Verrill

Benefits Law Update

The Employee Benefits & Executive Compensation Group

Client Advisory
December 2019

This Client Advisory highlights important developments in the law governing employee benefit plans and executive compensation over the past year. It offers insight into what these developments mean for employers and plan sponsors and previews developments we expect to see in 2020. The following topics are covered (click on a topic to go directly to the summary):

DOL Proposes New Electronic Distribution Rule

In October, the Department of Labor (DOL) announced a proposal to update the rules for electronic distribution of retirement plan disclosures. When finalized and adopted, the new safe harbor rules will update outmoded guidance that has been in place since 2002.

The new rules do not apply to disclosures regarding health and welfare benefit plans, which the DOL believes to be a more challenging matter that requires further study. Nevertheless, the new rules come as welcome news to employers and plan administrators who have been waiting for an electronic disclosure regime that reflects the modern workplace.

The new rules will apply to any disclosure document that a plan administrator is required to distribute broadly to retirement plan participants and beneficiaries under ERISA. In addition to summary plan descriptions, the new rules will cover documents that must be furnished because

of the passage of time (such as benefit statements and summary annual reports), as well as documents that must be furnished because of a specific triggering event (such as a summary of material modifications or blackout notice). The new rules will not cover documents that must be furnished in response to a specific request made by a participant or beneficiary under Section 104(b) of ERISA.

The new rules will permit a plan administrator to distribute a disclosure document by posting it to a website and sending an email to participants and beneficiaries alerting them that the document is available with a link to the document. Each participant and beneficiary who will receive documents under the new electronic disclosure regime must be notified in writing (i.e., on paper) that the new system will be used and they must be allowed to opt out of electronic distribution at any time.

The new rules do not replace traditional paper distribution methods, which still remain valid. So employers may continue to distribute disclosure materials the "old fashioned way" if they choose to do so.

The proposed rules provide detailed guidance regarding the content of email cover messages and specifications for websites hosting the documents that are required to be distributed. Plan administrators will need to comply with these technical requirements, some of which may change as the rules evolve toward finalization, in order to take full advantage of the new rules.

Plan administrators may not rely on the new rules until they are finalized, likely in 2020.

Errors in ACA Penalty Assessments Require Prompt Employer Action

While the individual mandate penalty under the Affordable Care Act (ACA) was reduced to $0 this year, the employer shared responsibility mandate and ACA reporting requirements remain intact, and employers continue to face potential assessments for failing to offer affordable, minimum value coverage to at least 95% of their full-time employees.

The IRS sends letters – known as "Letter 226-J" – informing employers that they owe a penalty based on information the employer provided on Forms 1094 and 1095-C, information employees provided on individual income tax returns, and information the insurance exchanges provide regarding eligibility for subsidies. An employer may receive Letter 226-J if any of its full-time employees enroll in exchange coverage for at least one month and receive a subsidy.

As we have worked with employers to respond to these letters, it has become clear that errors in reporting and factual inaccuracies are common. Typically, fixing these errors is all that is necessary to reduce or eliminate the penalty, but it is important to take prompt action.

Employers must respond to Letter 226-J within 30 days from the date of the letter. An extension may be requested, but our understanding is that IRS internal policy is to grant just one 30-day

extension per letter. Do not ignore the letter, as the IRS will next issue a Notice and Demand for payment, which can be subject to lien and levy enforcement actions.

Reach out to your Verrill attorney before you respond to Letter 226-J. We can help you review your filings, prepare a response, and navigate the process.

New Health Care Design Opportunity for Large Employers: Individual HRAs

In June, the Departments of Treasury, Labor, and Health and Human Services jointly finalized regulations that dramatically liberalize the rules for health reimbursement arrangements (HRAs). Prior to the issuance of these rules, large employers (those with 50 or more employees) were prohibited from offering HRAs that would reimburse employees for the cost of individual health insurance policies.

The final regulations create two new types of HRAs:

- individual health insurance coverage HRAs, or "ICHRAs"; and
- excepted benefit HRAs, or "EBHRAs."

EBHRAs allow employees to seek reimbursement of up to $1,800 (indexed for inflation after 2020) for a full range of benefits and are considered an "excepted benefit" under HIPAA if certain conditions are satisfied. The final regulations for EBHRAs closely track the proposed regulations.

ICHRAs are a significant development in health benefit planning. ICHRAs allow employers to reimburse expenses for health insurance premiums for Medicare coverage, as well as coverage purchased through the individual market and ACA Exchanges. Unlike EBHRAs, ICHRAs may constitute "minimum essential coverage" under the ACA. Accordingly, large employers may satisfy the ACA employer mandate to offer coverage to at least 95% of full-time employees by offering only an ICHRA, or offering an ICHRA for certain employees and traditional group health plan coverage to others.

