Employee Benefits Hot Topics 2021

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HEALTH & WELFARE HOT TOPICS

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Health & Welfare Hot Topics

- MHPAEA Audits
- ACA
- No Surprises Act
- Consolidated Appropriation Act Transparency Rules
- COVID-19
- COBRA Subsidies

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Mental Health Parity and Addiction Equity Act

- The Mental Health Parity Act of 1996 ("MHPA") provided that large group health plans may not impose annual or lifetime dollar limits on mental health benefits that are less favorable than any such limits imposed on medical/surgical benefits.
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") expanded protections:
  - 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 ("M/S").
  - Originally applied to group health plans and group health insurance coverage.
  - Amended by the Affordable Care Act ("ACA") to apply to individual health insurance coverage.

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Consolidated Appropriations Act, 2021 (CAA)

- December 21, 2020 Congress passed a year-end bill to fund the government through September 30, 2021 and provide economic relief in response to the coronavirus pandemic.
- The bipartisan package includes $1.4 trillion to fund the government, $900 billion for coronavirus relief, and other provisions.
- The CAA contained the COVID-Related Tax Relief Act of 2020, the Taxpayer Certainty and Disaster Tax Relief Act of 2020, and the No Surprises Act, which contain numerous provisions related to retirement and health plans.

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Mental Health Parity and Addiction Equity Act

- Under the CAA, group health plans and issuers that cover MH/SUD and M/S benefits must:
  - Prepare a comparative analysis of the design and application of any nonquantitative treatment limits ("NQTLs") that apply.
  - Beginning February 10, 2021, plans must supply this analysis and other information, if requested by federal regulators (the DOL for ERISA plans).

Mental Health Parity and Addiction Equity Act

- Although CAA does not define “comparative analysis” or provide details on its components, the DOL, HHS, and IRS have jointly issued FAQs elaborating on this new compliance obligation.
- CMS has previously issued guidance and templates for analyzing and documenting the processes, strategies, evidentiary standards, or other factors used in applying NQTLs to MH/SUD benefits.

Mental Health Parity and Addiction Equity Act

Initially, the DOL intends to focus on 4 specific NQTLs:

1. Prior authorization requirements for in-network and out-of-network inpatient services.
2. Concurrent review for in-network and out-of-network inpatient and out-of-network inpatient and outpatient services.
3. Standards for provider admission to networks including reimbursement rates.
4. Out-of-network reimbursement rates, including plan methods for determining usual, customary, and reasonable charges.

MHPAEA
Comparative Analysis

Under CAA, plans must make available to the DOL the following information:

- **Terms:**
  - The specific plan and coverage terms on NQTLs for MH/SUD and M/S benefits.
  - A description of these benefits, including which of the six parity classifications contains the benefit (e.g., inpatient in-network, outpatient in-network, pharmacy, etc.).
- **Factors —** The factors used to determine that the NQTLs should apply to the benefits.

MHPAEA Comparative Analysis

Under CAA, plans must make available to the DOL the following information (cont.):

- **Evidentiary standards —** The evidentiary standards and any other sources on which the plan relied to back up the factors used to design the NQTL and justify its application to a benefit.
- **Comparative analysis —** A separate analysis of each NQTL for benefits in each classification "demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the NQTLs" to MH/SUD benefits are "comparable to and applied no more stringently" than those used to apply NQTLs to M/S benefits.

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MHPAEA Comparative Analysis

Under CAA, plans must make available to the DOL the following information (cont.):

- **Robust discussion —** The comparative analysis must include a "robust discussion" of specific elements:
  - A clear description of the specific NQTL, plan terms, and policies at issue.
  - Identification of the specific MH/SUD and M/S benefits to which the NQTL applies within each benefit classification. This includes a clear statement as to which benefits identified are treated as MH/SUD and which are treated as M/S.
- **Findings and conclusions —** The results of the comparative analysis giving the plan's or issuer's specific findings on what is and is not in compliance with the parity law.

MHPAEA
Comparative Analysis

- The analysis must include:
  - The date of the analysis and the name, title, and position of the person or persons who performed or participated in the comparative analysis.
  - Conclusions or general statements without specific supporting evidence and detailed explanations are not acceptable, and productions of a large volume of documents without a clear explanation of how each document is relevant will not be acceptable.
  - All documents provided should support the underlying analysis process and the conclusions of the overall comparative analysis.

