Wiggin & Dana

Employment Advisory

Summer 2003

Proving Discrimination Claims May Now be Easier

The United States Supreme Court recently held that plaintiffs pursuing a "mixed motive" theory of discrimination need not present direct evidence of discrimination, but may prevail even if their claims are proven exclusively with circumstantial evidence. In *Desert Palace, Inc. v. Costa*, No. 02-679, the plaintiff, Catherina Costa, was employed by a casino as a warehouse worker and heavy equipment operator. She was the only woman in that job and the only woman in her bargaining unit. When Costa's employment was terminated after she was involved in a physical altercation with a co-worker, she sued Desert Palace for sex discrimination under Title VII and the statute that amended it, the 1991 Civil Rights Act.

The Jury Instruction

At trial, at Costa's request, the jury was instructed that the case before it was a "mixed motive" sex discrimination claim. In other words, Costa had demonstrated that both permissible (e.g., fighting on the job) and impermissible (e.g., discriminatory) reasons motivated the decision to terminate her employment. Desert Palace objected to the jury instruction. According to Desert Palace, under the Supreme Court's 1989 decision in *Price Waterhouse v. Hopkins*, a plaintiff was only entitled to a "mixed motive" instruction if she had adduced "direct" or "smoking gun" evidence of discrimination, and Costa had relied exclusively on circumstantial evidence. Desert Palace's objection to the instruction was overruled and it appealed the jury verdict in Costa's favor all the way up to the Supreme Court.

The Court's Ruling

In a unanimous ruling, the Supreme Court agreed with Costa and held that direct evidence was not necessary in order for a discrimination plaintiff to avail herself of the "mixed motive" instruction. In an exercise in statutory interpretation, the Supreme Court reasoned that the unambiguous language of the 1991 Civil Rights Act, which amended Title VII, was written in direct response to *Price Waterhouse* and any requirement of "direct evidence" was conspicuously absent from the statute. Rather, the statute requires a plaintiff to "demonstrate" that both permissible and impermissible reasons motivated the adverse employment action, and the statute defines "demonstrate" as to "meet the burdens of production and persuasion." Had Congress intended plaintiffs to be faced with the more difficult task of producing often non-existent "direct" evidence, it would have incorporated that requirement into the statute. Moreover, criminal cases, which require the government to prove its case "beyond a reasonable doubt," often are based solely on circumstantial evidence. Accordingly, the Court found no statutory basis for requiring plaintiffs relying on the "mixed motive" theory to produce direct evidence of discrimination.

Practical Implications

Employees are likely to find it easier to prove and win discrimination claims after this case. It is all the more important, therefore, that employers have appropriate measures in place to ensure that all adverse employment decisions can be shown to be based purely on legitimate, nondiscriminatory reasons.

Wiggin & Dana LLP
Counsellors at Law

New Haven, CT
Hartford, CT
Stamford, CT
Philadelphia, PA

info@wiggin.com
www.wiggin.com

The Wiggin & Dana Employment Advisory is a periodic newsletter designed to inform clients and other interested parties about recent developments in the fields of employment and benefits law. Nothing in the Employment Advisory constitutes legal advice, which can only be obtained as the result of personal consultation with an attorney. The information published here is believed accurate at the time of publication but is subject to change and does not purport to be a complete statement of all relevant issues. If you (or a colleague) are interested in being added to the distribution list for the Wiggin & Dana Employment Advisory, please contact Celia Paiva at 860.297.3742 or email her at cpaiva@wiggin.com.

Second Circuit Broadly Interprets Who Constitutes a "Supervisor" for Purposes of Imputing Liability to Employers for Sexual Harassment Claims.

In *Mack v. Otis Elevator Company,* 326 F.3d 116 (2d Cir. 2003), the Second Circuit refined the test for determining whether an employee is properly classified as a "supervisor" for purposes of imputing liability to the employer in sexual harassment cases alleging a hostile work environment.

