AMERICAN BAR ASSOCIATION
Tort Trial and Insurance Practice Section

Fall 2020

COMMITTEE NEWS

Health and Disability & Life Insurance Law

TEXAS

The Northern District of Texas Reaffirms the Right to Rely on an Opinion by a Non-Treating Specialist in ERISA Long-Term Disability Cases

Adam Reich and
Katie Derrig
Lewis Roca Rothgerber Christie

In *Ingerson v. Principal Life Ins. Co.*, No. 2:18-CV-227-Z-BR, 2020 WL 3118693 (N.D. Tex. June 12, 2020), an ERISA-governed long-term disability case, the U.S. District Court for the Northern District of Texas reaffirmed Fifth Circuit precedent allowing for independent physicians to give expert testimony based on their review of medical records rather than requiring them to examine a claimant personally.

On March 13, 2015, the plaintiff was terminated from his position as a sales manager. Ten days later, the plaintiff filed a claim for short-term disability benefits under a long-term disability ("LTD") policy issued by Principal. The plaintiff listed narcolepsy and "sleep disorder" as the qualifying conditions for the disability claim, and listed the date of occurrence as March 13, 2015. Principal initially approved short-term disability benefits based on the plaintiff's stated inability to perform his job and a statement by his physician that he suffered from "narcolepsy, difficulty staying awake, and extreme daytime fatigue."

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Cont. on page 10

Katie Derrig *is a 3L at the University of Arizona James E. Rogers College of Law and the Editor-in-Chief of Arizona Law Review. She graduated in 2015 from Arizona State University with her B.A. in Russian Language and has studied and taught English in Russia. Prior to law*
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In This Issue

Chairs Message

Dear Committee Members:

This is the first of several newsletters for the 2020-2021 bar year, which will be different than past years for two significant reasons.

First, the COVID-19 pandemic has upended all of our lives and our practices. As we each adjust how we practice law, so too must we adjust how our respective committees operate in this new environment. Our annual Mid-Winter Symposium, which the Health and Disability Insurance and Life Insurance Committees co-sponsor with the Insurance Regulation and Employee Benefits Committees, will be a series of webinars presented on a series of Fridays in January 2021. We hope to return to an in-person Mid-Winter Symposium in early 2022.

Additionally, second, this will be the Health and Disability Insurance Committee's and Life Insurance Committee's final year as separate committees. After discussing the issue for years, our Committees have decided to merge. Intellectually, the merger makes sense due to ERISA largely controlling all three types of insurance products and the fact that many of us handle claims involving all three products. Socially, in the past these two Committees have co-sponsored many panels successfully and thus have a long history of working together. We look forward to offering the same quality of learning opportunities and perhaps even improving our portion of the seminars. You will be hearing more information about the merger in the coming weeks and months.

Both Committees continue to publish our joint newsletter several times a year. We are continually looking for additional content, and you are welcome to contact us or Daniel Thiel (dthiel@lrrc.com), the Health and Disability Insurance Committee's Newsletter Vice-Chair, with any article ideas you have.

Sincerely,

Adam and Heather

Adam H. Garner

Chair of the Health and Disability Insurance Law Committee

***Adam H. Garner** is the founder of The Garner Firm, Ltd., a boutique employee benefits and employment law firm in Philadelphia, Pennsylvania. He represents employee benefit plan participants and their dependents in all facets of ERISA and employee benefits litigation as well as insureds in disability, life insurance, and bad faith litigation.*

Heather Karrh

Chair of the Life Insurance Law Committee

***Heather Karrh** is a partner in the firm of Rogers, Hofrichter & Karrh, LLC. Her practice involves representing plaintiffs in life, health and disability cases covered by ERISA and Georgia law. She is AV rated and has been selected as a Rising Star by Super Lawyers Magazine for 2009-2013. She received a J.D. from the University of Georgia School of Law and a B.A. from Tulane University with honors. She was born and raised in Swainsboro, Georgia. She now lives in College Park, Georgia.*

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MASSACHUSETTS

Denial Of Accidental Death Benefits Upheld

In *Arruda v. Zurich Am. Ins. Co.*, 951 F.3d 12 (1st Cir. 2020), the First Circuit Court of Appeals reversed a decision by the U.S. District Court of Massachusetts and held that Zurich's decision to deny accidental death benefits was not arbitrary and capricious.