An ICHRA must satisfy five requirements:

(1) *Enrollment* – Eligible employees must enroll in individual health insurance coverage (that provides more than excepted benefits such as limited dental and vision coverage).

(2) *Class* – The employer does not offer a major medical plan to the same "class" of employees who are eligible for the ICHRA reimbursement. All employees within a class of employees eligible for the ICHRA must be offered reimbursement coverage on the same terms with limited exceptions that allow differentiation based on age, number of dependents, and status as a former employee.

(3) *Opt-out* – Employees must be permitted to opt out of ICHRA coverage.

(4) *Substantiation* – The employer must have reasonable procedures in place for verifying and substantiating enrollment in individual health insurance coverage.

(5) *Notice* – Notices must be provided to employees at least 90 days before the beginning of each plan year that describe the ICHRA and its effect on any premium tax credit that might be available for the purchase of ACA Exchange coverage. (A model notice was released simultaneously with the final regulations.)

The most significant change to ICHRAs contained in the final rules is the addition of new "classes" of employees and endorsement of the ability to combine classes when identifying which groups of employees may receive ICHRA reimbursements versus an offer of traditional group health plan coverage. Specifically, the final rules provide employers with the flexibility to distinguish between hourly and salaried employees in addition to the previously identified classes of full-time, part-time, collectively bargained employees, seasonal employees, employees who work in a specific insurance rating area, foreign employees working abroad, and employees subject to a 90-day waiting period for traditional group health plan coverage.

The ability to combine classes provides employers with great flexibility and the opportunity to tailor health benefits for specific groups of employees. For example, an employer may offer ICHRA reimbursements rather than traditional group health plan coverage to just the part-time workers paid hourly working in a specific insurance rating area.

The final rules do not explain how an offer of an ICHRA can satisfy the ACA employer mandate requirement that coverage must be "affordable." Fortunately, the Department of Treasury recently proposed regulations that provide guidance regarding how to calculate whether an ICHRA provides "affordable" coverage. This guidance closely tracks IRS Notice 2018-88 and provides that an ICHRA offers "affordable" coverage if the difference between the amount of the reimbursement available through the ICHRA and the cost of self-only coverage for the lowest cost silver plan available to the employee on the ACA Exchange (in other words, an employee's out-of-pocket cost for coverage on the ACA Exchange after reimbursement from the ICHRA, if the employee purchases the lowest cost silver plan) does not exceed 1/12 of the employee's household income for the taxable year multiplied by the "required contribution percentage" for the year (9.78% in 2020).

Acknowledging that employers are not always aware of an employee's "household income," the proposed regulations adopt the W-2, rate of pay, and federal poverty line safe harbors that apply when measuring the affordability of traditional group health plan coverage and allow two simplifying safe harbors that permit employers to look back to the lowest cost silver plan from a prior year and consider the lowest cost silver plan in the area where an employee's primary site of employment is located.

The ICHRA final rules are effective January 1, 2020, but employers wishing to use an ICHRA to satisfy the ACA employer mandate may want to wait until the affordability rules are finalized prior to adopting a full-scale ICHRA program.

Newly Proposed Health Insurance Cost and Coverage Transparency Requirements

Acting on an executive order regarding health care transparency, the Departments of Treasury, Labor, and Health and Human Services have jointly proposed regulations that would require employer sponsored group health plans to disclose price and cost-sharing information to participants, beneficiaries, and enrollees. The proposed rule accompanies the recent final hospital price transparency rule requiring hospitals to provide a list of charges, including the charges negotiated with insurance companies, for the items and services they provide.

The proposed rule requires that plans and insurers disclose both rate information (information regarding the negotiated rate for in-network provider services and historical maximum reimbursement amounts for out-of-network providers) and personalized cost-sharing information (an estimate of the amount a covered individual would be required to pay for a covered item or service based on cost-sharing information (e.g., deductible, co-pay, out-of-pocket maximum)). The rate information must not only be disclosed to participants but also made available to the public.

Importantly, the proposed rule explains that an employer plan may satisfy the disclosure obligations by delegating the responsibility to the carrier or third-party administrator (TPA) for the plan.

The proposed rule may have significant implications for the relationship between plans and their service providers, as well as on the health care market as a result of the public disclosure requirement. However, several hospitals and health care industry groups recently filed suit to block the final hospital price transparency rule, and it is likely the proposed rate and cost-sharing transparency rule will face similar challenges.

