Sung Ohr as Acting General Counsel. President Biden has since nominated former Acting General Counsel Jennifer Abruzzo for the position. Abruzzo served as Acting GC in 2017 and awaits possible Senate confirmation.

Acting GC Ohr immediately took several actions including issuing GC 21-02, which had the effect of rescinding ten guidance memos that had been issued by GC Robb.[1] In the Memo, Acting GC Ohr said, "Section 1 of the [National Labor Relations Act] makes clear that the policy of the United States is to encourage the practice and procedure of collective bargaining and to protect the exercise by workers of their full freedom of association, self-organization, and designation of representatives of their own choosing for the purpose of negotiating the terms and conditions of their employment. As a career employee of the NLRB, I have endeavored to effectuate this policy. As Acting General Counsel, I will continue to work to realize the Act's purpose. I have determined that a number of outstanding General Counsel Memoranda are either inconsistent with the above-described policies and/or Board law, or are no longer necessary."

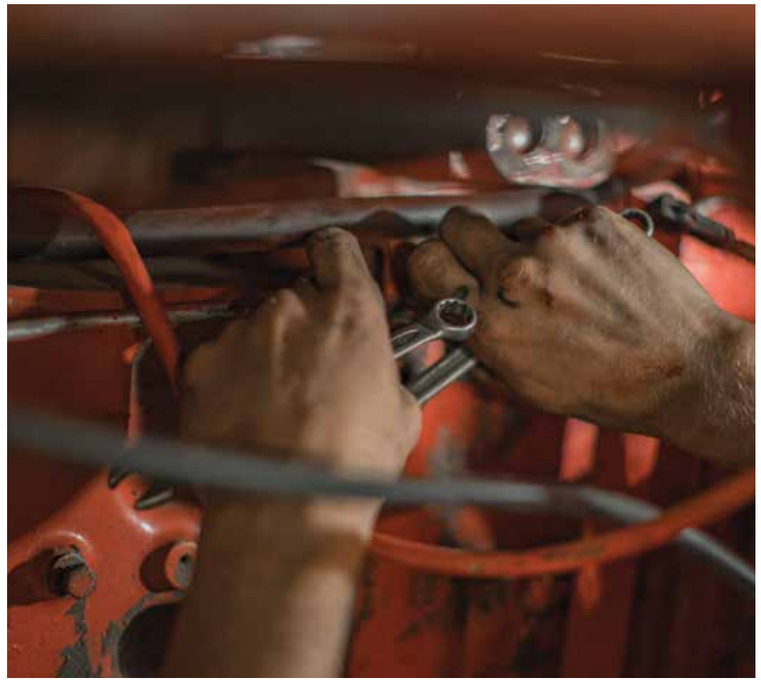
Of particular note, this included the recission of GC 18-04.[2] GC 18-04 gave guidance on employer handbooks after the NLRB decided *The Boeing Company, 365 NLRB No. 154* (Dec. 14, 2017). In *Boeing*, the Board set three categories of work rules and elucidated a balancing test in order to measure when employee rules and employee handbooks might impact protected activity. GC 18-04 elaborated on the three categories, giving specific examples and explaining the GC's guidance on the balancing test the Board employed in *Boeing*. Ohr rescinded the Memo, saying that the NLRB had issued many decisions since the *Boeing* decision and that the Memo was no longer needed.

The other rescinded memos dealt with the standard of negligence on duty of fair representation charges related to union record-keeping requirements, grievance tracking, deferral to arbitration, tracking union expenses relating to "fair share" payments by non-union bargaining-unit members, securing testimony of former supervisors and agents, burdens of proof on make-whole remedies, and union neutrality agreements.

Perhaps most visibly, Acting GC Ohr has attempted to issue a reprieve to Scabby the Rat. In a current case arising out of Region 25 involving the Operating Engineers, Ohr filed a Motion to Dismiss a Complaint issued by GC Robb which asked the Board to overturn *Eliason & Knuth of Arizona*, 355 NLRB 797 (2010), and find that the Union's use of banners and Scabby violated Sections 8(b)(4)(i) and (ii)(B) of the Act. Ohr has asked the Board to dismiss the Complaint because it "undermines current Board law and is not in the public interest."[3,4]

On March 31, 2021, Acting GC Ohr issued GC 21-03.[5] In 21-03, Acting GC Ohr gave perhaps his clearest indication of how he intends to enforce the National Labor Relations Act, stating, "I look forward to robustly enforcing the Act's provisions that protect employees' Section 7 rights with full knowledge that recent decisions issued by the current Board have restricted those protections." Specifically, GC 21-03 addressed "vigorous enforcement of the Mutual Aid or Protection and Inherently Concerted Doctrines."