Arruda was a participant in an employee benefit plan provided by his employer that included accidental death coverage. The coverage was funded by a policy issued by Zurich.

Arruda had a history of heart disease. In 2014, he had a defibrillator implanted in his chest. In May 2014, while driving, Arruda's car crossed a highway median into oncoming traffic and struck another car causing Arruda's car to hit a curb and flip multiple times. Arruda was pronounced dead on the scene. Arruda's widow filed a claim for accidental death benefits. After a lengthy investigation, Zurich denied the benefits. Suit followed.

The policy provided the benefit if the death was the result of a covered injury. A covered injury was defined as an injury directly caused by accidental means, which is independent of all other causes and results from a covered accident. A covered accident was defined as an accident that results in a covered loss. The policy also contained an exclusion that a loss would not be a covered loss if it was caused by, contributed to or resulted from illness or disease.

In its decision, Zurich relied on an opinion from a Dr. Bell that Arruda's death was caused by his heart disease. A similar opinion was rendered by a Dr. Angell. The autopsy report also concluded that the cause of death was hypertensive heart disease. Similarly, a Massachusetts State Police report and an EMS report attributed the death to a medical episode while driving and cardiac arrest. Finally, a Dr. Taff found that Arruda's accident was caused by several pre-existing illnesses or diseases. He also concluded that Arruda died from accidental bodily injuries.

Arruda's widow submitted a report from a former medical examiner, Dr. Laposata, that concluded Arruda's death resulted from injuries sustained in the auto accident. While Dr. Laposata could not explain what caused Arruda to travel across traffic lanes and hit another vehicle, she found no evidence that he experienced incapacitation by heart disease. The widow also submitted a log book report which tracked Arruda's defibrillator. The log showed no measured "events" prior to the accident.

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Joseph M. Hamilton is a Partner at Mirick O'Connell and Co-Chair of the Firm's Life, Health, Disability and ERISA Litigation Group. He concentrates his practice in life, health and disability insurance defense, and ERISA. Mr. Hamilton serves as counsel for numerous life, health and disability insurers and self-insureds at all levels of the state and federal courts. Mr. Hamilton is a past Chair of the ABA's Life Insurance Law Committee.
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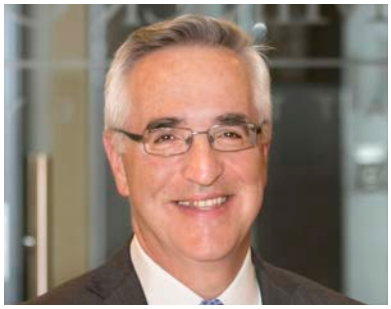

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IRS Guidance Allows Certain Mid-Year Benefit Election Changes in Response to COVID-19

On May 19, the IRS issued *Covid-19 Guidance Under 125 Cafeteria Plans & Related to High Deductible Health Plans*, 2020-22 I.R.B. 864 (2020) which permits an employer to amend its code section 125 cafeteria plan (Cafeteria Plan) to allow certain mid-year election changes, which are generally prohibited, related to health coverage, health flexible spending accounts and dependent care assistance programs as a result of 2019 Novel Coronavirus (COVID-19).

A Cafeteria Plan is an arrangement pursuant to which an employer offers employees the ability to choose between cash and one or more qualified benefit. This type of arrangement is what allows employees to get certain pre-tax benefits, such as paying for medical premiums on a pre-tax basis. In general, elections for benefits provided through a Cafeteria Plan are irrevocable for a plan year, however, if an employer desires, it can allow for certain prospective election changes as a result of a change in status or change in the cost of coverage, amongst other things. Employers are not required to allow for any of the permissible mid-year election changes specified under 26 U.S.C.A. § 125 (West) (the "Code"). In general, health flexible spending accounts may but are not required to allow participants to (i) carry over a certain amount in their health flexible spending account at the end of a plan year to use toward eligible medical expenses incurred in the subsequent year or (ii) use unused amounts during a grace period of up to two months and 15 days in the following year. Dependent care assistance programs may provide for a grace period but cannot permit carryover of unused funds.

