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Litigation Trends in Health & Welfare

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Litigation Trends in Health & Welfare

COBRA Notice Litigation

- DOL provides a model notice updated to comply with the ACA (including a Spanish translation), but COBRA regulations have not been updated to reflect ACA.
- COBRA notice violations have been popular with plaintiffs' class action lawyers in Florida.
- Class claims have included:
  - Timing, technical deficiencies with the notices.
  - Challenges based on English-only notices where the "average participant" in workforce may not speak English.

COBRA Notice Litigation

- In Hicks v. Lockheed Martin Corporation , No. 8:19-cv-00261, (M.D. Fla.), plaintiff, seeking to represent a class, alleged that Lockheed's COBRA notices did not comply with the DOL's regulation by failing:
  - to identify a termination date for the coverage, location of where payments should be sent and the name of the plan administrator.
- Even though Plaintiff complained about that the COBRA notice was deficient, Plaintiff, the spouse of the former Lockheed employee, added her spouse to her employer's coverage.
- While contending that its COBRA notices were in compliance, Lockheed settled the proposed class action for $1.25 million to purchase peace and end litigation costs.
- Lockheed's settlement occurred on September 3, 2019 and is the latest COBRA notice settlement.

COBRA Notice Litigation

- In Grant v. JPMorgan Chase & Co., No. 8:19-cv-01808 (M.D. Fla), plaintiff, seeking to represent a class, alleged that JPMorgan's COBRA notices did not comply with the DOL's regulation by failing to identify the plan administrator in the notice.
- Grant contended that the bank's COBRA process pushed participants towards the marketplace and that the bank provided its notice in two separate mailings, each of which had their own deficiencies.
- JP Morgan filed a motion to dismiss, arguing that:
  - the regulation only requires the bank to identify the "party responsible under the plan for the administration of continuation coverage benefits;"
  - it complied by directing the notice's recipients to the JPMorgan Chase accessHR Benefits Center; and
  - plaintiff did not show he was harmed by the notice.

COBRA Notice Litigation

- In Gilbert vs. SunTrust Banks, Inc. No. *9:15-cv-80415 (S.D. Fla.,)*, Plaintiffs' alleged that SunTrust provided them and other class members with a COBRA election notice that:
  - did not provide the name and address of the COBRA administrator; and
  - failed to adequately explain the plan's procedures for electing COBRA coverage.
- SunTrust filed a motion to dismiss, arguing that:
  - It did provide the name and address of the administrator on the first page of the election notice
  - The first page of the notice provided "SunTrust my HR Service Center," and provided a physical mailing address, telephone number, and web address for SunTrust's my HR Service Center); and
  - The plan's procedures for electing COBRA coverage were on the first page of the notice and were almost identical to the DOL's sample notice language.

COBRA Notice Litigation

- The court, however, denied the Sun Trust's motion, reasoning that the Sun Trust's notice:
  - Did not "clearly" identify the party responsible for administering continuation coverage in a manner calculated to be understood by the average plan participant; and
  - Did not adequately explain the procedures for electing coverage because the notice merely pointed the plan participant to an "unhelpful website and phone number."

- Sun Trust settled and agreed to establish a common fund of $290,000 and make changes to its COBRA Notice.

COBRA Notice Litigation

- In Valdivieso v. Cushman & Wakefield, Inc., 2017 WL 2191053 (M.D. Fla. 2017), plaintiff, a native Spanish-speaking former employee, alleged that the COBRA notice should have been provided in Spanish because the notice was not "written in a manner calculated to be understood by the average plan participant" was required by COBRA.
- The court allowed plaintiff's other claims related to the COBRA notice itself to continue but dismissed the language claim, explaining that the 68 year old individual with English as a second language was not "an average plan participant" within the meaning of the COBRA regulations.
- Although the former employee may not have understood the notice, the court concluded, there was no evidence it would not be understood by an average plan participant.
- This decision is consistent with the COBRA regulations, as COBRA does not require notices to be translated into other languages for individuals who do not speak English. However, language assistance or translation services are required for certain other benefits-related documents, such as summary plan descriptions (SPDs) and claims notices.