In addressing mutual aid and protection, Ohr was particularly critical of *Allstate Maintenance*, 367 NLRB No. 68 (2019), and *Quicken Loans*, 367 NLRB No. 112 (2019). *Allstate* and *Quicken* took, in Ohr's view, a too-narrow view of the "mutual aid and protection" doctrine when analyzing retaliation taken against employees for statements or complaints that could have been viewed as being made for mutual aid and protection. Acting GC Ohr also stated his intent to take a broader view of what constitutes "inherently concerted activity" in the unionized workforce, the non-unionized workforce, and relative to organizational campaigns. Ohr specifically noted that he will be looking to past Memoranda from the Division of Advice which found that employee conversations about workplace health and safety and racial discrimination "may be inherently concerted."[6,7]



[1] Office of the General Counsel, Memorandum GC 21-02, issued February 1, 2021.
[2] Office of the General Counsel, Memorandum GC 19-04 issued June 6, 2018, rescinded February 1, 2021.
[3] *International Union of Operating Engineers, Local No. 150 and Lippert Components, Inc.* (Case 25-CC-228342)
[4] Motion of the Acting General Counsel to the National Labor Relations Board to Remand the Complaint to the Regional Director for Dismissal or, Alternatively, to Dismiss the Complaint, Filed February 2, 2021.
[5] Office of the General Counsel, Memorandum 21-03.
[6] *North West Rural Electric Cooperative*, Case 18-CA-150605, Advice Memorandum dated September 21, 2015.
[7] *Milford Center*, Case 01-CA-156820, Advice Memorandum dated January 20, 2016.

SIGNIFICANT WORKPLACE CHANGES IN STORE UNDER THE BIDEN ADMINISTRATION

Under the Trump Administration, the law governing the workplace underwent significant changes. Under the Biden administration, employers can expect an equally stark reversal.

In many respects the law will revert back to where it was prior to Trump's taking office. In other respects, employers can expect an equally large swing in the opposite direction. In a wide range of areas, President Biden has touted support for numerous legislative and regulatory proposals that would significantly change the employment and labor law landscape. The possible changes are as follows:

EXPANDED LABOR RIGHTS

As discussed in more detail in a previous newsletter, President Biden has promised to sign the Protecting the Right to Organize (PRO) Act, which passed the House in March of 2021 but has since stalled in the Senate. The pro-worker legislation would provide for sweeping changes to the National Labor Relations Act, with the goal of enhancing the ability of unions to organize workers. Despite President Biden's support, the PRO Act faces stiff opposition due to the breadth of changes it proposes.

EQUAL PAY PROTECTIONS

President Biden has pledged to sign the Paycheck Fairness Act during his term. Under current law, an employer may, for example, pay a male employee more than a female employee where the reason for the disparity is based on a "factor other than sex." The Paycheck Fairness Act would limit such disparities to bona fide objective factors such as education, training, or experience. The act would also prohibit employers from restricting employees from discussing wage information and require companies to report to the EEOC compensation data correlated to employees' race, sex, and national origin.