As a result of the restrictions put into place in many states resulting in the closure of many day cares and summer camps as well as individuals' weariness to go to doctors' appointments, employers and employees alike were concerned that money previously set aside in health flexible spending accounts and dependent care assistance programs could be unused and ultimately forfeited due to unexpected changes in the need or availability of certain health and day care providers. The issuance of *Covid-19 Guidance Under 125 Cafeteria Plans and Related to High Deductible Health Plans*, 2020-22 I.R.B. 864 offers welcome relief.

Notice 2020-22 I.R.B. 864 allows an employer to amend its plans to (i) change health care coverage and/or (ii) change contributions to health flexible spending accounts or dependent care assistance programs, which were previously not permitted by the mid-year election change rules. It also extends the amount of time that employees can spend money that was contributed to a health flexible spending

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Megan Monson
Lowenstein Sandler LLP

With a focus on ensuring compliance and minimizing cost, Megan advises businesses and C-suite executives on a wide variety of employee benefits and executive compensation matters. She represents an array of public and private businesses of varying sizes and across multiple industries. Megan's experience ranges from plan design, implementation, and ongoing administration and compliance through termination. She provides legal counsel pertaining to tax qualified plans, welfare plans, and Affordable Care Act issues, as well as on deferred compensation and equity arrangements intended to attract and retain employees.

Megan also assists in the negotiation of employment and separation agreements and applies honed skills in both company and executive representation. Due to her exposure to analyzing the issues from both perspectives, Megan is able to effectively negotiate, identify, and advise on potential problems before progress can be obstructed. Moreover, she provides counsel on the employee benefits and executive compensation aspects of business transactions. This includes assisting with the transition of employee benefits arrangements; implementing new benefits arrangements such as retention bonuses, management incentives, and equity plans; complex 280G analyses and completion of shareholder votes; and negotiating the terms of benefits deal documents.

Prior to joining Lowenstein Sandler, Megan worked as a tax consultant for Deloitte Tax LLP. While attending law school, she served as a judicial intern for the Hon. Freda L. Wolfson of the U.S. District Court for the District of New Jersey.

MASSACHUSETTS

Autoerotic Asphyxiation Not Encompassed Within Accidental Death Coverage

In *Wightman v. Securian Life Ins. Co.*, 453 F. Supp. 3d 460 (D. Mass. 2020), *appeal dismissed,* No. 20-1493, 2020 WL 6588713 (1st Cir. Aug. 31, 2020), the U.S. District Court of Massachusetts upheld Securian's decision that a death due to autoerotic asphyxiation was not unintended, unexpected and unforeseen and also constituted a self-inflicted injury.

Colin Wightman was enrolled in a group life insurance plan provided by his employer, and funded by a policy issued by Securian. The claim was governed by ERISA. His wife was the beneficiary. In 2016, Wightman died in his apartment. He was found by his wife naked and hanging from the bathroom door with a belt looped around his neck. Previously, Wightman had been interested in autoerotic asphyxiation, had told his wife of his interest, and had received mental health treatment for it.

The medical examiner determined Wightman's death to be an accident due to autoerotic asphyxiation. Wightman's wife submitted a claim for benefits under the life insurance coverage. Securian paid benefits, but denied accidental benefits. Securian denied the benefits on the grounds that a death by autoerotic asphyxiation was not encompassed within the coverage, which required the accidental bodily injury to be unintended, unexpected and unforeseen. Securian also found that the claim was not payable based on the plan's exclusion for intentional self-inflicted injury or an attempted self-inflicted injury. Suit followed.

The court applied the *de novo* standard of review. The court first agreed with Securian that Wightman's death was not an accidental bodily injury covered under the policy. The court applied the analysis employed by the First Circuit in *Wickman v. Nw. Nat. Ins. Co.*, 908 F.2d 1077 (1st Cir. 1990). Applying that analysis, the court found that while Wightman did not expect to suffer the injury he experienced, the loss of oxygen and subsequent death was not unexpected, unintended or unforeseen. Therefore, Wightman's expectation was not reasonable.

The court also agreed with Securian that the claim was barred due to the exclusion for intentional self-inflicted injuries. The court found that when an individual purposely places a belt around his neck, purposely employs that belt to cutoff blood flow, and ultimately dies from the very strangulation which he initiated, that person has died from one continuous self-inflicted injury.

The court entered summary judgment in favor of Securian.