MHPAEA Comparative Analysis

- A self-compliance tool for the Mental Health Parity and Addiction Equity Act ("MHPAEA") is available from the DOL at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf
- The plan sponsor, third party administrators for M/S and MH/SD, and any outsourced precertification or cost management organization must work together to prepare the analysis.
- Legal counsel review is recommended, especially if audited, to ensure compliance with all of the requirements.

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MHPAEA Comparative Analysis

- The CAA outlines a specific process to follow when the DOL's review of a plan's comparative analysis indicates a parity violation has occurred.
  - After the DOL's initial determination, the plan must specify what actions it will take to correct the violation and/or provide an additional comparative analysis addressing the proposed parity violation within 45 days.
  - Based on this information, if the DOL makes a final determination that the plan is still in violation, the plan must notify all enrollees about the noncompliance within seven days of the DOL's determination.

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Mental Health Parity and Addiction Equity Act Penalties

- If the DOL makes a final determination that the plan is still in violation:
  - The DOL will share the information with state agencies.
  - Upon request, ERISA participants are entitled to receive the comparative analysis and supporting documentation.
  - Documents or communications related to the DOL's recommendations to a plan will not be subject to disclosure under the Freedom of Information Act ("FOIA").

Mental Health Parity and Addiction Equity Act Penalties

- DOL may refer violations to DOL Solicitor's Office for litigation.
  - Limited to equitable relief, requiring plans to provide reimbursement for and/or coverage for participants whose claims were improperly denied.
  - DOL does not have the authority to impose civil monetary penalties.
- ERISA plans are also subject to claims under Sections 502(a)(1) and (a)(3):
  - Class actions for denials of treatment.
  - Potential fiduciary duty claims:
    - Seek payment of benefits.
    - Court may also award reasonable attorney fees.

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Mental Health Parity and Addiction Equity Act Penalties

- IRS may impose excise taxes for a group health plan's failure to comply with MHPAEA, $100 per day for each individual to whom the failure relates.
- Plans must self-report violations:
  - If self-reported, for failures due to reasonable cause (and not due to willful neglect), all or part of the tax may be waived.
  - If discovered after notice of examination, minimum is generally $2,500.
  - Minimum increases to $15,000 if violations are more than de minimis.
  - Maximum for unintentional failures is the lesser of:
    - 10% of the amount paid during the preceding tax year of the employer for group health plans; or
    - $500,000.

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No Surprises Act

- Included in CAA, effective for plan years beginning on or after January 1, 2022:
  - Health plans must cover surprise bills without prior authorization.
  - In-network cost sharing applies based on a "recognized amount," which in most cases will be the median in-network payment amount under the plan for the same or similar services.
  - Plans must add deductible, out-of-pocket maximum, and consumer resource contact information to any paper or electronic insurance card issued to participants.

No Surprises Act

- Starting January 1, 2022, it will be illegal for providers to bill patients for more than the in-network cost-sharing due under patients' insurance plans in almost all scenarios where there are surprise out-of-network bills.
- The plan or insurer will pay the provider the Qualifying Payment Amount ("QPA")
  - *Based on the plan's or insurer's contracted rates in the same insurance market as where the out-of-network claim arises.*

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No Surprises Act

- Health plans must disclose information about broker commissions.
- Individual health insurance plans, including short-term limited duration insurance, must disclose to enrollees the amount of direct and indirect compensation paid to brokers for that enrollment.
- This disclosure must be made before the individual finalizes plan selection.
- Disclosure of broker and consultant commissions is also required for group health plans.
- Plans must also report information on broker compensation annually to the Secretary of HHS.

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No Surprises Act

- Federal external appeal rights apply if a health plan does not correctly identify and cover a surprise medical bill.
- Out-of-network providers cannot balance bill for:
  - Emergency services beyond the applicable in-network cost sharing amount.
  - Non-emergency services at an in-network hospital or other facility unless providers give prior written notice at least 72 hours in advance and obtain the patient's written consent.
    - Does not apply for ancillary services (such as anesthesia) or diagnostic services (such as radiology or lab work).

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No Surprises Act

- The No Surprises Act (“NSA”) permits access to Internal Dispute Resolution (“IDR”) for any surprise medical bill following a 30-day period when the plan and provider try to negotiate a payment amount.
- The IDR process follows so-called baseball-style arbitration rules:
  - Each party submits a final offer, and within 30 days the IDR entity determines which offer is most reasonable.
  - The IDR decision is binding, and the losing party must pay the cost of the arbitration process.