The proposed rule will not be effective until one year after finalization. Comments are due January 14, 2020.

Remedial Amendment Period Closing Soon for Self-Correcting 403(b) Plans

Tax exempt and governmental employers should be mindful that the IRS remedial amendment period to correct qualification defects in 403(b) plan documents will expire on March 31, 2020.

The IRS periodically issues guidance and lists of required amendments for 403(b) plans. Plan documents that are not updated for these required modifications may become defective. Under Rev. Proc. 2017-18, plan sponsors may self-correct plan document defects and some operational defects, provided they do so by March 31, 2020. This correction period is known as the "remedial

amendment period" and is open to sponsors of both pre-approved and individually designed plans.

A plan sponsor may self-correct a defective 403(b) plan provision by:

- adopting a pre-approved 403(b) plan by March 31, 2020, that has a 2017 opinion or advisory letter; or
- amending an individually designed plan by March 31, 2020.

The correction may involve adding required plan provisions or modifying existing defective provisions. As a general rule, the correction must be retroactive to the later of January 1, 2010, or the effective date of the plan or disqualifying amendment. If the plan was administered based on the defective provision, any resulting operational defect must be corrected as well.

In order to take advantage of the relief provided under Rev. Proc. 2017-18, a plan sponsor must have adopted a written plan document by December 31, 2009 (or the effective date of the plan, if later). If a plan sponsor did not have a written plan document in place by the required date, the sponsor may not self-correct plan qualification defects during the remedial amendment period. Instead, the plan sponsor must correct qualification defects under the IRS's Employee Plans Compliance Resolution System (EPCRS).

A plan sponsor's ability to retroactively correct operational defects is limited. An operational defect generally may not be corrected under Rev. Proc. 2017-18 unless:

- there is a plan document defect; and
- an operational defect results from the administration of the defective plan provision.

Other plan operational defects may be corrected under the procedures outlined in EPCRS.

Two examples of the types of plan defects and operational defects that may be corrected during the remedial amendment period are as follows.

> Example 1 – Plan Document Failure. Plan A, which was adopted January 1, 2009, does not contain required language limiting contributions and other annual additions under Section 415 of the Code. No participant has exceeded the Section 415 limit since January 1, 2009, so there is no operational defect. The Plan may be amended retroactive to January 1, 2010, to include the required Section 415 limits (prior to 2010 403(b) plans were not required to have a plan document, so there is no plan document failure for 2009).
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> Example 2 – Plan Failure and Operational Failure. Plan B, which was adopted January 1, 2011, excludes union employees from plan participation in violation of the universal availability rule for elective deferrals. Union employees were impermissibly excluded from plan participation since 2011. The plan must be amended retroactive to January 1, 2011, to cover union employees under the plan, and the plan sponsor must correct missing contributions and earnings based on principles in EPCRS. *Note:* if the union

employees were excluded because they were covered under another 403(b) plan maintained by the plan sponsor (a permissible exclusion under the universal availability rule), the 403(b) plan could be amended retroactive to January 1, 2011, to exclude union employees covered under the other 403(b) plan, and there would be no operational failure to correct.

The remedial amendment period under Rev. Proc. 2017-18 provides employers with a unique opportunity to review their 403(b) plans and correct defects retroactively without having to obtain IRS approval. We urge all employers sponsoring 403(b) plans to review their plan documents before the remedial amendment period expires on March 31, 2020.

IRS Opens Determination Letter Window to Cash Balance and Other Hybrid Plans

The IRS is now accepting determination letter applications from cash balance plans and other hybrid pension plans. During a one-year period from September 1, 2019, to August 31, 2020, the IRS will review individually designed hybrid plans to determine whether the plan document is compliant with all applicable rules through the 2017 required amendments list. The 2017 list includes the final hybrid plan regulations.

This marks an expansion of the determination letter program, after the IRS restricted the program in 2017 to focus on volume submitter plans and new individually designed plans.

This one-year window provides a valuable opportunity for plan sponsors to confirm that their plan is compliant with the final hybrid plan regulations, including the market-rate-of-interest rules. A plan's most recent determination letter likely did not consider these rules, because the IRS restricted the determination letter program before the final regulations became effective.

In addition to providing assurance that a plan is compliant in form, a current determination letter can be particularly useful during audits and investigations, and in the context of mergers and acquisitions.