The Faragher-Ellerth Defense

By way of background, the United States Supreme Court has ruled that employers are strictly liable for supervisory harassment so egregious as to violate Title VII. Employers may, nevertheless, be able to avoid liability by availing themselves of an affirmative defense, commonly known as the *Faragher-Ellerth* defense, after the Supreme Court cases in which it was first articulated. The *Faragher-Ellerth* defense is available where the employer exercised reasonable care to prevent and correct promptly any sexually harassing behavior and the complaining employee unreasonably failed to take advantage of any preventive or corrective opportunities provided by the employer or to avoid harm otherwise. The defense is not available, however, where the complaining employee alleges that he or she has suffered a tangible employment action, such as a termination, reduction in pay or demotion.

In contrast, an employer may not be held liable for a sexually hostile environment created by a co-worker, unless the employer knew or should have known about the sexual harassment and failed to take appropriate corrective action. Accordingly, it is important to determine, in the first instance, whether the alleged harasser is a supervisor or a co-worker for purposes of determining whether liability for the sexual harassment may be imputed to the employer.

In *Mack*, the plaintiff, an elevator mechanic for Otis Elevator Company ("Otis"), alleged that she was forced to endure a hostile work environment as a result of the sexually-charged acts and comments of the elevator "mechanic in charge" at her worksite. The district court ruled as a matter of law in favor of Otis, concluding that the plaintiff had failed to show she had been harassed by an Otis "supervisor" and, therefore, Otis could not be held vicariously liable.

Supervisory Status

The Second Circuit reversed, ruling that the test utilized by the district court to determine supervisory status was too restrictive, because it focused on whether the employee in question is empowered to take tangible employment actions with respect to his or her subordinates. The court reasoned that while the existence of a tangible employment action affects whether the *Faragher-Ellerth* affirmative defense is available to the employer, it does not affect the preliminary question of whether the employer may be held strictly liable for the actions of the accused harasser. Accordingly, the court stated that the test of supervisory status is whether "the authority given by the employer to the employee enabled or materially augmented the ability of the employee to create a hostile work environment for his subordinates."

Applying the test to the facts of the case, the *Mack* court found the alleged harasser to be the plaintiff's supervisor for purposes of imputing Title VII liability to Otis, observing that the alleged harasser directed the particulars of the plaintiff's workdays,

continued on page 7

New HIPAA Requirements - Impact on Employers and Health Plans

Federal privacy regulations issued in 2000 under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require sweeping changes in the way the health care system manages health information. Health care providers, health care clearinghouses and health plans (known as "covered entities") are directly governed by these requirements, and the government regulators who wrote the HIPAA rules emphasize that they do not have statutory authority to regulate employers. However, depending on the structure of your health plan and your employment-related needs for health information, the regulations can significantly affect your operations. Understanding who is covered by the HIPAA regulations and what information is included in their reach can help you sort through the HIPAA morass.

The HIPAA Privacy Rule and Employer-Sponsored Health Plans

The so-called "Administrative Simplification" requirements of HIPAA primarily address three separate components: 1) electronic transactions and code sets; 2) privacy; and 3) security. The privacy component has received the most attention recently, since compliance was required by April 14, 2003 (April 14, 2004 for small health plans). These detailed regulations, known as the "Privacy Rule," generally regulate how covered entities use and disclose "protected health information" (PHI). PHI is any individually identifiable health information that is transmitted or maintained in any form. As noted above, employers are not covered entities, but the broad definition of "health plan" means that the Privacy Rule will apply to a broad spectrum of employer-sponsored benefit programs, including:

- Medical benefit plans (insured or self-insured) with 50 or more participants or plans of any size that are administered by an outside vendor;
- Long term care coverage;
- Dental plans;
- Vision plans;
- Prescription drug plans;
- Some employee assistance plans or other mental health programs;
- Medicare Supplement plans;
- Flexible Spending Accounts/Personal Health Accounts; and
- Some executive physical programs.

HIPAA and Self-Insured Plans

If your organization offers any of the benefit programs listed above on a partially or fully self-insured basis (meaning some or all benefits are paid out of company assets, rather than by an insurance company), you may need to take a number of steps to ensure that these benefit programs are in compliance, including mailing your "Notice of Privacy Practices" to all participants, executing "business associate agreements" with your vendors, implementing policies to safeguard information and to allow participants to exercise HIPAA-guaranteed "individual rights," and making HIPAA-required amendments to the plan documents. Small health plans (which have until April 14, 2004 to come into compliance) should begin to address the requirements now, and larger plans may still have some loose ends that need tying.