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No Surprises Act

- The IDR process rules (cont.):
  - In making its determination, the IDR may consider a number of factors, including the plan's median in-network rate for the service but it may not consider the undiscounted provider charge or the amount public programs (such as Medicare) would pay for the service.
  - This approach is intended to minimize reliance on the IDR and encourage all parties to submit reasonable bids.
  - The CBO estimated the law will lower payments to some providers, resulting in a reduction of private health plan premiums between 0.5% and 1% on average, and – because the federal government subsidizes private insurance directly or through tax preferences – reducing the federal deficit by $17 billion over 10 years.

No Surprises Act

- Interim Final Regulations ("IFR") were issued on July 1, 2021 by HHS, Treasury, and DOL and the Office of Personnel Management ("OPM") to implement the NSA.
- All group health plans, even group health plans considered "grandfathered" under the Affordable Care Act ("ACA"), must comply.
  - Readopts Section 2719A of the Public Health Service Act (which was added by the ACA), extending the scope of this protection to all plans, including grandfathered plans beginning in 2022.

No Surprises Act

- The IFR includes additional clarity on how emergency services must be covered—plans and insurers cannot:
  - Limit the coverage of emergency services based on plan terms or conditions (other than the exclusion or coordination of benefits), waiting periods, or cost-sharing requirements.
  - Impose limits on out-of-network providers that are more restrictive than those for in-network emergency care.
  - Deny coverage for care received in an emergency setting based solely on diagnostic codes.

No Surprises Act

- Plans and insurers cannot (cont.):
  - Deny coverage for emergency care without first applying a prudent layperson standard (i.e., whether a prudent person would reasonably seek emergency care based on his or her symptoms).
  - Require a time limit between the onset of symptoms and when the patient sought emergency care or deny coverage simply because symptoms were not sudden.
  - Deny emergency services based on general plan exclusions (e.g., denying emergency coverage for pregnant dependents because a plan excludes dependent maternity care, etc.).

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No Surprises Act

- The IFR includes model notices and disclosure forms, as well as other related materials.
- Employers and other plans sponsors need to ensure that their summary plan descriptions and plan documents are updated in accordance with the NSA.
- Plans, insurers, providers, and facilities must post a publicly available notice about the NSA's patient protections and balance billing requirements on their websites.
  - Must include this disclosure on every explanation of benefits for items or services that fall under the NSA.

No Surprises Act

- Most state laws impose a minimum out-of-network payment requirement on health plans, either directly by specifying a “benchmark” payment, or indirectly by creating an arbitration process for insured health plans that are subject to their state laws.
- The NSA defers to “specified state laws” for determining how to resolve a payment dispute between a group health plan or insurer and out-of-network providers—the IFR confirms that this includes state laws that set a payment standard and those that use arbitration.

No Surprises Act

- In order for a state law to determine the "recognized amount" (which determines patient cost sharing) or QPA (the out-of-network rate), the state law must apply to:
  - the plan, insurer, or self-funded plan (if it has opted-in to state law);
  - the nonparticipating provider or facility involved; *and*
  - the item or service involved.
- Otherwise, the recognized amount must be determined under federal law, which would establish the patient cost sharing and the out-of-network rate.

No Surprises Act

- If state law applies to some but not all types of services or providers (e.g., if state law applies to anesthesia services, but not neonatology services) then recognized amounts would be handled separately under state and federal law.
- One major exception—air ambulance services would always be determined under Federal law since states are barred under the Airline Deregulation Act from setting payment rates for air ambulances.

No Surprises Act

- Self-funded plans can “opt-in” to state law requirements
  - But must opt-in for all items and services to which state law applies; and
  - Employer must provide a prominent notice to its participants that it is opting into the specified state law for out-of-network providers.
  - This is currently an option in only a handful of states—Maine, New Jersey, Nevada, Virginia, and Washington—and the scope of each state’s law varies.
  - This will be the only instance in which the specified state law applies to self-funded group health plans (which are not otherwise subject to state balance billing restrictions).

