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Strategic Insights into Employee Benefits

SECURE 2.0, Mental Health Parity, and Compliance Priorities

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SECURE 2.0—Background

- SECURE 2.0 Act of 2022 contains 90+ provisions intended to encourage individuals to save for retirement, encourage employers to offer retirement benefits, and ease administrative requirements for sponsors of retirement plans
- Many changes took effect in 2024, with more taking effect in 2025, and at least one major change taking effect in 2026
- Plan sponsors have until **December 31, 2026** to amend their retirement plans to comply with SECURE 2.0 requirements, even though key changes have already been implemented on an administrative basis*

* The same deadline applies for CARES Act and SECURE 1.0 changes!

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Key retirement plan changes already in effect*

- Triggering age for RMDs increased to 73 for individuals who reach age 72 after 2022 (on the way to 75 after 2032)
- Participant election to treat employer contributions as Roth contributions
- Expanded opportunities for in-service distributions for terminally ill participants, for victims of domestic violence, and small personal emergency expenses
- Employer matching contributions based on qualified student loan payments
- Increase in mandatory cash out threshold (from $5,000 to $7,000)

***** ***Some mandatory, some optional, some optional changes defaulted in by recordkeeping vendors***

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Key retirement plan changes effective 2025

- Increased catch-up contributions for participants ages 60 through 63—annual limit is increased to the greater of:
  - $10,000 (indexed for inflation) *or*
  - 150% of the regular catch-up limit amount (so $11,250 for 2025)
- Mandatory inclusion of “long-term, part-time” employees
  - Took effect for 401(k) plans as of January 1, 2024, because SECURE 1.0 included the rule for 401(k) plans
  - Effective beginning January 1, 2025 for 403(b) plans

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Key retirement plan change effective 2026

- Rothification of catch-up contributions in 401(k) and 403(b) plans
  - Catch-up contributions must be made as Roth after-tax contributions for participants whose prior year taxable wages exceed $145,000 (indexed)
  - If plan does not already have an elective Roth contribution option, Roth capability will need to be added in order to comply
  - Effective for taxable years beginning after 12/31/25

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Long-Term Part-Time Employees

- "Long term, part time" (LTPT) employees must be allowed to make ***elective deferrals*** to their employers' 401(k) plans and 403(b) plans
- LTPT requirements ***do not affect eligibility for employer contributions***
- An LTPT employee is a common law employee, age 21 or older, who is credited with at least 500 hours of service in each of two consecutive 12-month periods
- Service counts starting with the date of hire, but can switch to plan year measuring periods after end of initial 12-month period
- Service crediting for prior years
  - 403(b) Plans: Service after 1/1/23 counts for 403(b) plans, because the requirement was extended to 403(b) plans in SECURE 2.0
  - 401(k) Plans: Service after 1/1/21 counts for 401(k) plans, because SECURE 1.0 included an LTPT requirement for 401(k) plans (but requiring three consecutive years)

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Long-term part-time employees (cont'd)

- Retirement plans can and should apply their regular service crediting methodology to determine LTPT employees
  - Counting actual hours
  - Equivalencies (e.g., 45 hours for a week in which EE is credited with 1 hour)
  - No need to abandon elapsed time method if that's what plan uses!
- If an LTPT employee does become entitled to receive employer contributions, vesting service is based on 500 hours of service per 12-month period rather than 1,000 hours of service
- Effective dates:
  - 403(b) Plans: January 1, 2025
  - 401(k) Plans: January 1, 2024, applying original SECURE 1.0 rule—three consecutive 500-hour service periods—for 2024 plan year only

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Expansion of self-correction opportunities

- Under SECURE 2.0, an “eligible inadvertent failure” can be self-corrected at any time, so long as meaningful steps are taken to fix the error before the IRS discovers it
  - A failure that occurs despite the existence of “practices and procedures” that satisfy the “standards” set forth in guidance explaining the EPCRS (IRS Revenue Procedure 2021-30)
  - Egregious errors cannot be self-corrected
  - VCP applications still required for most retro amendment corrections and certain other fixes

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Self correction opportunities (cont'd)

- IRS Notice 2023-43 confirms that a plan sponsor must be able to show that compliance practices and procedures were in place when the failure occurred. We interpret this to mean **written** practices and procedures!
- Extension of IRS pre-examination notice pilot program puts an even higher premium on adoption of compliance practices and procedures and timely self-correction of errors
  - IRS will notify plan sponsor 90 days before an examination would otherwise begin
  - starts a 90-day period during which plan sponsor may review its plan document and operations to assess compliance status
  - any errors identified by the plan sponsor may be corrected under EPCRS self-correction principles

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Amendment Deadline and Next Steps

