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CERTIFICATE IN EMPLOYEE BENEFITS LAW SEMINAR

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TABLE OF CONTENTS

I. HEALTH & WELFARE PLANS IN THE AGE OF COVID-19

On March 27, 2020, the President signed the largest economic stimulus bill in United States history: the Coronavirus Aid, Relief, and Economic Security Act. The CARES Act was designed to support Americaôs health care system during the COVID-19 pandemic, get cash and other forms of economic relief to individual citizens, provide loans for small businesses, and to assist certain hard-hit industries. Many of the changes in the CARES Act affect or have implications for employee benefit programs.

A. Coverage Mandates

All group health plans ï fully insured or self-funded, and including grandfathered plans ï are required to cover qualifying items, services, and immunizations intended to prevent or mitigate COVID-19 without imposing any cost-sharing.

1. Diagnostic Testing

The Families First Coronavirus Response Act (ñFFCRAò), signed into law on March 18, 2020, requires group health plans and health insurers to cover the cost of FDA-approved in vitro diagnostic tests ï tests performed on blood or tissue samples -- for COVID-19. The CARES Act expands the types of covered tests to include tests submitted for an emergency use authorization with the FDA, developed and authorized by a state government, or otherwise directed to be covered by the Secretary of Health and Human Services (ñHHSò).

In addition to the test itself, no cost-sharing may be imposed for the professional services visit, including visits to the emergency room or urgent care, related to the test or evaluation of an individual to determine if a test is necessary.

Insurers and self-funded health plans must reimburse COVID-19 diagnostic testing providers at the health planôs or issuerôs negotiated rate in effect before the COVID-19 public health emergency (declared on January 31, 2020 to exist retroactive to January 27, 2020). If the health plan or issuer does not have a negotiated rate with a provider, the plan or issuer must reimburse the provider for the serviceôs cash price listed on the providerôs website, or the plan or issuer may negotiate a lower rate with the provider.

Each provider of COVID-19 diagnostic tests is required to publish the cash price of its COVID-19 diagnostic tests on its public website. The HHS Secretary may impose a penalty of up to $300 per day of violation on providers that fail to do so.

2. Qualifying Coronavirus Preventive Services

Group health plans must cover, without cost-sharing, services or immunizations designed to prevent or mitigate COVID-19 that meet one of the following requirements:

a. An evidence based item or service that has in effect a rating of ñAò or ñBò in the current recommendations of the U.S. Preventive Services Task Force [https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations]; or

b. An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

What is unique about this requirement is that coverage for recommended preventive services is required within 15 business days from the date the recommendation is made. Ordinarily, no-cost coverage for newly recommended preventive services begins on the first day of the plan year that begins on or after the one-year anniversary of the issue date.

This CARES Act also applies to grandfathered plans that are otherwise not subject to the ACAôs free preventive services requirements.

B. Changes to FSAs, HRAs, and HSAs

1. HDHPs with HSAs

a. Diagnostic Testing and Treatment. Under Internal Revenue Code (ñIRCò) Section 223(c)(2)(A), in order to qualify to contribute to a health savings account (ñHSAò) an individual must be enrolled in a high deductible health plan (ñHDHPò). By definition, HDHPs do not cover any non-preventive services prior to the satisfaction of the annual deductible.

In order to remove barriers to the nationôs COVID-19 response, the IRS released Notice 2020-15 that allows HDHPs to provide coverage for both COVID-19 diagnostic testing and treatments prior to satisfying the annual deductible.

While the CARES Act does not require group health plans to provide no-cost treatment, a handful of states (NM, MA, VT) have mandated insurers to cover no-cost COVID-19 treatment (legislation pending in MN, OH, MI). In addition, several insurers (Anthem, UnitedHealthcare, Humana, Cigna, Aetna) have stated they are voluntarily waiving cost-sharing for in-network COVID-19 treatment.

b. Exemption for Telehealth Services. For plan years beginning before January 1, 2022, HDHPs with HSAs can offer cost-free telehealth services and other remote-care services prior to satisfaction of the HDHPôs annual deductible. Telehealth services do not have to be COVID-related.