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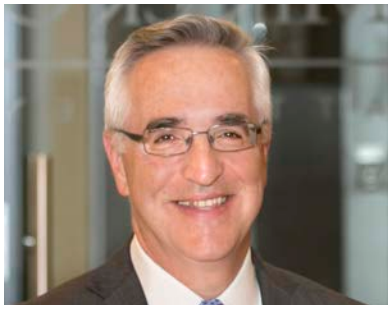

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DOL Releases New Model COBRA Notices Amid Continued Wave of Litigation



Sherril Colombo, Stefanie Mederos, and **Finn Pressly**

Littler Mendleson P.C.

Sherril Colombo *is the immediate former Chair of the ABA TIPs, Health & Disability Subcommittee. Sherril focuses her practice in the areas of ERISA, health and disability, COBRA rights and employment law. Sherril is also a Florida Board Certified Labor & Employment attorney.*

Stefanie Mederos *is a Shareholder at Littler Mendleson P.C. litigating ERISA group disability and life benefits, discrimination, retaliation, harassment and other wrongful termination matters. She spends her spare time with her husband and three daughters and volunteering for several community service organizations.*

Finn Pressly *is a partner in Littler's employee benefits practice group. He specializes exclusively in health and welfare benefit compliance and routinely advises employers in a wide-range of issues, including ERISA, COBRA, HIPAA, and the Affordable Care Act. He received his LL.M. in Taxation from the University of Florida, his J.D. from the Notre Dame Law School, and his B.A. from the University of Notre Dame. Finn is licensed to practice in Florida, Illinois, and Hawaii.*

On May 1, 2020, the Department of Labor released new versions of its model COBRA notices, adding a new action item for employers facing a contracting workforce and a growing wave of participant litigation.

The new general notice and election notice are nearly identical to their prior versions, with the exception of new sections explaining how Medicare eligibility affects COBRA participants. In particular, the new language outlines the Medicare election obligations and how these rules impact Medicare-eligible employees who have just lost their employer-sponsored active employee coverage. The new language also highlights that COBRA coverage usually pays secondary to Medicare (or what Medicare would have paid if no Medicare coverage has been elected). The DOL also issued a companion set of FAQs that offers more detailed information about the coordination between COBRA and Medicare.

Employers are not required to follow the model notices, so there is no specific "effective date" for implementing the changes recommended in the model notices. Employers that follow the model notices, however, will be deemed to have complied with COBRA's notice requirements. For that reason, employers concerned with COBRA compliance should consult with their COBRA administrators to ensure their notices are updated as quickly as possible.

The model notice is only one method to satisfy the COBRA notice requirements, although there is very little reason not to use the model notice or something very substantially similar to it. If the model notice is not used, the COBRA notice actually used by an employer must be written in such a manner so that it is understood by an average plan participant so that the participant can make an informed decision as to the rights and obligations for continued COBRA coverage.[1] This has been interpreted as creating an objective standard, rather than requiring an inquiry into the subjective perception of the plan participant. Class action lawsuits have recently arisen arguing novel theories as to what should be included in a COBRA notice when the model notice is not utilized. While recognizing that the model notice is not mandatory, plaintiffs in these class actions often argue that if certain terms from the model notice are not included in the COBRA notice, then the particular notice is misleading with the cumulative effect of not providing a participant with enough information to make an informed decision on continued coverage. These alleged deficiencies include the failure to identify the Plan Administrator and the Administrator's contact information, to provide the address for the COBRA payments, and the date continued coverage

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MASSACHUSETTS

Third Party Administrator Found To Be Proper Defendant In ERISA Benefit Suit

In *Willitts v. Life Ins. Co. of N. Am.,* No. 1:18-CV-11908-ADB, 2020 WL 2839091 (D. Mass. June 1, 2020), the U.S. District Court for the District of Massachusetts upheld the denial of further short term disability benefits, dismissed common law claims on ERISA preemption grounds, and held the third party administrator, LINA, was a proper party to the case.

Willitts filed a claim for STD benefits under the benefit plan provided by his employer. The plan was administered by LINA pursuant to a claims consulting agreement. Willitts filed a claim for STD benefits for depression and anxiety. After paying STD benefits for a period of time, LINA determined that Willitts was not entitled to further benefits. That determination was upheld on appeal. Suit followed.

The court first determined that the benefit plan was governed by ERISA and that the plan explicitly granted discretionary authority to LINA to determine whether a claimant was eligible for benefits.