Final Regulations on 401(k) Hardship Withdrawals

In September 2019, the Treasury Department issued final regulations governing hardship withdrawals from 401(k) plans. The final regulations update the existing 2004 regulations to reflect recent statutory changes made to the hardship withdrawal rules under Section 401(k) of the Internal Revenue Code, including:

- permitting the withdrawal of earnings on elective deferrals in the event of a hardship;
- permitting the withdrawal of QNECs, QMACs, and earnings on such contributions in the event of a hardship; and
- providing that a distribution will not be treated as failing to be made upon a participant's hardship solely because the participant does not take any available loan under the plan.

In addition, the final regulations eliminate the requirement under the existing regulatory safe harbor to suspend a participant from making elective deferrals or employee contributions for a period of six months following receipt of a hardship withdrawal.

The final regulations also update the list of deemed "immediate and heaving financial needs" by:

- adding a participant's "primary beneficiary" as an individual for whom qualifying medical, educational, and funeral expenses may be incurred;
- removing an unintended restriction on qualifying expenses for the repair of damage to a participant's principal residence; and
- adding a new expense to the list – expenses and losses (including loss of income) incurred by a participant as a result of a federally-declared disaster, provided the participant's principal residence or principal place of employment was located in an area designated by FEMA for individual assistance with respect to the disaster.

The final regulations are substantially similar to the proposed regulations issued last year, and 401(k) plans that complied with the proposed regulations will satisfy the final regulations. However, plan sponsors who made changes in response to the proposed regulations should review any prior plan amendments and administrative procedures to ensure that the plan complies with the final regulations in both form (*i.e*., the plan document) and in operation. For example, plan sponsors who amended their plans for the proposed regulations may wish to further amend their plans for the less strict standard in the final regulations regarding the employee representation requirement described below.

The final regulations also modify the rules for determining whether a distribution is necessary to satisfy an immediate and heavy financial need by eliminating the existing regulatory safe harbor and providing one general standard for determining whether the distribution is necessary. The new general standard has three components:

(1) A hardship withdrawal may not exceed the amount of the employee's need (including any amounts necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated to result from the distribution).

(2) The employee must have obtained all other currently available distributions (including distributions of ESOP dividends) under the plan and all other plans of deferred compensation, whether qualified or nonqualified, maintained by the employer.

(3) The employee must represent, in writing (including by using an electronic medium), that the employee has insufficient cash or other liquid assets *reasonably available* to satisfy the financial need.

Importantly, in response to a comment the Treasury Department received on the proposed regulations, the words "reasonably available" were added to the employee representation requirement in the final regulations. By adding these two words, the Department explained that an employee could make the representation that he or she meets this requirement even if the employee has cash or other liquid assets on hand, provided that cash or other assets is earmarked

for payment of another obligation in the near future (for example, rent). The employee representation requirement applies for distributions made on or after January 1, 2020, and a plan administrator may rely on the participant's representation unless the plan administrator has actual knowledge to the contrary.

The final regulations provide that a 401(k) plan generally may provide for additional conditions to demonstrate that a withdrawal is necessary to satisfy an immediate and heavy financial need. For example, a plan may require a participant to first obtain all nontaxable loans available under the plan before a hardship withdrawal may be made or impose a nondiscriminatory minimum dollar withdrawal amount. However, the final regulations no longer permit a plan to provide for a suspension of elective deferrals or employee contributions as a condition of obtaining a hardship withdrawal. This prohibition applies only for hardship withdrawals made on or after January 1, 2020, but plan sponsors may choose an earlier implementation date, as explained below.

Applicability Dates. The final regulations apply to hardship withdrawals made on or after January 1, 2020. However, plan sponsors have the option to apply them sooner – they may be applied to hardship withdrawals made in plan years beginning after December 31, 2018, and the prohibition on suspending elective deferrals and employee contributions may be applied as early as the first day of the first plan year beginning after December 31, 2018, even if the distribution was made in the prior plan year. This means a calendar year plan providing for hardship withdrawals under the pre-2019 safe harbor standards may either:

- be amended to provide that a participant who received a hardship withdrawal in the second half of 2018 is suspended from making contributions only until January 1, 2019; or
- continue to provide that contributions are suspended for the originally scheduled six months.

In addition, the revision to qualifying expenses for the repair of damage to a participant's principal residence may be applied to withdrawals made on or after a date that is as early as January 1, 2018.

If a plan sponsor chooses early application of the final regulations, the new rules requiring an employee representation and prohibiting suspension of elective deferrals and employee contributions may be disregarded with respect to hardship withdrawals made before January 1, 2020.

Plan Amendments. The Treasury Department and IRS expect that plan sponsors will need to amend the hardship withdrawal provisions in their 401(k) plans to reflect the final regulations.