BROADER ANTI-DISCRIMINATION LAWS

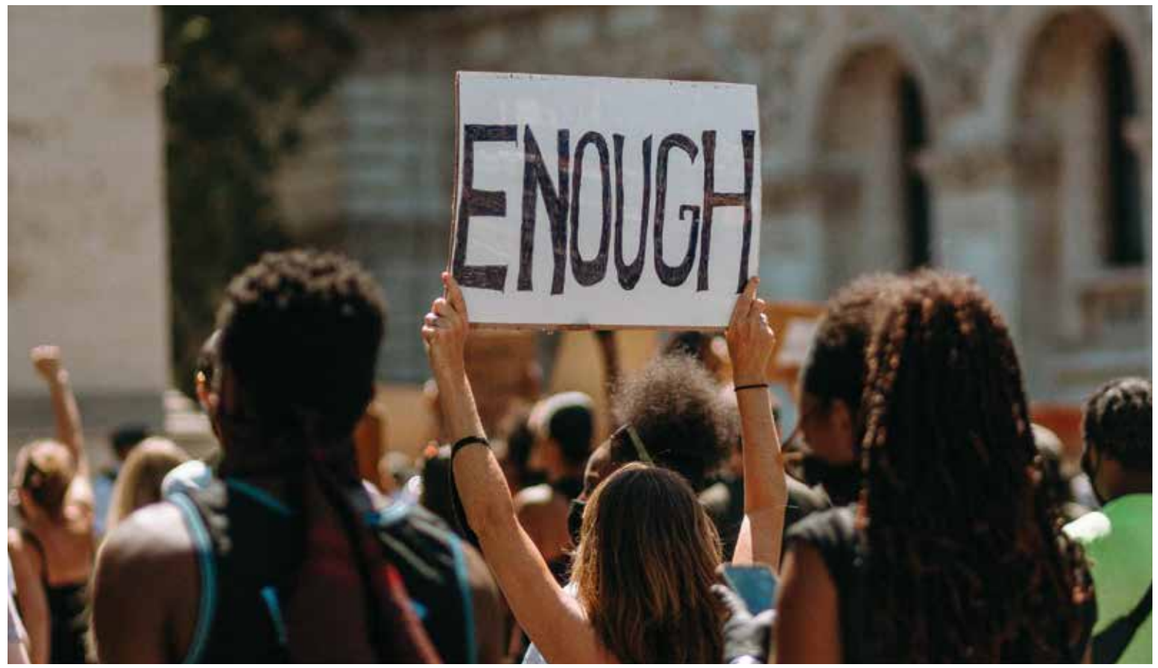
President Biden has stated his support for the Equality Act, which passed the house in February. The Equality Act would prohibit discrimination with respect to employment, housing, education, and public accommodation on the basis of sexual orientation and gender identity. Additionally, Biden has expressed support for expanding protections for pregnant, senior, and disabled employees.

EXPANDED PAID FAMILY LEAVE

President Biden has expressed support for providing employees up to 12 weeks of paid family and medical leave for who are not otherwise covered under the FMLA's leave provisions. Biden's camp has indicated that his proposal for paid leave would include provisions similar to those in the Family and Medical Insurance Leave Act (the FAMILY Act), which has previously been introduced in Congress.

ELIMINATION OF MANDATORY PRE-DISPUTE ARBITRATION

Democrats are expected to pass the Forced Arbitration Injustice Repeal Act of 2019, and Biden has indicated his support. The Act would invalidate pre-dispute arbitration agreements in the employment, civil rights, consumer, and antitrust contexts, and would require employers to litigate workplace disputes in court.



ELIMINATION OF CLASS-ACTION WAIVERS

The Supreme Court has expressly upheld class and collective action waivers in the employment context. Employers utilizing such waivers can currently mandate the resolution of employment-related claims on an individual basis in an arbitration proceeding, thereby minimizing their exposure to potential class-wide liability. President Biden has stated that he would sign legislation prohibiting employers from seeking such waivers.

INCREASED RESTRICTIONS ON NON-COMPETE AGREEMENTS

President Biden has proposed placing limits on non-compete and no-poaching agreements. More specifically, Biden has stated that he will work with Congress to prohibit non-compete agreements with the exception of those "that are absolutely necessary to protect a narrowly defined category of trade secrets" and to eliminate no-poaching agreements altogether.

EXPANDED MINIMUM WAGE

The federal minimum wage is currently less than half the highest state minimum wage (for example, it's $15 for large employers in New York City). Over the last few years, state and local governments nationwide have passed laws steadily increasing their minimum wage rates. President Biden has followed their lead, repeatedly calling for raising the federal minimum wage to $15.

OVERTIME RULE CHANGES

The Biden Administration is expected to ask the Department of Labor to implement benchmark-related increases to the minimum salary for overtime exemption, similar to what President Obama's DOL tried to implement in 2016. Such a change would result in more "white-collar" employees being eligible for overtime pay. Under the 2016 rule, the minimum salary for such workers to be exempt from overtime would have doubled from $23,660 to $47,476 and would have further increased every three years. With support from Congressional Democrats, it's likely the White House will seek to implement similar changes to the overtime laws through a combination of legislative and agency rulemaking processes.

The success of many of these proposed changes remains to be seen. While employers should not expect all of these changes, it is safe to say some of these changes are coming. This office will provide updates as matters develop.