Given that the benefit claim was governed by ERISA, the court dismissed Willitts' common law claims of breach of contract, breach of the implied covenant of good faith and fair dealing, breach of fiduciary duty, fraud, intentional infliction of emotional distress, and unjust enrichment.

LINA had also moved for dismissal on the grounds that it was not a proper party to the case because it only provided claims administration services and the employer self-funded the plan. However, the court found that the plan provided that LINA was the plan administrator and the named fiduciary for adjudicating claims for benefits and deciding any appeals. The key factor in the court's determination was the plan document naming LINA as the plan administrator. Perhaps it would have been a better course to have simply named LINA the claim administrator.

Going to the merits of the case, the court found that LINA's determination was not arbitrary or capricious. The court held that LINA had a reasonable basis to deny benefits based upon the fact that there was no documentation of work tasks or activities that Willitts was unable to perform or documentation of performance deficits at work. The medical records submitted by Willitts were based solely on self-reported symptoms and did not include any objective medical evidence to support the disability claim.

The court granted summary judgment in favor of LINA.

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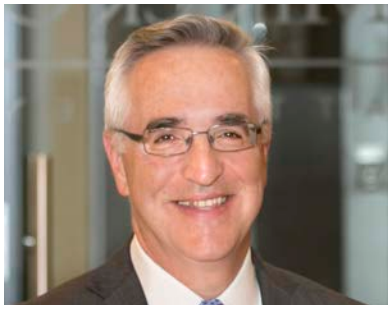

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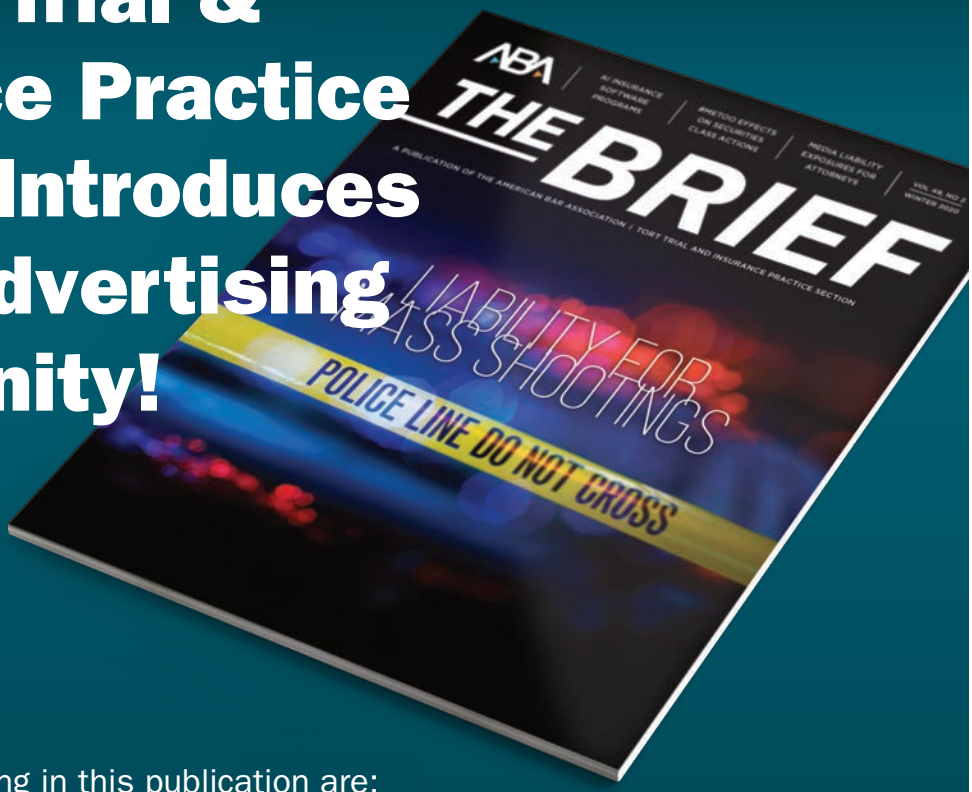

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THE BRIEF

The Northern... Continued from page 1

Two months later, plaintiff's former employer informed Principal that the plaintiff had been terminated for performance issues. Principal then requested that the plaintiff provide medical records from his physician to support his disability claim. The plaintiff failed to provide these records by the deadline. Principal then notified the plaintiff it was denying both continuing short-term disability benefits and LTD benefits due to insufficient evidence of an alleged disability or inability to work.