Although many third-party administrators and other health plan vendors have become very familiar with the Privacy Rule's requirements, in most cases they are not covered entities in their own right. This means that the compliance obligation (and associated penalties for noncompliance) ultimately fall on the plan sponsor. If you have not yet executed agreements containing the HIPAA-required contractual provisions (known as "business associate agreements") with these vendors, look to see whether they can take on some of the HIPAA responsibilities on your behalf, such as handling "individual rights" requests.

HIPAA and Fully-Insured Health Plans

If **all** the benefits your company provides to its employees are fully insured, **and** if the insurer/HMO does not provide you with any identifiable health information, your health plan HIPAA compliance obligations will be minimal. You must refrain from retaliating against an individual for exercising his or her privacy rights (for instance, if an employee complains to the HIPAA regulators about the HMO's use of her information), and may not require employees to waive their rights to file complaints as a

continued on page 4

New HIPAA Requirements - Impact on Employers and Health Plans

continued from page 3

condition of participating in the health plan. To document your compliance efforts with these provisions, review all enrollment materials to ensure they do not contain hidden waiver provisions, and adopt policies to implement the non-retaliation and non-waiver requirements.

What's Outside the "HIPAA Box"?

Some forms of insurance and other benefits are excepted from HIPAA's requirements: life insurance, long- and short-term disability coverage, workers' compensation programs, accidental death and dismemberment (AD&D), auto insurance, and reinsurance/stop loss coverage are not directly covered by the Privacy Rule (although they may be impacted, as discussed below). A health plan that is a covered entity, however, may not disclose PHI for use by these programs without an individual authorization. For instance, information from the health plan cannot be used to determine a workers' compensation claim.

The Privacy Rule also contains an important exclusion for "employment records," such as health information received in connection with sick leave requests, fitness-for-duty examinations, FMLA certifications, requests for ADA accommodations, and other information that your company receives in its capacity as an employer. While this information generally is not subject to HIPAA, you should be aware that other state and federal confidentiality provisions may apply. For instance, the ADA's confidentiality requirement applies even to information conveyed orally, and many states have laws regarding the confidentiality of personnel and medical files.

Other HIPAA Considerations

If a company needs health information regarding its employees for reasons not related to the health plan, the HIPAA Privacy Rule will also impact how this information is collected. If a health care provider treating an employee is covered by the HIPAA Privacy Rule, he or she will not be able to release any information to the employer without a HIPAA-compliant authorization form. If your policies require that health information be sent directly to the employer (such as drug test results), consider revising any internal release forms to meet the HIPAA requirements for a valid authorization. Note that there are some exceptions. Legally required disclosures such as the drug and alcohol tests for certain commercial drivers mandated by the Department of Transportation will not require employee authorization, and disclosures to the employer that are necessary to comply with workers' compensation laws are also permitted.

Special rules apply to in-house health care providers such as on-site clinics or occupational health nurses. Generally, if these providers engage in standard electronic transactions (claims for payment, first reports of injury, etc.), they will be covered by the Privacy Rule, which means they must have their own set of policies and procedures, a Notice of Privacy Practices, and are subject to the whole panoply of HIPAA requirements. Such providers can disclose information relating to work-related illnesses or injuries to the employer, if the information is necessary for the employer to comply with its obligations under OSHA or similar laws, and if a notice to that effect is given to employees or posted at the clinic. If your organization contracts with

continued on page 6

Greater Flexibility to Charge Retirement Plan Expenses to Participant Accounts

New Department of Labor ("DOL") guidance provides significant flexibility in charging plan expenses to participant accounts under defined contribution retirement plans, such as 401(k) plans. As a result of this guidance, plan sponsors looking to reduce costs are likely to charge to participants some plan expenses that they now pay themselves, and plan fiduciaries may change how expenses currently charged to participants are allocated.