THE SIXTH CIRCUIT'S BURDEN-SHIFTING FRAMEWORK

The effect an employer's failure to maintain adequate records can have on collection litigation

The United States Court of Appeals for the Sixth Circuit recently heard a case in which a union and its associated ERISA funds were seeking to collect fringe benefit contributions from an employer. Bound to a Collective Bargaining Agreement ("CBA") with the union, the employer was required to make contributions to the funds based on all hours worked by its employees within the union's craft jurisdiction. To monitor compliance with the employer's obligations to the funds, the funds conducted a payroll compliance audit on the employer's books and records. The completed audit revealed that the employer had not been making contributions to the funds for three of its employees and owed the funds $199,260.96 in delinquent contributions, along with interest and late charges.

Pursuant to 29 U.S.C. § 1059, an employer has the duty to keep proper records of wages, hours, and other probative facts concerning the nature and amount of work performed by its employees to determine the benefits due or which may become due. Critically, none of the records produced by the employer in this case identified the location of the work performed by its employees. The only evidence that the employer presented was an affidavit stating that the employees performed work "nearly exclusively" outside the geographic jurisdiction of the union. Accordingly, the district court held that the employer was liable to the funds for the audit deficiencies.

In reviewing the lower court's decision, the Court of Appeals applied the burden-shifting framework from *Michigan Laborer's Health Care Fund v. Grimaldi Concrete, Inc*. F.3d 692 (6th Cir. 1994). This framework provides that once trust funds produce evidence that an employer is not making contributions to the funds as required by a CBA, the burden shifts to the employer to produce records showing that the work performed was not within the union's craft jurisdiction. The Sixth Circuit's rationale for this framework is that an employer is in a much better position than the funds to know where its employees performed their hours worked. Furthermore, no distinction between craft jurisdiction and geographic jurisdiction is made for the purposes of the burden-shifting framework.

Here, once the funds presented the audit report to establish that the employer was obligated to pay delinquent contributions, the burden shifted to the employer to show that the work was not performed in the union's craft jurisdiction. Although the employer submitted an affidavit, the Court found that it was insufficient to satisfy the employer's burden of identifying the location of work performed by its employees. Therefore, because the employer failed to meet its burden, the Court upheld the district court's decision requiring the employer to remit payment to the funds for fringe benefit contributions, interest, and liquidated damages.

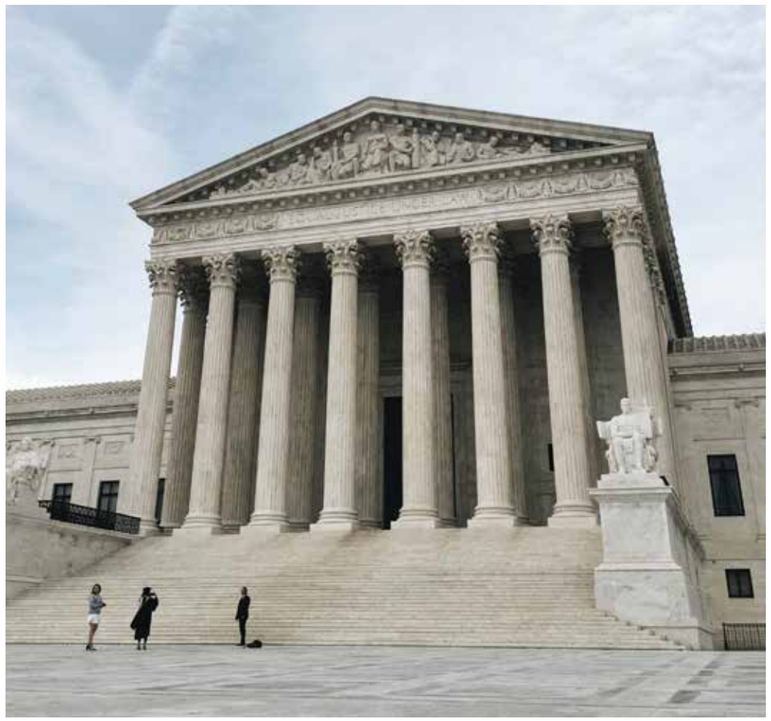
This case is a great illustration of the effect an employer's failure to maintain adequate records can have on collection litigation. Once it is established that the employer has an obligation to pay delinquent contributions to the trust funds, the employer bears the burden of showing that the work performed was not covered by a CBA.