As a rule, individually designed plans have until December 31, 2021, to be amended for the final regulations. Pre-approved 401(k) plans (*e.g.*, volume submitter and prototype plans), as well as individually designed and pre-approved 403(b) plans, may have an earlier amendment deadline.

Note for 403(b) Plan Sponsors. The final regulations generally apply to 403(b) plans too. However, earnings attributable to Section 403(b) elective deferrals remain ineligible for distribution on account of hardship, and QNECs and QMACs in a Section 403(b) plan that are in a custodial account continue to be ineligible for hardship withdrawals. QNECs and QMACs in a Section 403(b) plan that are not in a custodial account may be withdrawn in the event of hardship.

Massachusetts Among Several States Implementing Paid Leave Programs

This year, Massachusetts rolled out the first stages of its paid family and medical leave program. The program requires employers and employees to make contributions, and the Commonwealth provides income replacement for new parents, individuals dealing with a serious medical condition, and individuals caring for a family member with a serious medical condition.

Although benefits under Massachusetts's program are not available until January 1, 2021, employers were required to begin collecting contributions on October 1, 2019, with the first payment to the Commonwealth due on January 31, 2020.

Recent years have seen a proliferation of paid leave laws and they have taken a variety of forms. Dozens of states and municipalities require employers to provide paid sick leave. Maine now requires paid time off that can be used for any reason. And along with Massachusetts, California, Connecticut, New Jersey, New York, Rhode Island, Washington State, and Washington D.C. have adopted state-run paid leave programs.

Massachusetts's program is representative of the basic structure of these state-run programs. The program is funded by a payroll tax, which employers are required to collect and remit on a quarterly basis. When an employee goes on leave, the employee applies to the newly formed Massachusetts Department of Family and Medical Leave for benefits, and the Commonwealth makes payments directly to the employee.

The program provides:

- 20 weeks of paid medical leave for an employee's own serious health condition;
- 12 weeks of paid family leave following birth, adoption, or foster care;
- 12 weeks of paid family leave for a family member's serious health condition; and
- 26 weeks of paid family leave to care for a family member who is a member of the armed services.

An employee may take up to a total of 26 weeks of family and medical leave in any 52-week period. Leave may be taken intermittently. While on leave, the employee receives a percentage of their average weekly wages prior to going on leave, up to a maximum of $850 per week. All employers are required to provide certain information about their employee population to the Department of Family and Medical Leave on a quarterly basis.

Every employee in Massachusetts is eligible for benefits and is required to make contributions to the program. All employers who employ at least 25 individuals in Massachusetts are required to make employer contributions, unless the employer maintains a qualifying private plan and applies to the Department of Family and Medical Leave for an exemption. If an employer receives an exemption, its employees are not required to make contributions and are not eligible for benefits under the Commonwealth's program.

Exemptions are available to employers that maintain a paid family and medical leave program that provides benefits at least as generous as the Commonwealth's program and meets a number of specific requirements. Employer programs may be either insured or self-funded, but self-funded programs are required to purchase a surety bond.

Employers seeking an exemption may apply at any time. Exemptions take effect for the quarter following the application, and must be renewed annually. However, employers may receive an exemption for the program's first quarter (October 1 through December 31, 2019) by applying before December 20, 2019.

Employers in Massachusetts who have not already received an exemption from the program should prepare to make the first quarter remittance and information reporting. For any employer interested in applying for an exemption, we can review an existing paid leave program for qualification or design a new qualifying program, and assist in applying for an exemption.

All employers need to be aware of any state and local paid leave laws in their area and be vigilant about any new developments.

Legislative Update

Paid Leave Tax Credit – The 2017 Tax Cuts and Jobs Act included a two-year pilot project that provides a tax credit to employers that offer at least two weeks of paid leave to low and moderate income employees. That pilot project is set to expire for tax years beginning after 2019. Some members of Congress have been working to extend the program, but as of publication, their efforts have been to no avail. Therefore, employers taking advantage of the credit should assume that 2019 may be the last year it is available.

Note that the IRS recently issued 2019 Instructions for Form 8994, Employer Credit for Paid Family and Medical Leave, which employers will want to review in order to claim the tax credit for 2019.

SECURE Act – In May, the House of Representatives voted 417-3 to pass the Setting Every Community Up for Retirement Security Act (SECURE Act). We understand that the corresponding legislation in the Senate is being held up by only three legislators (Ted Cruz, Mike Lee, and Pat Toomey) who will not allow its passage using unanimous written consent.