COBRA Notice Litigation

- Valdivieso argued that Cushman & Wakefield's COBRA election notice was deficient because:
  - The notice did not specify a specific date when coverage would end.
  - Plaintiff could not determine whether the monthly coverage would end at the beginning or the end of the 18th month and whether it would end on the day that was exactly 18 months in the future.
  - Notice failed to mention the address to which he must send payment.
- Cushman & Wakefield's COBRA Election Notice provided:
  - that coverage may generally last for up to 18 months
  - If you choose to elect COBRA coverage, you do not have to send any premium payment(s) with the COBRA Coverage Election Form. Additional information about payment will be provided to you after you make your election.

COBRA Election Notice Requirements

- DOL's model election notice, updated in May 2014, provides less detail than the requirements specified below, which are in the 2004 final regulations (29 C.F.R. § 2590.606-4(b)(4)(viii)).
  - The name of the plan under which COBRA coverage is available; and the name, address, and telephone number of the party responsible under the plan for COBRA administration.
  - The identification of the qualifying event.
  - The identification, by status or name, of each qualified beneficiary, and the date on which coverage will terminate unless COBRA coverage is elected.
  - A statement that: (a) each qualified beneficiary has an independent election right; (b) a covered employee or a qualified beneficiary/spouse may elect COBRA coverage on behalf of all other qualified beneficiaries regarding the qualifying event; and (c) a parent or legal guardian may elect COBRA coverage on a minor child's behalf.
  - An explanation of other coverage options, such as the Health Insurance Marketplace, and special enrollment opportunity for another group health plan under certain circumstances.
  - An explanation of the plan's procedures for electing COBRA coverage, including the election period deadline.
  - An explanation of the consequences of failing to elect or waiving COBRA coverage.

COBRA Election Notice Requirements

- A description of the COBRA coverage (or a reference to the summary plan description), including the start date.
- A description of the COBRA coverage (or a reference to the summary plan description), including the start date.
- An explanation of the maximum coverage period, the termination date, and any early termination events.
- A description of when COBRA coverage can be extended.
- A description of the disability determination procedures and notice requirements
- A description of the premium amount.
- A description of the premiums due dates, the right to pay on a monthly basis, the grace period, the address to send payments, and the consequences of delayed payment and nonpayment.
- An explanation of the importance of keeping the plan administrator informed of the current addresses of qualified beneficiaries.
- A statement that the notice does not fully describe all COBRA rights under the law or other plan rights, and that more complete information regarding such rights is available in the SPD or from the plan administrator.

Best Practices for COBRA Notices

- COBRA notice should comply with 2004 final regulations (29 C.F.R. § 2590.606-4(b)(4)(viii)), which contains more details, not just with DOL's model election notice, updated in May 2014.
- Employers should consider offering important notices, including COBRA, in languages spoken by a significant number of its employees, to ensure that its employees and former employees understand their rights..

2. Mental Health Parity: Audits and Litigation

- Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), effective July 1, 2014, is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.
  - Essentially requires benefits for medical and surgical services under a group health plan to be comparable (in parity) with mental health services
  - Applies to group health plans of employers that employer 50 or more employees
- Increased enforcement action by the Department of Labor's Employee Benefit Security Administration
  - Unfair penalties related to mental health and substance use disorder benefits eliminated
  - Inequitable residential treatment exclusions removed
  - Overly stringent prior authorization requirements eliminated
  - Improper written treatment plans requirements eliminated
  - Unnecessary delays in treatment eradicated

Mental Health Parity-MHPAEA

- "EBSA will continue its enforcement efforts to detect mental health parity noncompliance, . . . [including] focus on evaluating treatment limitations that are imposed on benefits to treat opioid addiction and other substance use disorders. . . . [and] improper limitations . . . imposed on mental health and substance use disorder benefits through noncompliant cost sharing, benefit limitations, or through administrative practices that enforce neutral plan terms such as medical necessity requirements more stringently when applied to mental health and substance abuse disorders."