   Several states have moved to require insurers to cover telehealth services with no or reduced cost sharing, and numerous states have issued new licensure rules making it easier for medical professionals to provide telehealth services and for patients to access it. For instance, new rules allow for audio-only telehealth visits and permitting out-of-state telehealth providers to provide patient services.

2. Over-the-Counter Drugs and Menstrual Care Products

   Under the CARES Act, and at the Plan Sponsorôs option, over-the-counter medicines and drugs can once again be paid for with HSA, FSA, and HRA dollars without a doctorôs prescription. In addition, menstrual care products are now treated as a qualified over-the-counter medical expense and can be paid for with funds from an HSA, FSA, and HRA should the Plan choose to allow coverage for OTC products.

   Plans may be amended to provide reimbursement for OTC retroactively to January 1, 2020.

3. Mid-Year Plan Changes

   Under normal circumstances, employeesô health coverage (if employee contributions are run through a Section 125 cafeteria plan) and health flexible spending account elections are limited to a once-annual open enrollment period and cannot be changed mid-year without a qualifying event.

   In light of the pandemic, the IRS issued guidance (Notice 2020-29 *available at* https://www.irs.gov/pub/irs-drop/n-20-29.pdf) that allows (but does not require) employees to offer flexibility to change health coverage choices and FSA elections. Employers may choose to allow employees to enroll, dis-enroll, or switch plans (if an employer offers more than one health benefit plan), and to start, stop or change contributions to health FSAs. If an employer decides to amend its cafeteria plan to provide this flexibility, the employer may limit the period during which such changes may be made, and is not required to provide unlimited election changes.

4. Carryover of Unused Balances

   Under existing rules, an employeeôs unused balance remaining in a health FSA or dependent care FSA at the end of the plan year is generally forfeit unless, for a health

FSA, the employer allows a carryover ($500) or a grace period (generally 2 months and 15 days).

Because COVID-19 limited the availability of medical care and child care, employees are likely to have larger unused amounts at the end of such plan years or grace periods. Consequently, the IRS has allowed that, at the employerôs discretion, § 125 plans may permit employees to apply those unused amounts to pay or reimburse medical care expenses or dependent care expenses, respectively, incurred through December 31, 2020.

C. Continuation of Coverage Issues during Lay-Off or Furlough

- A layoff is a termination of employment. The employee is no longer on the payroll of the company or entitled to participate in the employerôs benefit programs. If the employerôs leave policies provide for the cashing out of unpaid PTO hours, the laid off employee should be paid these hours in his or her final compensation. A laid off employee must be offered COBRA (or state-mandated continuation plans for smaller groups).

- Furloughed employees are those who are not currently working any hours but they remain an employee of the company. Furloughs are also knowns as ñtemporary layoffsò or ñunpaid leave.ò Furloughed employeesô eligibility to continue participating in an employerôs benefit programs is dependent on the employerôs underlying benefit contracts and established unpaid leave practices.

- Individuals on protected leave ï either standard FMLA, emergency FMLA under the FFCRA, or other state mandated protected-leave programs, must continue to be treated as an active, full-time employee. Prior to the beginning of a protected leave, employees should be advised of their rights to continue benefit programs at the active employee premium share, and arrangements made by the employer to collect that premium.

1. <u>ACA Employer Mandate Concerns</u>

   If an employer is of the size where the ACAôs employer shared responsibility mandate kicks in and the employer uses the ACAôs safe harbor lookback periods to calculate eligibility for benefits, furloughed employees in a stability period must be offered group health insurance as though they remain a full-time employee.

a. The ACA Employer Mandate. Although the individual mandate has been stricken from the law, employers with 50 or more ñfull-time equivalent employeesò must offer at least 95% of their employees that work 30 or more hours per week 1) affordable health benefit coverage that 2) meets the ACAôs minimum essential requirements test. Failure to make such coverage available can result in employer shared responsibility payments of $2,570 to $3,880 per employee depending on the nature of the violation.

b. Full-time Equivalent Employees. The ACA establishes several different safe harbor methods for an employer to determine an employeeôs eligibility for group health benefits. One such safe harbor is the lookback period of measurement.