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No Surprises Act

- The IFR defines the "insurance market" to be the individual market, small group market, or large group market as defined under federal law.
  - Limited forms of coverage (such as short-term plans, excepted benefits, and health reimbursement arrangements or other account-based plans) and Medicare Advantage plans or Medicaid managed care plans are not included in the QPA calculation.
- For self-funded group health plans, the relevant "insurance market" is all group health plans offered by that employer or plan sponsor.
- Alternatively, an employer or plan sponsor that uses a third-party entity can direct the third-party administrator to calculate the QPA on their behalf using all group health plans that are administered by that entity.

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No Surprises Act

- Under the IFR, plans and insurers must then make certain disclosures with each initial payment or notice of denial of payment.
- They must disclose the following items:
  - the QPA for each item or service involved.
  - a statement certifying that the QPA is the recognized amount (for purposes of patient cost sharing) and was calculated in compliance with the methodology in the IFR.
  - a statement confirming the option for a 30-day open negotiation period to determine the total payment amount followed by initiation of the IDR process within 4 days of the end of the open negotiation period.

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Cost Sharing Transparency

Transparency in Coverage Final Rule included in the CAA (*subject to phase in*) *(new guidance delays some deadlines):*

- Before the CAA, the relevant agencies (i.e., the Departments of Labor, Treasury, and Health and Human Services (the "Departments") were directed to issue implementing regulations to guide plan sponsors and administrators.
- However, the CAA included provisions that substantially modified the cost transparency regulations.

Cost Sharing Transparency

In FAQs issued August 20, 2021, the Departments delayed several requirements:

- Self-insured group health plans and insurance companies to disclose in-network rates negotiated with health care providers, historic net prices for prescription drugs, and historic net reimbursement to out-of-network providers, for plan years *beginning January 1, 2022*.
  - Enforcement of the. machine-readable file requirement for healthcare services postponed to *July 1, 2022.*
  - Enforcement of the machine-readable files containing prescription drug pricing information postponed *until future regulations are issued.*

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Cost Sharing Transparency

In FAQs issued August 20, 2021, the Departments delayed several requirements:

- Cost-sharing information for over 500 “shoppable services,” effective for plan years beginning January 1, 2023.
- CAA required that information for all services be available and also via telephone (originally effective as of January 1, 2022.)
  - *The Departments will not enforce this provision until at least January 1, 2023.*
- Cost-sharing for all services, effective for plan years beginning January 1, 2024. *CAA provides January 1, 2023, so this is an open issue*.

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Cost Sharing Transparency

Health plans must begin providing an advanced explanation of benefits.

- Beginning in 2022, consumers can request advance information about how services will be covered before they are provided.
  - For scheduled services, consumers can submit requests and within three business days, the health plan must provide written information including:
    - Whether the provider/facility participates in-network; and
    - A good faith estimate of what the plan will pay and what patient cost liability may be.
- *Enforcement has been delayed until the Departments issue regulations.*
  - *Instead, the Departments will apply a reasonable, good faith compliance standard when enforcing this requirement.*

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Cost Sharing Transparency

- Health plans must provide transitional continuity of coverage when a provider leaves the network, effective for plan years beginning on or after January 1, 2022.
- Health plans and issuers must notify enrollees when a provider/facility leaves the plan network while it is providing ongoing care.
  - In certain cases, health plans must also provide transitional coverage for up to 90 days or until treatment ends (whichever is earlier) at in-network rates.
  - Applies to treatment for serious or complex health conditions, institutional or inpatient care, nonelective surgery, pregnancy, and care for patients with terminal illness.

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Cost Sharing Transparency

- Health plans must maintain accurate provider network directories.
  - Must establish a verification process to update provider directory information at least every 90 days.
  - Must respond within 1 business day to requests from individuals about whether a provider or facility is in-network.
  - Providers and facilities are also required to provide timely updates to health plans when the content of their directory information changes.
  - Consumers who rely on incorrect information conveyed by plans or posted in directories are entitled to have services covered with in-network cost sharing applied.

COVID-19 Vaccines

- While most employers were not requiring vaccines, “delta variant” of COVID-19 has caused many large employers to follow lead of the Federal government and mandate vaccines and provide incentives, including:
  - Paid time off;
  - Small value gift cards (less than $100); or
  - Cash incentives (less than $150).
- Some employers are adding the shot to wellness plans.
  - *Please note a reasonable alternative must be provided in that scenario.*
- *Since the Pfizer COVID-19 has received full FDA approval, some employers are now mandating the vaccine.*

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American Rescue Plan Act (ARPA)

- COBRA Subsidy
  - Up to 6 months of 100% subsidized coverage from 4-1-21 to 9-30-21.
  - For COBRA qualified beneficiaries whose qualifying event was an involuntary termination of employment or reduction in hours.
  - The subsidy applies to an “assistance eligible individual,” which includes both an employee and dependents who had elected or will elect COBRA.
    - Does not include voluntary terminations or termination “for cause”.