- Employers must amend their plan documents to incorporate the requirements of SECURE 1.0, the CARES Act, and SECURE 2.0 by last day of the first plan year beginning after December 31, 2025 (no later than December 31, 2026, for calendar year plans)
- If choosing to adopt optional changes, work with record keepers (and document provider, if it is not the record keeper) to memorialize effective dates
- Update payroll systems to apply Roth catch-up contributions for highly paid participant group
- Enroll long-term, part-time employees, if any
- Stand by for new plan documents (late 2025 through 2026)

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DOL-EBSA Enforcement Initiatives

- Health plan investigations (mainly self-funded plans)
  - Cybersecurity
    - 2024 guidance confirms that fiduciary duties regarding cybersecurity apply to health and welfare plans
    - Keep this in mind when selecting and monitoring TPAs and other plan service providers
  - Administrative fees
    - Increasing scrutiny corresponds to increasing litigation
    - Fiduciary duties regarding reasonableness of fees are the same as the duties that apply to retirement plans
  - NQTL comparative analysis
    - More enforcement activity expected now that MHPAEA regs have been finalized
    - Initial focus likely to be on compliance assistance

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DOL-EBSA Enforcement Initiatives (cont'd)

- Retirement plan investigations
  - Administrative fees and selection of service providers
  - Missing participant search efforts
  - Terminated Vested Participant Program
- Retirement savings lost and found database
  - SECURE 2.0 directed DOL to establish an online database to help individuals find unclaimed retirement benefits by identifying the current plan administrator of ERISA retirement plans in which they are or were participants or beneficiaries
  - Voluntary Information Collection Requests were sent to retirement plan administrators and their authorized recordkeepers to begin populating the RSLF database

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Mental Health Parity—Quick Refresher

- Mental Health Parity Act (MHPA) and the Mental Health Parity and Addiction Equity Act (MHPAEA)
- Group Health Plans (GHPs) that provide medical/surgical (M/S) benefits and mental health or substance use disorder (MH/SUD) benefits are subject to three mandates:
    1. *Equal application of annual or lifetime dollar limits*;
    2. Parity regarding financial requirements and quantitative treatment limitations; and
    3. Parity regarding nonquantitative treatment limitations (NQTLs).

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NQTL Comparative Analysis—Requirement

- GHPs must complete a written NQTL Comparative Analysis that must be produced to the DOL, CMS, state agencies, and participants upon request.
  - Section 203 of Consolidated Appropriation Act 2021 - effective 2/10/2021
  - Analysis tests whether GHP imposes any NQTL that is more restrictive for MH/SUD benefits, as written or in operation, than the predominant NQTL for substantially all M/S benefits in the same classification (6 elements).
- Final Regulations Published 9/9/2024
  - Memorialize NQTL Comparative Analysis requirement.
  - Plan fiduciary certification regarding NQTL Comparative Analysis service provider.
  - Other changes: define whether condition is MH or SUD (2025), eliminated state and local MHPAEA opt out (2025), identify standards that affect NQTL comparative analysis (2026).

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NQTL Comparative Analysis—Enforcement

- DOL and CMS are already requesting NQTL comparative analyses.
- The DOL's most recent report to Congress delivered July 2023—of 216 NQTL comparative analyses reviewed by DOL and 21 reviewed by CMS, **none** were found to meet regulators' expectations.
- NQTL comparative analysis report must be made available to:
  - DOL, CMS, Treasury, and any applicable state authority 10 business days after request; and
  - plan participant or beneficiary 30 days after request.
- If the agency determines the initial response is insufficient, additional information must be provided within 10 business days of the follow-up request.
- If NQTL is determined not in compliance, the plan has 45 days to address the findings.
- If the agency makes a final determination of noncompliance: (1) it may prohibit the plan from imposing the NQTL for MH/SUD benefits until the plan proves compliance or remedies the violation, and (2) the plan must notify all participants and beneficiaries, service providers, and claims fiduciaries of the plan's noncompliance within 7 business days.

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MHPAEA Compliance—Action Items

- Fully-insured—talk to your carrier (or broker/benefits consultant) about MHPAEA compliance for your GHP
  - Insurance carrier responsible for producing NQTL comparative analysis
- Self-Insured—work with TPA (or benefits consultant/vendor/outside counsel) to:
  - Complete MHPAEA compliance testing,
  - Generate NQTL comparative analysis report, and
  - Implement changes recommended by testing and analysis.
- **Caution**—carefully read vendor reports and presentations!

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HIPAA—Reproductive Health Care

- Final Rule (published 4/26/2024) regarding uses and disclosures of PHI "potentially relating to reproductive health care."
- Reproductive Health Care = "health care . . . that affects the health of an individual in matters relating to the reproductive system and its functions and processes." (*E.g.*, pregnancy, fertility, contraception, abortion care.)
- Prohibit the use and disclosure of PHI for the following non-healthcare purposes:
    - To conduct a criminal, civil, or administrative investigation into any person for seeking, obtaining, providing, or facilitating *lawful* reproductive health care;
    - To impose criminal, civil, or administrative liability on any person seeking, obtaining, providing, or facilitating *lawful* reproductive health care; and
    - To identify any person for any purpose described in the above two prohibitions.
- Attestation required: https://www.hhs.gov/sites/default/files/model-attestation.pdf
- Implement by 12/23/2024, updated NPP by 2/16/2026.