The SECURE Act has been described as the most significant retirement plan legislation since the 2006 Pension Protection Act. If passed, it would affect virtually all plan sponsors. Some of the major provisions include:

(1) Encouraging Employer-Provided Plans – the Act would:

- permit unrelated employers to pool their resources by participating in a new type of multiple employer retirement plan.
- increase the amount of the tax credit available to certain employers for qualified start-up costs and provide for an additional nonrefundable credit for small employers that establish retirement plans that include automatic enrollment or add automatic enrollment as a feature to an existing plan.
- allow an employer to adopt a qualified retirement plan after the close of a taxable year.

(2) Lifetime Income Provisions – the Act would:

- require employers to provide defined contribution plan participants with an estimate of the amount of monthly annuity income the participant's account balance could produce in retirement.
- create a new fiduciary safe harbor for employers who opt to include a lifetime income investment option in their defined contribution plan.
- permit participants to make direct trustee-to-trustee transfers to an eligible employer plan or IRA.

(3) Changes Affecting Plan Distributions – the Act would:

- change the post-death required minimum distribution (RMD) rules for non-defined benefit plans to generally require that all distributions after death be made by the end of the tenth calendar year following the year of death.
- increase the age at which RMDs must begin from 70½ to 72.
- permit individuals to take penalty-free withdrawals for expenses related to the birth or adoption of a child.
- prohibit plan loans made through credit cards.

(4) Changes Affecting Plan Administration – the Act would:

- require that 401(k) plans permit participation by long-term, part-time employees who work at least 500 hours in three consecutive 12-month periods and have reached age 21.
- increase the automatic enrollment safe harbor limit to 15 percent from 10 percent.
- make numerous changes to nonelective 401(k) safe harbor plans.
- require the IRS and DOL to modify Form 5500 so that all members of a multiple employer plan may file a consolidated Form 5500.

(5) Defined Benefit Plan Provisions – the Act would:

- permit certain frozen "community newspaper plans" to elect to apply alternative funding rules.
- set certain PBGC insurance premiums.
- provide nondiscrimination, minimum coverage, and 401(a)(26) relief for "soft frozen" plans.

(6) Changes Affecting IRAs and Other Plans – the Act would:

- repeal the prohibition on contributions (and deductions) to a traditional IRA for individuals who have attained age 70½ by the end of a year.
- treat as compensation amounts includible in income and paid to aid individuals in their pursuit of graduate or postdoctoral study or research for IRA contribution purposes.

A host of other changes would affect 529 plans, 403(b) plans, and church plans.

Although the window for passage in 2019 is closing, benefits professionals will want to continue monitoring the Act next year. Verrill is following this legislation closely and will provide updates and additional information if it passes.

Litigation Round-up

Cross-Plan Offsetting *(Peterson v. UnitedHealth Group Inc.)* – Cross-plan offsetting is a process used by health insurers and third-party administrators (TPAs) to recoup overpayments to a healthcare provider under one health plan they administers, by underpaying the same provider under a different health plan that they administer.

The U.S. Court of Appeals for the Eighth Circuit recently ruled in *Peterson v. UnitedHealth Group Inc.* that a TPA may not rely on general grants of administrative authority to interpret a plan document as authorizing cross-plan offsetting. In other words, without specific authorization of cross-plan offsetting in the plan document, the Court concluded the practice was impermissible.

Perhaps more importantly, the Court noted that cross-plan offsetting is "in tension" with the TPA's fiduciary duties under ERISA. The Court opined that cross-plan offsetting "at the very least approaches the line of what is permissible" under ERISA.

While on appeal, the DOL filed an amicus brief in support of the providers, concluding that cross-plan offsetting violated ERISA's exclusive benefit rule (a fiduciary can't fail to pay a beneficiary under one health plan in order to recover money for a different heath plan). Moreover, the DOL noted that TPA-insurers appear to benefit from this practice to the detriment of self-insured plans. United Health Care benefited from the overpayment recoupments because all the plans that overpaid were insured plans and an overwhelming percentage of the cross-plan payments came from self-insured plans. Essentially, United Health Care appeared to be diverting funds

from the self-insured plans it administered to reimburse itself for overpayments under its own, fully insured plans. United Health Care initially asked the Supreme Court to overturn the Eighth Circuit, but resolved the matter with the providers and dropped the appeal.

Self-insured health plan sponsors should determine whether their TPAs engage in cross-plan offsetting, and if so, consult legal counsel to help evaluate the risk, consider their options, and update their plan language, as necessary.