American Rescue Plan Act (ARPA)

- COBRA Subsidy (cont.)
  - The subsidy ends if the qualified beneficiary's maximum COBRA coverage period ends or if the individual is eligible for another group health plan or Medicare.
  - ARPA also provides additional enrollment options for individuals who already had an involuntary termination of employment or reduction in hours within the last 18 months and did not timely elect COBRA or dropped COBRA.
  - Additionally, employers are permitted to allow assistance eligible individuals to change elections to other plan options that have the same or lower cost premiums (*this is optional*).

American Rescue Plan Act (ARPA)

- COBRA Subsidy (cont.)
  - The assistance eligible individual does not pay the COBRA premium, but rather the premium initially is “advanced” by the employer, plan, or insurer.
  - Reimbursed by the government through a refundable tax credit against the tax imposed by Internal Revenue Code (“Code”) Section 3111(b), the Medicare hospital insurance tax.
  - The tax credit is fully refundable, meaning that even if the amount of the credit exceeds their Medicare hospital insurance tax obligations (including where they do not owe any Medicare hospital insurance tax), they will receive a payment from the IRS.
    - Through quarterly employment tax return (typically a Form 941).
    - Advance payments of the tax credit on Form 7200.

American Rescue Plan Act (ARPA)

- COBRA Subsidy (cont.)
  - ARPA provides that a "person to whom premiums are payable" is entitled to claim the tax credit for COBRA premiums not paid by an assistance eligible individual ("AEI") due to the subsidy.
  - In the case of any group health plan which is a multiemployer plan, the plan.
  - For other self-funded plans, and insured plans that are subject to federal COBRA, the employer maintaining the plan.
  - In the case of any group health plan (such as insured plans sponsored by small employers that are not subject to federal COBRA, but are subject to state continuation coverage requirements), the insurer providing the coverage.

American Rescue Plan Act (ARPA)

- COBRA Subsidy (cont.)
  - ARPA requires employers to update COBRA notices sent to AEIs to describe the subsidy and to issue extended COBRA election notices within 60 days of the date of applicability.
  - Employers also must issue notice of expiration of COBRA subsidy, final deadline is 9/30 for all remaining AEIs.
  - Failure to do so is treated as a failure of the COBRA notice requirements.

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ERISA FIDUCIARY OVERVIEW / BEST PRACTICES

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Employee Retirement Income Security Act of 1974 ("ERISA")

- Established in 1974 as a federal law to:
  - Regulate employee benefit plans;
  - Curb perceived abuses; and
  - Establish minimum standards for employee benefit plans.
- A main goal was to **establish fiduciary standards** for employee benefit plans and to **protect plan participants**.

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Who Is a Fiduciary?

- A person is a fiduciary if he/she/it:
  - Exercises discretionary authority or control over management of an employee benefit plan;
  - Renders investment advice for a fee; or
  - Has discretionary authority or responsibility in the administration of an employee benefit plan.

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Who Is a Fiduciary?

- A corporation, as well as an individual, may be a fiduciary.
  - If it can be shown that the officers have individual discretionary roles as to plan administration, the individuals are fiduciaries.
- A Committee is a fiduciary.

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Who Is a Fiduciary?

- A person who merely calculates benefits based on the plan document's provisions is not a fiduciary.
- Plan professionals, such as accountants, attorneys, actuaries, and non-investment consultants are not fiduciaries—unless they have exercised discretion and control over the plan or its assets.

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Settlor v. Fiduciary Functions ("Two Hats")

- Courts distinguish settlor (*i.e.*, plan sponsor) functions from plan fiduciary functions.
  - Generally, the decisions to establish a plan, set benefit levels, amend, or terminate a plan are settlor functions—not fiduciary functions.
  - Claims review would generally be considered a fiduciary function.
  - Investment decisions are considered a fiduciary function.