MHPAEA—Litigation

- On June 5, 2019, in Kerry W. v. Anthem Blue Cross and Shield, No. 2:19-cv-67 (D. Utah), the District Court judge granted Anthem Blue Cross and Shield's motion to dismiss the plaintiffs' cause of action for violation of MHPAEA. The district judge determined that a denial of a mental health benefit claim based on medical necessity cannot be transformed into a cause of action for violation of the MHPAEA through conclusory allegations.
- The court noted that the plaintiffs did not allege facts demonstrating that, through the administration of claims, the plan provided more generous coverage on the medical/surgical side as compared to the mental health side.
- The court agreed with Anthem's positon that the plaintiffs' arguments that Anthem handled the appeal erroneously did not identify a treatment limitation or make some comparison to Anthem's decision-making process in the context of a claim for inpatient rehabilitation or at a skilled nursing facility.

MHPAEA—Special Topic: Autism

- In recent years, there has been increased demand for coverage of autism treatment benefits in employer group health plans, and a corresponding uptick in litigation by participants seeking coverage for these benefits.
- Employer group health plans should be aware of these trends, as well as of compliance concerns with coverage gaps. In particular, they should consider plan terms relating to autism treatment coverage and any limitations placed on those benefits in light of potential legal risk, as well as the financial and clinical impact of autism-related coverage.
- The DOL has specifically proposed that a plan cannot deny (as experimental or investigative) claims for Applied Behavioral Analysis therapy to treat children with Autism Spectrum Disorder supported by professionally recognized treatment guidelines when the plan approves treatment for medical/surgical conditions that are supported by similar guidelines.

MHPAEA—Autism Litigation

- Much of the litigation relates to whether treatment for medical and surgical services under a group plan are comparable to mental health services.
- In particular, coverage for autism treatment, as well as comparable treatment of residential services have been the subject of litigation.
- Plaintiffs have challenged the denial of treatment for Autism Spectrum Disorders, including Applied Behavioral Therapy and Wilderness Therapy, as a violation of the MHPAEA.

MHPAEA—Autism Litigation

- Challenges have been made to the number of visits limitations placed on treatments based on patient's age.
- *In* ***W.P. v. Anthem Ins. Cos.,*** No. 1:15-cv-00562 (S.D. Indiana 2018), Plaintiff asserted that Anthem violated the federal Mental Health Parity and Addiction Equity Act by limiting the hours of ABA therapy that would be covered for children ages seven and older.
- The parties settled, and Anthem paid $1.625 to a common fund.
- Anthem also agreed to stop using guidelines that limited ABA coverage based solely on the individual's age.

3. ERISA Fiduciary Duty

- Fiduciary is expected to follow a prudent procedure in selecting a health care service provider.
- Fiduciary is required to monitor the service provider at reasonable intervals in such manner as may be reasonably expected to ensure that their performance has been in compliance with the terms of the plan and statutory standards, and satisfies the needs of the plan.
- Monitoring health and welfare service providers is complicated by the fact that employers often have multiple third-party administrators ("TPAs") with different networks in different geographies and potentially a separate pharmacy benefits manager ("PBM") that offers a formulary and retail/mail order pharmacies.

Fiduciary Duty—TPA Fees

- The DOL and plaintiffs' firms have increasingly focused on whether plan fiduciaries have assured that a plan is not paying more than reasonable fees and expenses.
- While much of this focus has been on retirement plans, there has been greater activity involving health and welfare benefit plans.
- In a recent case and the first of its kind, Acosta v. Chimes District of Columbia, Inc. 2019 WL 931710 (D. MD. Feb. 26, 2019), the DOL asserted that the plan fiduciaries breached their duty to a health plan by allowing the plan to pay excessive plan fees.