Pension Plan Mortality Table Litigation *(DuBuske v. PepsiCo, Inc.)* – In early December 2018, a new kind of lawsuit was filed against Metropolitan Life Insurance Company. The plaintiffs, MetLife retirees, claimed that MetLife's defined benefit pension plan used outdated mortality tables or factors to calculate benefits under certain optional forms of annuity, and as a result their monthly payments were too small in violation of ERISA.

Similar lawsuits were filed against American Airlines, PepsiCo, US Bancorp, AT&T, and other high profile companies (and their pension plan's fiduciaries) in the succeeding months. Plaintiffs in each case have sought class certification.

The specific allegations differ from lawsuit to lawsuit, but a common theory underlies all of them. Plaintiffs assert that, when ERISA requires an optional annuity to be "actuarially equivalent" to the normal form – typically a single life annuity – ERISA is imposing a requirement that the mortality tables used to determine actuarial equivalence must be reasonable; reasonableness precludes the use of older tables as mortality improves; and, therefore, using older tables results in a forfeiture of vested benefits. Plan fiduciaries are charged with a breach of their responsibilities by using the mortality factors prescribed by the plan document. Plaintiffs generally seek reformation of their pension plan, recalculation of their benefits under new factors, and corrective payments of the allegedly past due amounts.

Most defendants have responded with motions to dismiss. In addition to defending particular plan terms, the motions include the fundamental contentions that:

- the alleged ERISA requirement does not exist; and
- to the extent claims are derived from a requirement for qualified plans under the tax laws, such a requirement can neither be imported into ERISA nor challenged on its own by plan participants.

Further, defendants point out that fiduciaries are required to follow plan terms unless the terms violate ERISA. Therefore, in the absence of an ERISA requirement, failing to use the mortality factors prescribed by the plan document would itself be a breach of fiduciary duty.

One year after the first cases were filed, the ongoing litigation is in early stages. PepsiCo, alone among the defendants, prevailed on a motion to dismiss the lawsuit against it in September 2019. *DuBuske v. PepsiCo, Inc.* (S.D.N.Y.). The *PepsiCo* plaintiffs were granted leave to amend their case, but then agreed on November 22 to dismiss the lawsuit. The only other rulings were in favor of plaintiffs, with American Airlines and US Bancorp losing motions to dismiss earlier this

year. *Torres v. American Airlines, Inc.* (N.D. Tex.); *Smith v. US Bancorp* (C.D. Minn.). Other defendants' (and plaintiffs') motions are pending.

It is too soon to predict the outcome of the pension plan mortality table litigation. No court has examined the merits of a lawsuit in any depth and more lawsuits may be brought. Plan sponsors should not reflexively change pension plan mortality assumptions in reaction to the litigation itself. Plan sponsors should, however, see this litigation as a reminder to be cognizant of their plan design and review the discretionary actuarial equivalence assumptions from time to time with the help of the plan actuary.

403(b) Plan Fee Litigation – Class action lawsuits alleging breaches of fiduciary duty by many prominent universities and their plan administrative committees continued in 2019, with a number of cases settling and others presumably heading in that direction.

Topping the list of settlements this year were the cases brought against Johns Hopkins ($14 million), Vanderbilt University ($14.5 million), and MIT ($18.1 million). Other notable 2019 settlements in 403(b) plan fiduciary breach cases include Brown University ($3.5 million) and Duke University ($10.7 million). Cases against Georgetown University, Columbia, Northwestern University, Yale University, University of Pennsylvania, and others are in various stages of litigation or appellate review or pre-trial motions.

The facts and circumstances of these cases vary, but all involve the payment of allegedly excessive investment fees and record keeping fees. In addition, a number of common factors appear to be present in most of the cases:

- Using multiple record keeping firms
- Offering too many investment options (typically dozens or more associated with the distinct investment platform of each record keeping firm)
- Using proprietary investment options offered by the record keeping firm
- Entering into opaque or excessive revenue sharing arrangements
- Using retail (expensive) mutual fund share classes when institutional (less expensive) share classes are available
- Failure to monitor the performance of the record keeper (including failure over many years to seek alternatives through an RFP process)
- Failure to monitor fees and expenses paid by the plan and plan participants

Employers in higher education, many of whom are still in the cross hairs of plaintiffs' attorneys, have drawn important conclusions from these cases regarding plan administration and investment fees and have enhanced their fiduciary oversight activities as a result.

But the cases have meaning for all tax exempt employers, and are well worth following. Most employers would benefit from a fiduciary governance check-up as part of a regular legal compliance review of internal practices.