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Fiduciary Responsibilities

- A fiduciary must discharge duties with respect to the plan:
  - Solely in the interest of participants and beneficiaries;
  - For the exclusive purpose of providing benefits to participants and defraying reasonable expenses of administering the plan;
  - In accordance with the prudent man standard;
  - By diversifying the plan's assets; and
  - In accordance with the terms of the plan document.

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Fiduciary Liability

- Fiduciaries who breach their duty **are personally liable for losses** resulting from the breach.
- Fiduciaries may be removed for violating ERISA.
- A civil penalty can be assessed against a fiduciary (or a knowing participant) involved in a breach of duty.
- Tax penalties can be assessed.
- Criminal charges can be made.

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Co-Fiduciary Liability

- A fiduciary **is liable for the acts of other fiduciaries**, if the fiduciary:
  - Knowingly participates in, or conceals, an act or omission of another fiduciary, knowing it to be a breach;
  - Allows another fiduciary to breach its duty; or
  - Has knowledge of a breach and does not take reasonable steps to remedy the breach.

Fiduciary Liability

- A fiduciary who breaches his or her duties may be required to:
  - **Make good to the plan any losses resulting from such breach**;
  - Restore to the plan any profits made by the fiduciary as a result of the breach; and
  - Step down as a fiduciary and provide such other relief as a court may deem appropriate.
- Failure to comply with ERISA's fiduciary rules may subject a fiduciary to personal liability (both civil and criminal).

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DOL & IRS Audits

- Increasing
- Focus on:
  - Plan fees
  - Documented and followed procedures and processes
  - Selection and monitoring of plan providers
  - Missing participants
  - Issues raised in successful litigation (DOL is pursuing)

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ERISA Litigation Focus

- Historically, breach of fiduciary duty class action complaints alleged:
  - **Failure to monitor** fees and service providers
  - Recordkeeping fees are too high or paid through **revenue sharing**
  - **Share classes** are more expensive than others
  - **Failure to conduct** RFIs and RFPs to ensure fees are reasonable

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U.S. Retirement Plan Assets

- **$34.9 trillion** - Q4 2020
- **$9.6 trillion** - Defined contribution plan assets
  - **$6.7 trillion** in 401(k) plans
  - $1.2 trillion in 403(b) plan

Data from the Investment Company Institute

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ERISA Litigation Still on the Rise

- > ***90 lawsuits filed against DC plans for excessive fees in 2020*** (Euclid Specialty data), while only about 20 were filed in all of 2019 (Bloomberg Law data).
- Just over 200 new ERISA class actions were filed in 2020, an all-time record that represents an ***80% increase over the number filed in 2019 and more than double the number filed in 2018*** (Groom data).
- More claims brought against relatively smaller plans (*i.e.*, plans with <$100M in assets).
  - 2020 saw a rise in smaller plans

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ERISA Litigation Still on the Rise

- Spike can be explained by:
  - the ***maturing body*** of law under ERISA,
  - an ***emerging blueprint*** for filing and litigating cases,
  - ***new tools*** available to plaintiffs' attorneys, and
  - even the global pandemic.

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401(k) Plan Fee Settlements

- **$39.8M –** Reliance Trust Co. (Insperity 401(k) Plan) (2021)
- **$39.5M –** McKinsey (2021)
- **$17.5M -** DeMoulas Super Markets (2020)
- **$9.7M –** BlackRock (2021)
- **$2.55M –** Teva Pharmaceuticals (2021)
- **$4.05M –** Cerner Corp. (2021)

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401(k) Plan Fee Settlements

- **$55M** – ABB, Inc. (2019) (12 years of litigation)
- **$23.65M** – Anthem (2019)
- **$17M** – Philips North America (2018)
- **$24M** – BB&T (2018)
- **$21.9M** – Deutsche (2018)
- **$12M** – Allianz (2018)
- **$16.75M** – Northrop Grumman Corp. (2017)

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Best Practices to Avoid Liability

- Follow a ***prudent and deliberative*** fiduciary process.
  - Establish ***objective processes*** for evaluating and selecting plan investment options and service providers.
    - Committee Charter
    - Investment Policy Statement
  - ***Thoroughly document*** decisions in minutes (and resolutions, where necessary).
- Hold and attend ***regular committee meetings***.
  - Consistently document the good process followed
  - Minutes
- Delegation

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Delegation

- Fiduciary duties may be allocated or delegated:
  - Amongst trustees;
  - To non-named fiduciaries; and
  - To investment advisors.
- The key to delegation is the **prudent selection and continual monitoring** of the person / entity to whom the duties are delegated.