Fiduciary Duty—TPA Fees

- The *Chimes* court addressed the standards for reviewing plan fees and expenses, particularly the process followed by the plan fiduciaries in both selecting plan service providers and monitoring the fees and expenses charged to the health plan.
- The Court found that the employer engaged in an adequate investigative process, including contacting other organizations in similar circumstances and obtaining information regarding the TPA as a reputable, credible, and effective health and welfare plan manager and administrator for health benefits.

Fiduciary Duty—TPA Fees

- The *Chimes* Court further found that the employer continued to monitor other service providers and interacted with similar employers to gauge whether the value of the services received by the plan was reasonable in comparison to the fees they were paying.
- While the employer did not send out formal, written RFPs for the purchase of TPA services, the testimony the employer's executives satisfied the Court that their informal search activities were the functional equivalent of an RFP.
- Ultimately the court found in favor of the defendants. However, the case is an important reminder that health and welfare plans may also be scrutinized for the reasonableness of fees and expenses.

Fiduciary Duty—TPAs

- The DOL has also increased scrutiny of TPAs regarding their often undisclosed, hidden, and excessive fees.
- Courts have even found that a TPA to a group health plan can inadvertently make itself a fiduciary if it exercises discretionary authority and control over plan assets by determining the timing and amount of its compensation without prior approval from the plan sponsor. In that situation, TPAs may be exposed to claims of self-dealing in plan assets and, among other penalties, disgorgement of administrative fees.

4. Wellness Plans

- Effective January 1, 2019, EEOC withdraw the incentive limits of its wellness program regulations.
- Although the HIPAA rules, as amended by the Affordable Care Act (ACA), generally allow incentives up to 30 percent of the total premium cost (50 percent in the case of tobacco cessation), it is now questionable to what extent incentives are allowed with respect to those wellness programs that are also regulated under the ADA or GINA final rules.
- EEOC indicated that it expected to have new rules by 2021.
- Although the incentive limits were vacated, the other requirements of the EEOC regulations, including notice and consent requirements continue to apply.

Wellness Plans—Litigation

On July 16, 2019, a class action lawsuit was filed against Yale University, challenging the legality of its wellness program that requires a payment (described as a annual penalty) of $1,300 if a participant failed to provide certain medical and genetic information, including certain screens and tests and consultation with a health coach.

- In **Kwesell, et al v. Yale University** No. 3:19-cv-1098 (D. Conn.), plaintiffs, with the assistance of the AARP, seeks to end the program or make the program voluntary because the practice of requiring the submission of medical information or paying a fine violates the American with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA).

Wellness Plans—Litigation

- Plaintiffs' contend that Yale illegally coerced workers into sharing private medical information because the penalty was too high not to comply and anything but voluntary.
- Plaintiffs accuse Yale of not only slashing employees' expected income, but violating their civil rights.
- Plaintiffs note that the ADA and the GINA prohibit employers from extracting medical or genetic information from employees unless that information is provided voluntarily.

Wellness Plans—Litigation

- Until recently, the rules established by the Equal Employment Opportunity Commission allowed employers to provide financial incentives for employees who "voluntarily" participate in wellness programs, as long as the incentive did not exceed 30 percent of the overall cost of the individual health plan.
- In 2016, however, AARP sued to overturn the EEOC rules, arguing that the cost of refusing participation meant that some wellness programs were only "voluntary" in theory.
- The U.S. District Court for the District of Columbia ruled in August 2017 there was no basis for the 30 percent limit and ordered the EEOC to review its rules. The EEOC subsequently withdrew the incentive portion of the rules.
- With no 30% incentive cap in place, the current rules do not explicitly prohibit employers from offering financial incentives in exchange for participation in wellness programs.

Wellness Plans—Best Practices

- With the filing of the Yale University wellness litigation, and until the EEOC guidance on permissible incentives is issued, the most feasible options are:
  - Review and revisit wellness programs: Lower incentive limits so that incentives or penalties are lower than 30%.
  - Offer No Wellness Incentive or Penalty for Programs Subject to the ADA or to GINA: Ceasing to offer any incentives for wellness program components subject to the ADA or GINA rules is the most conservative course of action and ensures compliance with the "voluntary" requirement.

Questions?

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