The plaintiff appealed, submitting a letter from his physician stating that plaintiff was in treatment for narcolepsy. He also submitted two letters from his former employer explaining how the plaintiff's medical condition prevented him from fulfilling his job duties. Principal then sought a peer review of the claim with a specialist in pulmonary and occupational medicine. That physician found that the plaintiff was capable of performing his job on a full-time basis with several restrictions and limitations in place.

After reviewing this additional information, Principal reinstated the plaintiff's benefits, requiring that he provide periodic updates on his status and treatment, and that he remain "unable to perform the majority of the Substantial and Material Duties of his Own Occupation."

Although it approved benefits, Principal continued its evaluation of the claim. After an extensive interview of the plaintiff by a third-party investigator and an examination by an independent neuropsychologist, who stated that he believed the plaintiff "could function without limitation in the workplace," Principal determined that the plaintiff was no longer eligible for short-term or LTD benefits.

The plaintiff appealed the decision, providing additional records documenting his treatment. In response, Principal requested an examination of the plaintiff by either a sleep specialist or an occupational medicine specialist, but the plaintiff did not respond. Principal then sought a panel review by specialists in internal medicine and sleep medicine who conducted a peer-to-peer call with the plaintiff's physician. The peer review report found that the plaintiff could perform his job duties without restriction or limitation.

Another report issued by Dr. Newman, a pulmonary disease and sleep medicine specialist, affirmed this finding, concluding that the plaintiff could perform his job duties for the relevant period without restriction. Dr. Newman's report relied on the plaintiff's medical records, noting that the plaintiff had not undergone a sleep study since 1999, the narcolepsy was mild, the plaintiff had failed to utilize treatments that would help the condition, and the plaintiff needed to see a sleep disorder specialist. Based on these reports, Principal affirmed its denial of the plaintiff's claim for LTD benefits.

***Adam Reich Bio**... Cont. from page 1*

and federal courts throughout the United States in a variety of areas, including catastrophic personal injury and wrongful death, claims under the Federal Employers Liability Act, and commercial disputes. Adam graduated magna cum laude from the Sandra Day O'Connor College of Law at Arizona State University in 2011 and is licensed to practice in Arizona.

***Katie Derrig Bio**... Cont. from page 1*

school, Katie worked as a Plan Documents Specialist for a retirement plan third-party administrator, where she was certified as both a Qualified Pension Administrator and Qualified 401(k) Administrator through the American Society of Pension Professionals & Actuaries. Katie has accepted a post-graduate job offer with Lewis Roca Rothgerber Christie LLP, expected Fall 2021.

The plaintiff then brought suit in federal court to recover disability benefits and attorney's fees under ERISA section 1132(a)(1)(B), claiming Principal abused its discretion in denying his disability claim. Principal denied liability and filed a counterclaim seeking attorney's fees. A magistrate judge tried the case on the administrative record and briefings, and found that the plaintiff had failed to meet his "burden to show his narcolepsy prevented him from performing the majority of the substantial and material duties" of his job from the time his benefits were denied through June 12, 2017. In making this determination, the magistrate reviewed the persuasiveness of each party's case *de novo* to determine if the plaintiff sufficiently established his disability under the policy.

The magistrate relied heavily on the opinion of Dr. Newman, finding it to be one of the few persuasive pieces of evidence. She found the report compelling because Dr. Newman: (1) was a sleep specialist and based his opinion on records relevant to the time period at issue; (2) considered the plaintiff's explanation of his duties and the letter from Saiz stating the plaintiff was terminated due to his health issues; and (3) cited reasons for his findings which were supported by the record. Because the report was one of the few opinions the magistrate found persuasive, and it indicated that the plaintiff was fully able to complete his job duties without restriction, the judge recommended a judgment in favor of Principal.

In an unusual twist, the magistrate also awarded attorney's fees to Principal. The judge reasoned that attorney's fees are awardable under ERISA, and fees can be awarded where "the court can fairly call the outcome of the litigation some success on the merits" for the party seeking the award. Because Principal had achieved success on the merits, the magistrate awarded it attorneys' fees.