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Fiduciary Insurance & Indemnification

- Fiduciary Insurance
  - Coverage
  - Source of premium payment
  - Recourse waiver
  - However, the proliferation of 401(k) lawsuits has resulted in a serious spike in fiduciary liability insurance premiums and the policies are becoming more restrictive, with more exclusions, lower caps on coverage, and higher retention fees to renew policies.
- Indemnification

Case Example - Benefit of Prudent Procedure

- ***Wildman v. American Century Services, LLC***
  - Expert testimony: Up to $31,748,030 in damages from underperforming investments.
  - Fiduciaries had procedure to review and select and followed it.
  - Defendant was offering only proprietary funds, but the fiduciaries properly **documented** their deliberative process and reasons.
  - Breach of fiduciary duty claims were **dismissed**.

Fiduciary Lessons

- Fiduciaries must **set up processes and follow them**
- Monitor delegees
  - **Selection and continual monitoring** is required for investment adviser, recordkeeper, auditor, etc.
- Fiduciaries should **prudently select and monitor** investments based on both fund performance and expenses

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RETIREMENT PLANS HOT TOPICS

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Retirement Plans Hot Topics

- Cybersecurity
- Missing participants
- EPCRS Updates
- Target Date Funds
- ESG
- Cycle 3 Restatements
- SECURE 2.0

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Cybersecurity

- The DOL has begun a new cybersecurity audit initiative for retirement plans.
- First set of guidance (issued April 2021):
  - *Tips for Hiring a Service Provider*: to assist in selecting providers that have robust cybersecurity practices in place.
  - *Cybersecurity Program Best Practices*: a list of 12 best practices that recordkeepers and those responsible for plan-related IT systems should include in their cybersecurity plan.
  - *Online Security Tips*: a document addressed to plan participants to encourage them in implementing online risk mitigation techniques, such as multi-factor authentication.

***Guidance available in materials*

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Cybersecurity

- Recent investigations are asking plan fiduciaries to document how they and their service providers are complying.
- Plan fiduciaries should:
  - Review the DOL guidance.
  - Inventory what cybersecurity practices are currently in place (review internal procedures and request procedures from all service providers).
  - Incorporate the DOL's best practices into future service provider requests for proposals.
  - Take steps to align cybersecurity programs and processes with the guidance provided.
  - Have cybersecurity insurance.

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Missing Participants

- On January 12, 2021, the DOL issued three distinct pieces of guidance on missing participants:
  - A “Best Practices” document, which appears to be aimed at describing practices plan fiduciaries should consider;
  - Compliance Assistance Release 2021-01, which describes the approach to be taken by regional offices in investigations under the terminated vested participants (“TVP”) enforcement project; and
  - Field Assistance Bulletin 2021-01, outlining the enforcement policy authorizing use of the PBGC missing participant program for missing and nonresponsive participants.

***Guidance available in materials*

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Missing Participants

- The Biden administration may review and revise this Trump administration guidance.
- Even before the 2021 guidance, the DOL took the position that ERISA plan fiduciaries had a duty to locate missing participants.
  - The DOL reviews this issue during retirement plan audits.
  - If the DOL believes that the ERISA plan fiduciaries failed to satisfy their duty, the DOL letter regarding the audit will allege a breach of fiduciary duty and require corrective actions.

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EPCRS Updates

- The Internal Revenue Service ("IRS") released an updated Employee Plans Compliance Resolution System ("EPCRS") on July 16 (Rev. Proc. 2021-30). Plan sponsors use EPCRS to correct plan failures.
  - *Self-Correction Program ("SCP")*—correct certain plan failures without contacting the IRS or paying a user fee
  - *Voluntary Correction Program ("VCP")*—correct failures not eligible for SCP and to get the approval of the IRS that the failures were properly corrected
  - *Audit CAP*—resolve failures discovered during an IRS audit that can't be corrected using SCP

EPCRS Updates

- The VCP anonymous submission procedure was eliminated, effective Jan. 1, 2022.
- An anonymous, no-fee, VCP pre-submission conference procedure was added.
- Self-correction under SCP was expanded:
  - for availability of correction by plan amendment; and
  - SCP correction period for significant failures extended by one year.
- Two new benefit overpayment correction methods designed to encourage employers to avoid seeking recoupment of benefit overpayments made to participants.