RUTLEDGE V. PHARMACEUTICAL CARE MANAGEMENT

Supreme Court decision introduces a new carve-out to ERISA preemption

On December 10, 2020, the Supreme Court issued a decision on the case of *Rutledge v. Pharmaceutical Care Management*, which clarified the broad, and sometimes cloudy, scope of ERISA preemption. The Court held that an Arkansas statute regulating reimbursement rates for pharmacy benefit managers ("PBMs") was not preempted by ERISA. This decision opens the door for states to impose healthcare cost control measures on ERISA health plans and remain insulated from ERISA preemption.

Rutledge deals specifically with a state requirement that PBMs reimburse pharmacies at no less than their acquisition costs for prescription drugs. Generally, ERISA preempts any state laws that "relate to" employee benefits, including healthcare benefits. This large-scale ERISA preemption of individual state laws allows an ERISA plan to operate with uniformity in its rules relating to plan structure, benefit choices, eligibility standards and central matters of plan administration. ERISA plans adhere to the requirements of the federal ERISA laws, as opposed to all the different rules and requirements each state may have in place for healthcare administration. However, the Supreme Court has addressed the scope of what may "relate to" the administration of an ERISA plan and has carved out certain exceptions for types of state laws that may apply to ERISA plans.



With *Rutledge*, the Supreme Court recognized that "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan," and, thus, would not be preempted by ERISA.[1] The Court found that a state law may not "relate to" employee benefits when the state law merely affects costs. It decided that state regulation of a third party or intermediary that contracts with an ERISA health plan does not "directly regulate health benefit plans at all."[2] This means that the decision of *Rutledge* is not limited in applicability to PBMs, but also applies to the many types of entities that a health plan may hire.

The Court's decision in *Rutledge* supports state laws focused on health care regulation. This expands the states' abilities to apply consumer protections to entities that contract with healthcare plans, including ERISA plans, and improve overall healthcare affordability. The Arkansas regulation at issue in *Rutledge* requires PBMs to participate in a pharmacy's appeal process and abide by its enforcement mechanisms to ensure proper reimbursement for prescription drugs. Other state laws prohibiting surprise billing or requiring disclosures of out-of-network rates may now be applicable to such third-party intermediaries that contract with ERISA plans.

The test for permissible state reform laws attempting to regulate an ERISA plan, established by the case of *New York, et. al. v. Travelers*, is as follows: whether the requirement placed by the state law or regulation is so economically coercive that it effectively forces the plan to adopt a certain scheme of coverage.[3] The Court found that state cost control measures that create an economic incentive for plans or "merely" increase plan costs, like those focused on cost reform, do not exert a coercive effect and are not preempted by ERISA. The *Rutledge* decision expands the types of state laws that may now apply to ERISA plans.

[1] *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 480 (2020).
[2] *Rutledge v. Pharm. Care Mgmt. Ass'n*, 141 S. Ct. 474, 481 (2020).
[3] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 668 (1995).

“The ruling reiterates the need for funds to be clear and concise in their communications.

FIFTH CIRCUIT DECISION COULD HAVE LASTING IMPLICATIONS FOR ERISA FUNDS’ REQUIREMENTS

A recent Fifth Circuit court decision could have a lasting impact on ERISA funds and the requirements imposed on funds in their communications to participants and participants’ beneficiaries. The Fifth Circuit recently held in *Theriot v. Bldg. Trades United Pension Trust Fund* that a pension plan mishandled the claims review process and must reconsider whether to pay benefits to the daughter of a woman who died one day after converting her monthly benefit payment to one lump-sum payment.[1]

The dispute arose after Theriot’s mother completed a form requesting the conversion and returned it to the pension fund on April 4, 2017; she then died the following day, on April 5, 2017. The fund sent a letter to Theriot dated April 18, 2017 and declined to pay her the death benefits available under the lump-sum payout. Theriot then challenged this decision in January 2018, nearly nine months after the fund’s initial letter declining to pay out the benefits.