The plaintiff objected to the magistrate's findings, claiming it was error for the judge to rely on Dr. Newman's report where he did not personally examine or test the plaintiff and objecting to the finding of attorney's fees for Principal. In rejecting the first argument, the court relied on both Supreme Court and Fifth Circuit precedent holding that physicians may rely on reports from other physicians to develop their own opinions without needing to examine the claimant personally.

More specifically, the court cited to *Anderson v. Cytec Indus., Inc.*, 619 F.3d 505 (5th Cir. 2010), which held that expert evaluations of a psychiatrist and a psychologist based solely on a review of the claimant's medical records could not be invalidated merely because they did not personally examine the claimant. To come to this conclusion, both the court in *Anderson*, 619 F.3d 505 and *Ingerson* relied on Supreme Court precedent that held there is no requirement for plan administrators to "give special deference to the opinions of *treating* physicians." Because there is

no requirement to give deference to treating physician opinions, the court reasoned that a "medical report not based on direct examination" could not be invalidated solely on that basis.

The district judge also denied the plaintiff's objection to the award of attorney's fees to Principal. In his objection, the plaintiff pointed to the five-factor test of appropriateness of an attorney's fees award found in *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255 (5th Cir. 1980); he claimed that two of the factors weighed in his favor, and so the magistrate erred in recommending the award of fees to Principal. The district judge rejected this argument, noting that it is within the magistrate's discretion to award fees, and they have no requirement to consider the *Bowen* factors. The court further found that the magistrate has discretion to award fees where the claimant has shown "some degree of success on the merits." *Id.* Because the only requirement to award fees is a showing of some degree of success on the merits, the district judge held that the factors in *Iron Workers Local No. 272*, 624 F.2d 1255 could not be construed as a strict requirement and upheld the fee award.

Denial... Continued from page 4

The district court held that Zurich's decision was arbitrary and capricious. Zurich appealed.

The First Circuit held that Zurich's determination that Arruda's death was caused or contributed to by pre-existing medical conditions was supported by substantial evidence and was not arbitrary and capricious. The court found that the record before Zurich of the causes that contributed to Arruda's death were all consistent that his crash was caused, at least in part, or was contributed to by his pre-existing medical conditions. Taking all of those materials and medical opinions as a whole, the court held that Zurich's conclusion was not undermined because Arruda's expert, Dr. Laposata's opinion differed. As the court noted, in the First Circuit "the existence of contradictory evidence does not, in itself, make the administrator's decision arbitrary." The court seemed to be particularly convinced that the third party reviewer used by Zurich on appeal, Dr. Taff, could be relied upon by Zurich because he carefully ruled out other possible causes of Arruda's accident, gave a detailed account of Arruda's medical history, acknowledged potentially conflicting evidence, and came to a reasoned conclusion. The court also noted that a reviewing court should not find an insurer's decision to be arbitrary when the insurer relies on several independent experts.

IRS Guidance... Continued from page 5

account or dependent care assistance program. For contributions made in 2019 that could have been used through a grace period in 2020, those amounts can be used to pay or reimburse eligible medical or dependent care expenses, respectively, through December 31, 2020. This relief is extended to both plans with a grace period and plans that provide for a carryover.

With respect to employer sponsored health-coverage (whether or not self-insured), the guidance allows (i) employees to make new elections if they initially declined coverage, (ii) to revoke an existing election and enroll in different health coverage with that employer or (iii) to revoke an existing election, provided such employee attests in writing that the employee has or will immediately enroll in other health coverage not sponsored by the employer. A sample attestation is provided in *Covid-19 Guidance Under 125 Cafeteria Plans and Related to High Deductible Health Plans*, 2020-22 I.R.B. 864.

Individuals with health flexible spending accounts or dependent care assistance could revoke an election, make a new election or increase or decrease an existing election.

To take advantage of the relief afforded by Notice 2020-22 I.R.B. 864, an employer must amend its plan prior to December 31, 2021, which amendment may be retroactive to January 1, 2020, provided proper procedures are followed.

According to the Notice, to prevent an employee from making an adverse selection in coverage, an employer may choose to limit permitted election changes to circumstances that increase or improve the employee's coverage (e.g., switching from self to family coverage).

Employers should review the guidance and consider, in consultation with advisors, whether to revise their Cafeteria Plans to allow for any or all of the permitted changes.