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Retirement Plan Litigation 2024—Forfeitures

- Forfeitures = generally, amounts attributable to nonvested employer contributions and employer contributions attributable to the accounts of lost or missing participants.
- Forfeitures Account ≠ “ERISA” / “Plan” Account
- Putative class action lawsuits generally allege the employer improperly used forfeitures to reduce employer contributions to the plan rather than to pay plan administrative expenses.

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Forfeitures Litigation - Takeaways

- Don’t panic—litigation is ongoing (for example):
  - Motion to Dismiss **granted**: Barragan v. Honeywell Int’l, Inc., 24-cv-4529 (D. N.J. Dec. 19, 2024); Dimou v. Thermo Fisher Scientific Inc., et al., 23-cv-1743 (S.D. Cal. 9/19/2024); Hutchins v. HP Inc., 23-cv-05875, (N.D. Cal. June 17, 2024).
  - Motion to Dismiss **denied**: Rodriguez v. Intuit Inc., 23-cv-5053 (N.D. Cal. Aug. 12, 2024); Perez-Cruet v. Qualcomm, 23-cv-1890 (S.D. Cal. May 24, 2024).
- Follow the terms of your plan.
  - ERISA § 404(a)(1)(D); Sievert v. Knight-Swift Transp. Holdings, Inc., 24-cv-2443 (D. Ariz.).
- Review the forfeiture balance in the plan at least annually.
  - IRS Spring 2010 Newsletter guidance.
- Review and discuss plan document forfeiture provisions at fiduciary committee meetings.
- Consider amending plan document to specify an ordering rule for the use of forfeitures.

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Health Plan Litigation—Tobacco Surcharge

- New wave of putative class actions and DOL enforcement actions targeting tobacco surcharge programs through which tobacco users are subject to an additional surcharge on the employee's share of medical insurance premiums.
- Examples:
  - Ruiz v. Bass Pro Group LLC et al., 24-cv-03122 (W.D. Mo.)
  - Su .v Flying Food Group LLC et al., 23-cv-6583 (N.D. Ill.)
- Three primary allegations:
  - No "reasonable alternative" standard available to avoid full amount of the surcharge;
  - No communication regarding "reasonable alternative" standard; and
  - Collection of surcharge constitutes breach of fiduciary duty.

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Tobacco Surcharge Litigation - Takeaways

- Carefully consider scope and objective of tobacco surcharge
- Ensure compliance with all HIPAA wellness program requirements:
  - Design: Must be reasonably designed to promote health or prevent disease;
  - Frequency: Employees must be able to qualify for full surcharge exception at least once each year;
  - Size: Surcharges must not exceed certain limits; and
  - Uniform Availability: Exception must be available to all "similarly situated" individuals.
    - Must allow a reasonable alternative standard to any individual who does not meet the initial standard.
- Do not prorate surcharge reduction for "reasonable alternative."
- Availability of "reasonable alternative" must be contained in all documents describing program.

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Health Plan Litigation—Admin and Other Fees

- Lewandowski v. Johnson & Johnson, 24-cv-671 (D. N.J.)
- Navarro v. Wells Fargo & Co., 24-cv-3043 (D. Minn.)
- Putative class actions alleging that individual fiduciaries responsible for employers' prescription drug plan caused the plan to pay the plan's pharmacy benefit manager (PBM) unreasonably high prices for generic prescription drugs.
  - Wells Fargo lawsuit also alleges that the defendants caused the plan to pay excessive administrative fees to the PBM.
- A true "wave" of litigation?
  - Only two cases of this exact type (others concern related topics).
  - Both plans are funded by a trust.
  - Legitimate questions regarding standing and duty to negotiate individual drug prices.
- H&W plan fiduciaries are generally subject to same fiduciary obligations as retirement plan fiduciaries.

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Health Plan Fee Litigation - Takeaways

- Establish a group health plan fiduciary committee that maintains a Charter, holds regular meetings, and takes meeting minutes.
- Ensure that the terms of the employer's fiduciary liability insurance policy extend to group health plan fiduciary activities.
- Use an RFP process to assure competitive pricing and quality service from all plan vendors.
- Request and carefully review broker and benefits consultant compensation disclosures and monitor their fees.
- Collect and review the terms of all administrative services and PBM agreements.
- Review and benchmark fees and costs for medical and prescription drug goods and services to the extent comparison data is available.

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