In March 2018, the fund responded and stated that Theriot’s request for review—the January 5, 2018, letter—”[wa]s untimely” because the fund’s plan document requires a request for review to be submitted within 60 days of a notice of denial, which was noticed on April 18, 2017. Due to the untimely request for review, the fund stated that it “reserve[d] the right to assert that [Theriot] . . . failed to exhaust administrative remedies” and that Theriot had foreclosed her ability to seek judicial review. The fund also attached a copy of the plan’s relevant provision regarding the procedural requirements to exhaust administrative remedies.

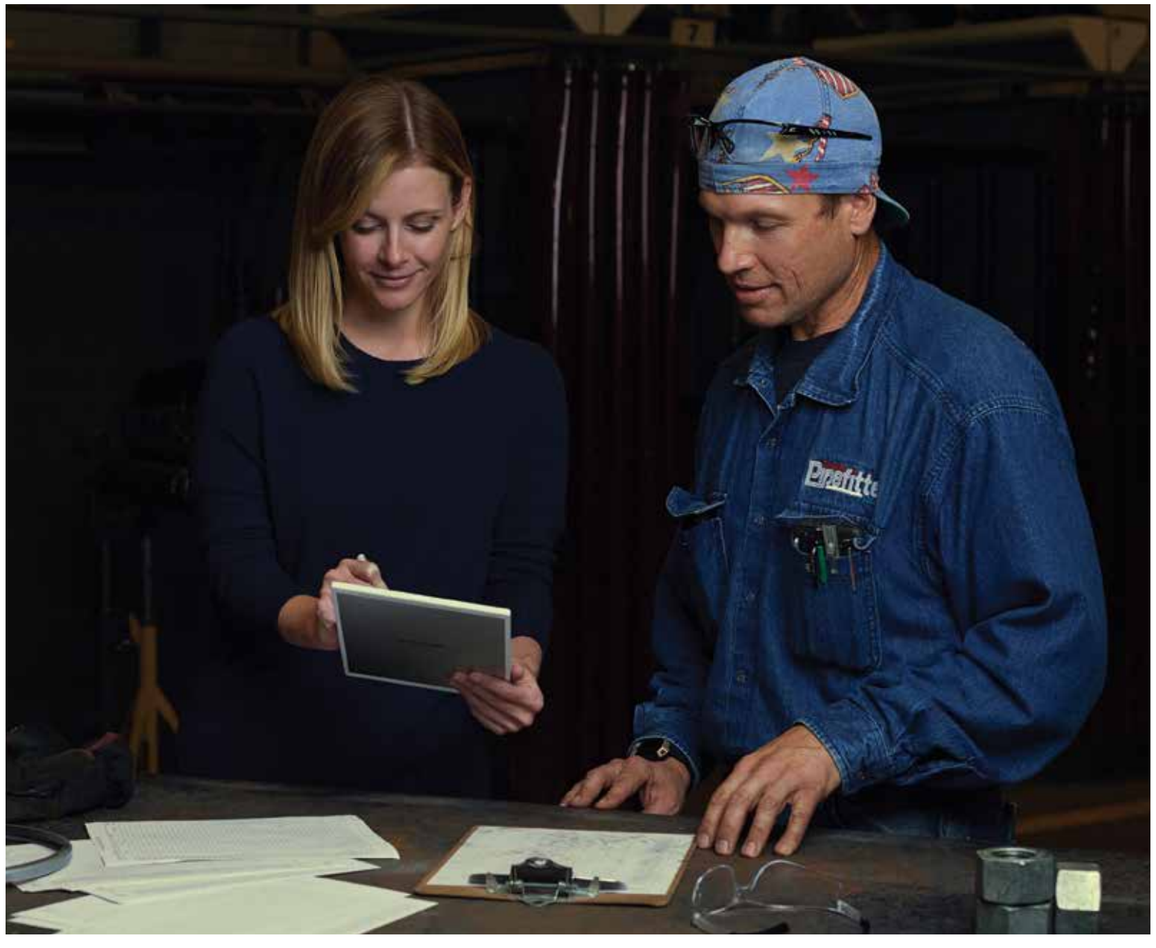
In ordering the pension fund to reconsider the claim on the merits, the Fifth Circuit reasoned that the fund did not substantially comply with ERISA’s requirement that a denial letter explain the plan’s administrative review procedures, as the letter it sent to Theriot failed to give a sufficient explanation of the available administrative appeal rights, and the letter “actively discouraged” her from seeking review of the decision by telling her she’d filed her request too late.