In Field Assistance Bulletin 2003-3, the DOL:

- Approves charging some expenses to participant accounts on a per capita basis (as an equal dollar amount per participant), rather than as a percentage of each participant's account balance,

- Allows certain expenses to be charged to a particular participant's account, rather than spread over all participants (the DOL reverses its prior position to permit plans to charge individual participants for the cost of determining whether domestic relations orders are qualified); and

- Permits plan expenses to be charged to terminated vested participants that are paid by the employer for other participants.

Permissible Per Capita Charges

The DOL indicates that, in the absence of plan provisions specifying a method of charging expenses, plan fiduciaries have discretion in how expenses are allocated to participant accounts. As with other fiduciary decisions under the Employee Retirement Income Security Act of 1974 ("ERISA"), fiduciaries must act prudently and solely in the interest of plan participants. In deciding how expenses are to be charged, the DOL indicates that the plan fiduciary "weighs the competing interests of various classes of the plan's participants and the effects of various allocation methods on those interests." As a result of that process, the fiduciary might decide on a rational method for allocating expenses that "disfavors" a particular class of participants. (Of course, plan fiduciaries may not choose an allocation method where their personal benefit is more than incidental.) While the guidance indicates that charging expenses in proportion to account balances in most cases would be an equitable method of allocating expenses, a fiduciary might instead decide that a per capita charge is appropriate for fixed administrative expenses, such as:

- Recordkeeping
- Legal
- Auditing
- Annual reporting
- Claims processing and administration.

It would not be appropriate, however, to charge participants on a per capita basis for expenses, such as investment management fees, that are based on account balances.

The fiduciary would decide in each case the prudent method of charging participant accounts. However, to the extent that the plan documents specify an expense allocation method, plan fiduciaries are bound to follow it, as long as the method is consistent with ERISA. Thus, plan sponsors may want to spell out in the plan document how the various expenses are to be charged.

Permissible Charges to Individual Participant Accounts

Consistent with this new flexibility, the DOL guidance also addresses charging plan expenses to a particular participant's account, and specifically indicates that such individual charges might be justified for:

- Expenses for investment advice (the DOL also indicates that expenses for investment advice services might be charged on a pro rata or per capita basis, without regard to actual utilization of the services)
- Expenses of effecting hardship withdrawals
- Expenses of calculating benefits payable under different distribution options

continued on page 6

New HIPAA Requirements - Impact on Employers and Health Plans

continued from page 4

outside medical providers covered by the HIPAA Privacy Rule to provide needed medical information (such as fitness-for-duty examinations), these providers generally can require that the employee sign an authorization form as a condition of providing the care. If any in-house or contracted medical providers are covered by the HIPAA Privacy Rule in their own right, you should ensure that they are aware of HIPAA's requirements and have implemented a compliance plan.

Conclusion

The HIPAA privacy regulations are lengthy and complex, and many employers are understandably confused about their effect and reach. Although the Privacy Rule does not directly regulate employers, self-insured health plans and other non-insured employer plans providing medical benefits (such as flexible spending plans) have significant compliance obligations. As a practical matter, the privacy requirements may require some changes in your employment policies and administrative practices. Assess the health information that you receive, revise your existing policies and forms if necessary, and contact legal counsel or expert HIPAA consultants for complicated compliance questions.

Greater Flexibility to Charge Retirement Plan Expenses to Participant Accounts

continued from page 5

- Expenses for benefit distributions (such as monthly check writing)
- Expenses for determining whether a domestic relations order or a medical child support order is a "qualified" order - a "QDRO" or a "QMCSO." This guidance reverses the DOL's prior position that the costs of QDRO determinations could not be charged directly to the account of the affected participant.

Other similar expenses might also be charged to particular participant accounts.

Greater Charges Possible for Terminated Vested Accounts

The DOL guidance would allow a plan to charge expenses to the accounts of terminated vested participants, even though those expenses are paid by the employer for active participants. This guidance is likely to encourage plan sponsors to pass through to former employees some of the cost of maintaining their accounts where they leave their moneys in the plan. Under IRS regulations, however, the charges could not be such as to constitute a "significant detriment" to participants continuing to maintain their accounts under the plan after termination of employment—the IRS has indicated informally that this may be an issue for employers that want to impose these charges.