The major takeaways from the 403(b) plan fee litigation are:

- Don't offer too many investment options
- Offer passive investment fund options (even if managed fund options are the finest kind)
- Avoid use of multiple record keepers (something not likely to be a problem outside of the higher education universe)
- Monitor administrative and investment fees regularly
- Seek competitive bids from service providers through an RFP process from time to time
- Make sure fiduciary committee members are engaged in the work
- Maintain good documentation of fiduciary governance activities

2020 Supreme Court Preview – Following a dearth of ERISA cases during the past term, the Supreme Court has several employee benefits cases on the docket for the current 2019-2020 term. The cases range across several areas. Here is a brief summary of each case before the nation's highest court:

IBM v. Jander, U.S., No. 18-1165. This case, argued November 6, 2019, requests that the Court provide additional clarification regarding the pleading standard articulated in its prior decision *Fifth Third Bancorp v. Dudenhoeffer*. In *Dudenhoeffer*, the Court articulated a new pleading standard for stock-drop cases through which plaintiffs allege they were harmed because plan fiduciaries caused the plan to continue holding company stock despite knowledge the stock value was falling. Under *Dudenhoeffer*, plaintiffs are required to plausibly allege an alternative to continuing to hold the stock that the fiduciary could have taken without violating insider trading laws and that a prudent fiduciary in the same circumstances would not have viewed as more likely to do more harm than good.

IBM represents the only Circuit Court case after *Dudenhoeffer* where ERISA claims involving alleged breaches of fiduciary duty in a stock-drop case were not dismissed and asks whether IBM insiders could be liable under ERISA for not promptly disclosing issues affecting the company that led to a 7% drop in stock price. The Second Circuit concluded that fiduciaries for the IBM plan who were also insiders of the company may have had a duty to more promptly disclose the problems that led the stock price to drop, while the fiduciaries argue they were not required to disclose more information to plan participants than what is ordinarily required to be disclosed under corporate securities law.

Intel Corp. Investment Policy Comm. v. Sulyma, U.S., No. 18-1116. ERISA's statute of limitations for breach of fiduciary duty claims generally provides plan participants and beneficiaries up to six years to initiate a cause of action but caps the period at three years if the plaintiff has "actual knowledge" of the alleged breach. In this case, argued December 4, 2019, the Court is asked to determine whether a "plaintiff" has "actual knowledge" of an alleged fiduciary breach where the alleged breach was apparent in ERISA-required disclosures that the plaintiff claims he did not read because the documents were posted to an internet web site and he disregarded the e-mail notification with links to the documents.

Combined Cases – *Moda Health Plan, Inc. v. United States*, U.S., No. 18-1028; *Maine Cmty. Health Options v. United States*, U.S., No. 18-1023; *Land of Lincoln Mut. Health Ins. Co. v. United States*,

U.S., No. 18-1038. In these combined cases, argued on December 10, 2019, health insurers are seeking approximately $12 billion in payments they claim they are due under the Affordable Care Act's risk corridor program. The ACA risk corridor program was designed to compensate insurers who lost money by providing insurance through the ACA exchanges and required insurers that profited following the new ACA requirements to pay a portion of their profits to the government.

A post-ACA rider requiring budget neutrality, however, limited the amount of money the Department of Health & Human Services could use to make these "risk corridor" payments to the amount collected from the profitable insurers. The issues before the Court concern esoteric matters regarding the implied repeal of unambiguous statutory language through a subsequent rider. The outcome will have a significant effect on insurers and the health care marketplace generally.

Thole v. U.S. Bank, N.A., U.S., No. 17-1712. Plaintiffs in this case asks the Court to consider whether they have standing to bring a claim for breach of fiduciary duty regarding a defined benefit plan when the plan is fully funded. The Plaintiffs allege U.S. Bank violated the fiduciary principles of prudence and loyalty when it invested the entirety of the plan's assets in high-risk equities resulting in massive losses to the plan. The United States Court of Appeals for the Eighth Circuit dismissed the plaintiffs' case, stating that because the plan is a defined benefit plan – where participants are entitled to a specified benefit amount, not an individual portion of the plan's funds – the participants did not have standing to sue because the plan had since recovered and, thus, the participant hadn't suffered any financial losses. Argument for this case is scheduled for January 13, 2020.

In addition to the above, the Solicitor General recently urged the Court to hear *Rutledge v. Pharm. Care Mgmt. Assoc.*, U.S., No. 18-540, and rule on ERISA preemption of state attempts to regulate pharmacy benefit managers (PBMs). We will provide updates regarding opinions issued by the Supreme Court through our blog – Benefits Law Update.

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