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Target Date Funds

- Target date funds ("TDFs") have increased in popularity since plan sponsors were able to automatically enroll employees in a TDF as the plan's qualified default investment alternative ("QDIA") (investment made when a participant does not make his or her own in a participant-directed defined contribution plan).
  - By the end of 2020, TDFs held $2.8 trillion in assets, a 22% increase over 2019 (according to Morningstar).
  - At year end of 2018, 27% of 401(k) plan assets now invested in TDFs (ICI).

Target Date Funds

- As TDFs have increased, so has scrutiny, by the Biden DOL, Congress, and plaintiffs' attorneys.
- The Government Accountability Office ("GAO") was asked to review TDFs to evaluate whether the expenses and risk allocations are appropriate for the participants enrolled in them.

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Target Date Funds

- Fiduciary questions rather than “setting and forgetting”:
  - How are plan fiduciaries documenting and recording their process for the selection and monitoring of TDFs?
  - Are fees and expenses reasonable considering the glidepath and asset allocation of the TDFs?
  - Has sufficient information and disclosure been provided to plan fiduciaries, and how is the plan disclosing information to participants to aid their understanding of how the TDFs are structured?

ESG

- The Biden DOL will not enforce two final rules (from November and December 2020) that restricted ERISA retirement plans' consideration of environmental, social, and governance ("ESG") factors in the investment of plan assets (March 10, 2021 enforcement policy statement).
- This statement followed President Biden's executive order directing federal agencies to review regulations issued during the Trump Administration that may be inconsistent with his administration's policy objectives related to health and the environment.

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ESG

- The DOL “intends to revisit the” ESG rules, but provided no timeline for doing so.
- Private litigants may still seek to enforce these regulations through ERISA breach of fiduciary duty claims.

Cycle 3 Restatement

- Every six years, employers must restate their pre-approved qualified 401(k) plan documents to incorporate any recent legislative and regulatory changes that occurred since the documents were last rewritten.
- "Cycle 3" restatements will need to be amended and adopted by plan sponsors by the deadline of July 31, 2022.
  - There are penalties for non-compliance.
- You should inquire with your third party administrator if you have not yet heard about its timeline for your plan's restatement.

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Cycle 3 Restatement

- IRS approval letters for Cycle 3 plan documents only consider the legislative and statutory changes made prior to February 1, 2017.
- New laws that have been passed since still need to be addressed in separate, good-faith amendments, such as:
  - Hardships (January 2019 Treasury Regulations)
  - SECURE Act
  - CARES Act

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SECURE 2.0

- **Required Minimum Distributions**
  - Provisions that would affect RMDs include those that would set new beginning dates for RMDs at age 73 beginning in 2027 and age 75 beginning in 2033 and a reduction in excise tax penalties for RMD failures.
  - These changes would result in funds staying in the plan for a longer period and could even lower fees.
- **Catch Up Contributions**
  - SECURE 2.0 would increase the catch-up contribution limit to $10,000, and $5,000 for SIMPLE IRA.
  - It would establish, for taxable years beginning in 2023, that 62, 63, and 64 would be that ages at which individuals would be eligible to make catch-up contributions.

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SECURE 2.0

- **Long-Term Part-Time Employees**
  - SECURE 2.0 would amend SECURE 1.0 to reduce the time period from three years of 500 hours or more to two years of 500 hours or more.
  - Prior service for vesting would not apply (applicable if the employer provides contributions, which is not required for this group).

SECURE 2.0

- **Retirement Savings Lost and Found**
  - Under SECURE 2.0, the Pension Benefit Guaranty Corporation (“PBGC”) would be required to update its existing online database of lost accounts to include the unclaimed accounts of $6,000 or less of all former employees.
  - It also provides that employers would be allowed to transfer to the PBGC the retirement accounts of former employees with a balance of less than $1,000, to be invested in U.S. Treasury securities.

UPCOMING PLAN AMENDMENT DEADLINES

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Plan Amendment Deadlines

- Employers that implemented any of the CAA cafeteria plan changes must amend their plan documents by no later than December 31, 2021(for changes applicable to the 2020 plan year).
- An amendment increasing the dependent care FSA maximum must be adopted by December 31, 2021.

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OPEN DISCUSSION AND QUESTIONS WITH THE PRESENTERS

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