Summary Plan Descriptions Must Disclose Charges

The DOL indicates that plans are required to include a summary of fees and charges that might reduce benefits. Thus, a plan changing its expense allocation procedures should apprise participants of fees and charges that may affect their benefits through a "summary of material modifications."

In all cases, the DOL reiterates that expenses can only be charged to participant accounts if (1) the expenses relate to the plan (and are not instead expenses for services for the employer or another plan), and (2) are reasonable in amount relative to the services performed.

When is a Shareholder an Employee?

In *Clackamas Gastroenterology Associates, P.C. v. Wells,* decided on April 22, 2003, the United States Supreme Court held that physicians who perform medical services and manage a relatively small medical practice in the form of a professional corporation may or may not be "employees" under the Americans With Disabilities Act (the "ADA"), depending on whether or not they enjoy the "right to control" the work of others. Although this case involved a medical practice, its holding should be of great interest to professional corporations of all types. Moreover, the Court's "right to control" test undoubtedly will be used by lower courts to determine who is an "employee" under other federal employment laws.

The Holding

The Supreme Court held that the right to control test should have been used to determine if the physician-shareholders were "employees." The Court determined that, unlike the partnership analogy used by the District Court, the right to control test better suits the remedial purposes of the ADA by focusing on the nature and extent to which an individual sets the terms and conditions of employment. It summarized the test as follows: "if the shareholder-directors operate independently and manage the business, they are proprietors and not employees; if they are subject to the firm's control, they are employees." Moreover, the fact that a person holds a title of partner, officer or director or is subject to an employment agreement is not dispositive of the issue. Since this test had not been applied to the physician-shareholders of Clackamas, the Court remanded the case to the District Court for further fact-finding.

Why this is Important

The definition of "employee" that courts choose to apply is important in two respects. First, as in this case, it determines whether an employer meets the threshold for ADA coverage. Second, it also determines whether the shareholders themselves will be able to invoke the protections of these laws. This holds true not only for the ADA, but, as the Supreme Court noted, also Title VII, and the ADEA. Perhaps most importantly, shareholders of professional corporations can no longer assume that they are not employees within the meaning of federal employment laws. Because the right to control test enunciated by the Supreme Court is fact-based, the employee status of shareholders in professional corporations will vary from corporation to corporation, and perhaps even from person to person within the same corporation. Careful attention will have to be paid to the extent to which the corporation controls or dictates the manner in which professional services are performed, or leaves the manner of performance to the complete discretion of the shareholder.

Second Circuit Broadly Interprets Who Constitutes a "Supervisor"

continued from page 2

including her work assignments. He was also the senior employee on the work site, therefore possessing a special dominance over on-site employees, arising out of their remoteness from others with authority to exercise power on behalf of Otis. The court concluded that Otis could, therefore, be held vicariously liable, subject to the *Faragher-Ellerth* special defense since the plaintiff had suffered no tangible employment action.

Application to Employers

This case provides one more reason for employers to train *all* employees regarding appropriate workplace behavior, even where the employees might not be considered by the employer to be "supervisors" in the traditional sense, since the misconduct of such employees could result in liability for the employer.

Labor, Employment and Benefits Department

John G. Zandy, Chair
203.498.4330

Karen L. Clute
203.498.4349

Sherry L. Dominick
203.498.4331

Stephen B. Harris
860.297.3732

Peter J. Lefeber
203.498.4329

Lawrence Peikes
203.363.7609

Peter M. Wendzel
860.297.3705

Marcia K. Keegan
860.297.3733

Christian L. Lindgren
860.297.3723

William J. Albinger
Lori Rittman Clark
Joan Allen Rowe
Jennifer Neyan Willcox
Gayle C. Wintjen

Mary F. Bohan, paralegal
Lori J. Noyes, paralegal
Gisele C. Roemer, paralegal
Robin D. Clark, Affirmative Action Specialist