As you may know, 29 C.F.R. § 2560.503-1(j)(4) requires any denial notice to “describ[e] any voluntary appeal procedures offered by the plan.” Courts have required that a denial notice need only “substantially compl[y]” with ERISA’s requirement that the notice describe the available administrative remedies.[2] A denial notice substantially complies with ERISA if it fulfills the purpose of ERISA § 1133, which is to afford the claimant “an explanation of the denial of benefits that is adequate to ensure meaningful review of that denial.”[3]

Theriot could have serious implications for the communications that an ERISA fund has with its participants and participants’ beneficiaries; specifically, it appears the Fifth Circuit has expanded the requirements imposed on ERISA funds and incorporated a question as to whether a fund’s communication “actively discourages” a claimant from seeking administrative review of a denial of benefits claim. The ruling reiterates the need for funds to be clear and concise in their communications to participants and beneficiaries, to substantially comply with the notice requirements of ERISA, and to outline the administrative procedures available to a claimant under the fund’s plan document.

If you have any questions regarding your fund’s communications with participants and beneficiaries, would like clarification on the requirements contained in ERISA, or would like J+K to review your fund’s form communications, please feel free to contact our office.

[1] 2021 BL 88481, 5th Cir., No. 20-30126, unpublished March 12, 2021.
[2] *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256–57 (5th Cir. 2005).
[3] *Lafleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 154 (5th Cir. 2009).



PLAN LANGUAGE RAISES QUESTION OF SUBROGATION RIGHTS

A lawsuit filed in Pennsylvania federal court is raising the question of whether the plan language in a Summary Plan Description authorizes ERISA-governed health benefit plans to seek reimbursement directly from a plan member.

A Princeton University health insurance plan ("Health Plan") has been named as one of the defendants in a class action lawsuit alleging that the Health Plan wrongfully demanded reimbursement for claims paid out in personal injury settlements. Additional defendants include the Health Plan's claims administrator and subrogation contractor, Aetna Life Insurance Company and The Rawlings Company LLC, respectively. The plaintiffs consist of members of the Health Plan that had reimbursement demands asserted against them by the defendants after seeking recovery for personal injuries. The lead plaintiff, Andre Corbitt, alleges that after receiving a settlement for a 2016 injury in which he received treatment that was paid for by the Health Plan, the Health Plan violated the terms of his insurance policy, ERISA and New Jersey state law by demanding reimbursement for the claims it had paid directly to providers from him, a plan member. The plaintiffs are seeking to recover the monies they repaid to the Health Plan as a result of the defendants' subrogation demands.

Corbitt argues that nothing in his insurance policy allowed any of the defendants to subrogate directly from a plan participant. He references the Health Plan's Summary Plan Description language which states that "the Princeton University Health Care Plan has the right to pursue subrogation against any person or insurer," and argues that the language does not authorize the defendants to recoup monies from the plan members directly, but instead, only from responsible third parties. He states that the language is legally insufficient to hold plan members personally responsible for repaying health plans for benefits paid to third-party injuries. Corbitt alleges that by asserting entitlement to reimbursements, the defendants "actively, affirmatively, and systematically" misinformed the plan members.

Defendants responded to the Complaint in early March by filing a Motion to Dismiss for Failure to State a Claim, arguing that the language of the Health Plan's subrogation provisions does permit the defendants to seek reimbursement from the plan members. The defendants claim that "any person or insurer" applies to both plan members and third parties, thus authorizing them to seek reimbursement directly from plan members after they have received a settlement. They also state that the present lawsuit mimics several other class actions filed by the same counsel in which participants of ERISA-governed health benefit plans have attempted to recover benefits that they repaid to their health plans, but that all reimbursements were pursuant to the agreed-upon subrogation provisions of their plans.

In the initial Complaint, Corbitt states that the defendants were in violation of New Jersey's Collateral Source Statute, which bars insurers from demanding reimbursement from personal injury recoveries. (N.J.S.A. § 2A:15-97). The defendants refute this claim in their Motion to Dismiss, citing Section 514(a) of ERISA, which states that ERISA preempts any state law relating to an employee benefits plan. (29 U.S.C. § 1144(a)).

After initially being filed in Pennsylvania state court, this case has since been removed to federal court, since it arises under ERISA. The court has yet to make a ruling in the defendants' Motion to Dismiss.

The plaintiffs are seeking to recover the monies they repaid to the Health Plan as a result of the defendants' subrogation demands.

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