DOL Releases... Continued from page 7

terminates if coverage is elected, among other alleged technicalities. The plaintiffs also often argue they have suffered both economic and informational injury, which entitles them to relief. Motions to dismiss these cases are not often successful, and the claims (to date) have mostly resolved on a class-wide basis before adjudication on the merits.

In an action for allegedly providing a deficient COBRA notice, a court may award statutory penalties, injunctive and other equitable relief, attorney's fees and costs, and "such other relief as it deems proper."[2] Statutory penalties are in the court's discretion up to a maximum of $110 per day.[3] They are meant to be punitive in nature and, as a result, courts consider several factors in determining the appropriate penalty, including the extent to which the plaintiff suffered injury or prejudice and if the violator acted with bad faith or gross negligence. Invoking the provision for other relief, plaintiffs also often seek actual damages, which courts have determined include expenses incurred as a result of the COBRA violation minus deductibles and premiums incurred from the date of the qualifying event to the date of any COBRA notice.

While the amounts of damages at issue may seem relatively small on an individual basis, plaintiffs in COBRA violation actions routinely seek class certification to allow multiple employees or former employees to jointly seek relief, contending that they have the right to do so because they are asserting the same or similar allegations. The plaintiffs in those actions often collectively seek hundreds of thousands of dollars in damages.

An employer cannot escape liability for issuing an improper COBRA notice, even if it has contracted with a third-party administrator to issue such notices. As a result, employers should pay careful attention to the terms of their COBRA notices to ensure that they comply with COBRA's requirements. Employers negotiating new service agreements should also keep a close eye on the indemnification provisions in their agreements to ensure that they have adequate protection in the event the third-party administrator fails to properly issue the notices.

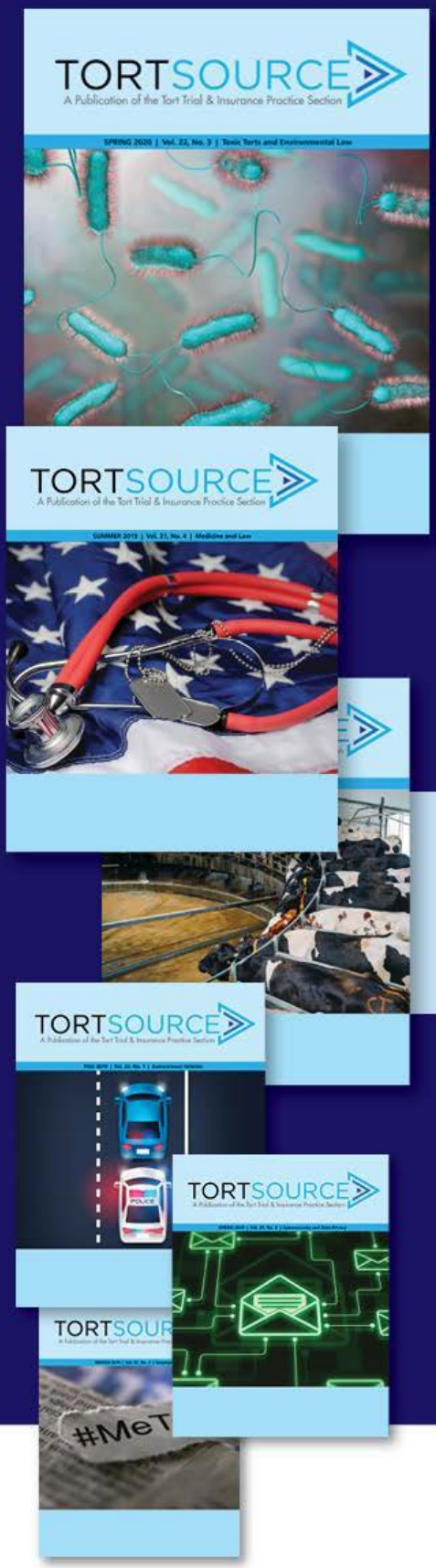
Lastly, note the DOL's model notices are available in both English and Spanish. Employers with a multilingual workforce may want to consider whether they should produce translated versions of the notice, based on the language(s) spoken by the "average plan participant."

Endnotes

1 29 CFR § 2590.606-4(b)(4).

2 29 U.S.C.A. § 1132(c)(1) & (g) (West).

3 29 U.S.C.A. § 1132(c)(1) (setting forth penalties of $100 per day); 29 C.F.R. § 2575.502c-1 (increasing penalties to $110 per day).



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