Business Practice
William A. Perrone
203.363.7604

Health Care
Maureen Weaver
203.498.4384

Litigation
Shaun S. Sullivan
203.498.4315

Real Estate, Environmental and Land Use
Susan J. Bryson
203.498.4337

Trusts and Estates
Leonard Leader
203.363.7602

Utilities and Regulated Industries
Linda L. Randell
203.498.4322

Changes to Federal Contractors' Affirmative Action Obligations Towards Veterans

The Jobs for Veterans Act, which was signed by President Bush in November, 2002, will bring some significant changes to federal contractors' affirmative action obligations towards veterans. Specifically, for those contracts or subcontracts entered into after December 1, 2003, the threshold amount for coverage under the Vietnam Era Veterans Readjustment Act will increase from $25,000 to $100,000. This means that there may be some federal contractors who will have affirmative action obligations towards women, minorities, and individuals with disabilities but who will no longer have obligations towards veterans. Additionally, this Act has modified the definition of "covered veterans" to include: (i) Disabled veterans; (ii) Veterans who served on active duty in the Armed Forces during a war or in a campaign or expedition for which a campaign badge has been authorized; (iii) Veterans who, while serving on active duty in the Armed Forces, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order no. 12985 (61 Fed. Reg. 1209); and (iv) Recently separated veterans." The definition of "recently separated veterans" changed from one year to three years from the date of discharge.

Amendments made to the Connecticut FMLA

Effective October 1, 2003, Connecticut employers will be required to allow employees to use up to two weeks of sick leave to attend to a serious health condition of the employee's child, spouse or parent, or for the birth or adoption of a child. For purposes of the statute, "sick leave" means an absence from work for which compensation is provided through an employer's bona fide written policy providing compensation for loss of wages occasioned by illness, but does not include absences from work for which compensation is provided through an employer's plan, including, but not limited to, a short or long-term disability plan, whether or not such a plan is self-insured.

The new public act also allows employers to determine the twenty-four month period under which an employee may take state mandated leave in one of four ways: (1) consecutive calendar years; (2) any fixed twenty-four month period; (3) a twenty-four month period measured forward from an employee's first day of leave; or (4) a rolling twenty-four month period measured backward from an employee's first day of leave.

Proposed COBRA Rules - Immediate attention may be required

The 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) gives employees and beneficiaries the right to continue coverage under covered employer-sponsored group health plans in certain situations. The IRS previously issued regulations outlining what plans are subject to the COBRA requirements, which events trigger COBRA continuation rights, and what sort of continuation coverage must be offered. But the Department of Labor (DOL) which has jurisdiction over enforcement of COBRA's notice and disclosure requirements—the area that has been the focus of most litigation regarding COBRA entitlement—only recently issued regulations in this area. The long-awaited DOL rules were published in proposed form on May 28, 2003, and if finalized will require compliance by the first day of the plan year beginning on or after January 1, 2004. There are some surprises in the rules that plans should address now, however, so employers are encouraged to contact their COBRA administrator and review their current procedures.

Initial General COBRA Notice

The initial COBRA notice must be provided to employees and spouses within 90 days of when coverage under the employer's health plan commences. (Note that if a "qualifying event" occurs before the 90 days have passed, employees and spouses are entitled to the election notice and the initial notice at the same time.) Besides specifying a deadline, the regulations also outline content requirements for the initial notice. If an employee and his/her spouse reside at the same address and their plan coverage is effective simultaneously, the plan can send a single notice to both at that address. The proposed regulations also sanction the practice of including the initial notice in the summary plan description (SPD). Since the SPD generally must be provided within the same time-frame as the initial COBRA notice, plans can streamline administration by including the initial COBRA disclosure notice in the SPD. The regulations also include a "model" initial notice that plans can tailor to their particular requirements.

Action Items

Two aspects of the proposed rules on initial notices may require immediate attention:

First, the DOL indicates in the preamble to these regulations that, effective with their publication, it will no longer consider use of the model notice published in ERISA Technical Release 86-2 (June 26, 1986) to be good faith compliance with the statute. Review the notice that your plan currently uses and contact your COBRA administrator if necessary regarding implementing the new requirements. A downloadable version of the new model "initial" notice of COBRA coverage can be found in the "Employee Benefits" section of our web-site at www.wiggin.com.

Second, determine whether your employees potentially may be eligible for what is known as "trade adjustment assistance" (TAA) under the Trade Act of 2002. This law requires a second 60-day COBRA election period for individuals eligible for TAA (usually, workers who have lost their jobs or whose hours of work or wages have been reduced due to increased imports and other aspects of international trade). Although a description of this TAA right to a second election period is not included in the model initial notice, DOL indicates that it believes information on the possibility of this new second election period in the event of TAA eligibility should be included in the SPD as part of the COBRA continuation discussion.

Notice of Qualifying Event

Events that trigger COBRA coverage include termination of employment, reduction in hours, death of an employee, enrollment in Medicare, divorce or legal separation of a spouse, and losing status as a dependent under a group health plan. The COBRA plan administrator must be given notice of these "qualifying events," and the proposed regulations lay out the timing and content of such notices. For qualifying events within the knowledge of covered employees and qualified beneficiaries (divorce or legal separation, a dependent "aging out" of dependent status, or notice of disability or a second qualifying event while on COBRA continuation coverage), the notice obligation falls on the employee/beneficiary, who must give notice within 60 days of the qualifying event. The plan, however, must have reasonable procedures explained in the plan's SPD that specify who is designated to receive notices of the occurrence of a qualifying event and the means by which notice can be given. The plan can require the

employee/beneficiary to use a written notice form, if the notice is easily available free of cost. Describing these notification procedures in the plan's SPD is important, because if no procedures are specified, then notice will generally be deemed to have been given simply if the employee/beneficiary orally informs someone in the area that usually handles employee benefits or a company officer about the qualifying event.

The employer must notify the plan administrator with respect to the occurrence of the following qualifying events: termination, reduction in hours, death, the employee's enrollment in Medicare, or the employer's commencement of a bankruptcy proceeding (with respect to retired employees). As was the case previously, employers must notify plan administrators about these qualifying events within 30 days after the date of the event, but the proposed regulations clarify that if the plan terms require continuation coverage to begin with the loss of coverage, the thirty-day period for providing notice of the qualifying event also begins with loss of coverage (if, for instance, coverage would not terminate until the end of the month). While the regulation does not specify the format for these notices or provide any sort of model, the employer notice must give the plan administrator sufficient information to determine the plan and covered employee affected, and the type and date of the qualifying event.

Plan Administrator's Notice Obligations

Plan administrators also have notice obligations under COBRA. The regulations provide guidance on the timing and content of the COBRA election notice, and impose two new notice requirements:

First, where individuals have notified the plan administrator of the qualifying event (and thus are presumably expecting COBRA continuation coverage), the plan administrator must notify those individuals if it determines that they are not eligible, and give an explanation for the decision. This notice must be provided within fourteen days of receiving notice of the qualifying event.

Second, the plan administrator also must provide a specific notice when continuation coverage terminates before the end of the maximum period (for nonpayment of premiums, for example). The notice must explain why coverage is being terminated, the date of termination, any rights to elect alternative or individual coverage, and must be provided "as soon as administratively practicable" after the administrator makes the decision to terminate coverage.

The DOL has also proposed changes to the content of COBRA election notices. The proposed regulations include a model election notice that, when appropriately tailored for plan specifics, would be considered compliance with the content requirements, although its use is not required. A downloadable version of the model election notice is available in the Employee Benefits section of our web-site, www.wiggin.com. If another form of notice is used, it must include sufficient information to allow the employee/beneficiary to decide whether to elect continuation coverage, including premium amounts and due dates, any alternative coverage or conversion options, possible extensions of the continuation period for disability or second qualifying events, and the consequences of failing to elect COBRA coverage on other rights (in particular, an explanation of how failing to elect coverage will affect the rights guaranteed by the portability provisions of HIPAA). The plan administrator has fourteen days from receiving notice of a qualifying event to provide the election notice. The proposed regulations confirm that if, as often is the case, an employer serves as the plan administrator, and the employer has the responsibility for giving notice of the qualifying event, the employer has forty-four days from the qualifying event to provide the notice (the employer's own thirty day period for providing notice of the qualifying event to the administrator plus fourteen days for providing the election notice).

Conclusion

The new rules specify the timing and content of COBRA notices that have been in common usage for a number of years, and validate some longstanding practices. The 2004 effective date should not lull any plan sponsors into thinking compliance can be postponed, however, as some changes to current procedures may be required now.