In the lookback measurement method, the employer may establish a 3-month to 12-month ñmeasurement periodò where an employeeôs hours are calculated, and employees who have worked an average of 30 hours per week over the lookback period are considered to be benefit eligible for the subsequent ñstability period.ò

The stability periodôs length is equal to the measurement periodôs length. During the stability period, regardless of the number of hours the employee works, so long as the employee has not been terminated, that employee is entitled to the benefits of a full-time active employee.

2. COBRA

Laid off employees have suffered a termination of employment, which is a COBRA Qualifying Event. Furloughed employees have suffered a reduction in hours that made them benefit ineligible which is also a COBRA qualifying event. Some insurance contracts allow an employer to keep furloughed employees, or those who have a temporary decrease in hours, to remain ñfull time eligibleò for a specific period. In the absence of such a provision, furloughed employees must be offered COBRA.

An employer may choose to subsidize a personôs COBRA premiums. Employers with self-funded group health plans are subject to annual nondiscrimination testing and subsidizing COBRA coverage could adversely affect the Planôs status with the result being highly compensation participants will lose the benefit of the tax exemption.

D. HIPAA Compliance Concerns

HIPAA Privacy and Security rules are still in effect during the COVID-19 public health emergency, however the HHSô Office for Civil Rights is choosing to waive certain sanctions and penalties for noncompliance with certain provisions of the Privacy Rule at this time.

Particularly, HIPAA Privacy Rules for telehealth services that require providers to have HIPAA-compliant platforms (Skype, FaceTime, Facebook Messenger video chat, and the like are *not* e-PHI compliant) have been relaxed. OCR will ñuse enforcement discretionò if a covered entity is not in compliance with certain rules in relation to good faith efforts to provide telehealth services during the pandemic.

II. RETIREMENT PLANS AND COVID-19

Although much of the CARES Act was focused on economic stimulus for businesses, a few of the Actôs provisions change some of the rules for retirement plans.

A. Expansion of In-Service Distribution Rules

Through the end of 2020, the CARES Act allows a new type of hardship withdrawal for participants in 401(k) plans and individual retirement accounts who are affected by COVID-19. This new coronavirus-related distribution is not subject to the 10% early distribution penalty from retirement plans under IRC Section 72(t).

Participants may take up to $100,000 from the retirement plan account. The amount distributed may be re-contributed to the retirement plan, or to another plan, within three years after the date the distribution is received, without regard to any plan limit on contributions. If the individual does not re-contribute the distribution within that time period, income taxation on the distribution may be spread over a 3-year period. Federal income tax withholding is not required on a coronavirus-related distribution, and a direct rollover need not be offered.

In order to be eligible for a coronavirus-related distribution, an individual must

1. be diagnosed with COVID-19 by a CDC-approved test.
2. have a spouse or dependent diagnosed with COVID-19 by a CDC-approved test,
3. experience ñadverse financial consequences as a result of being quarantined, being furloughed or laid off, or having work hours reduced due toò COVID-19,
4. be unable to work due to COVID-19 child care issues,
5. close or reduce hours in a business owned or operated by the individual, due to COVID-19, or
6. experience ñother factorsò as determined by the Secretary of the Treasury.

The administrator of the plan may rely on the individualôs certification that the individual qualifies for a coronavirus-related distribution under these categories.

This is an optional benefit that a plan sponsor is not required to make available. However, employers choosing to allow this may make the distributions available retroactively to January 1, 2020.

If an employer does not treat a distribution as coronavirus-related, a qualified individual may still treat a distribution that meets the requirements as a coronavirus-related distribution on the individualôs federal income tax return.

Plan amendments necessary to take advantage the expanded distribution and loan options (below) are not required until the last day of the first plan year beginning on or after January 1, 2022 (January 1, 2024 for governmental plans).

B. Loans from Qualified Plans

Through December 31, 2020, the CARES Act doubles the current retirement plan loan limits to the lesser of $100,000 or 100% of the participantôs vested account balance for the next six months. The $50,000 loan limit, for loans from qualified plans to ñqualified individualsò made during the 180-day period from the date of enactment, is increased to $100,000, and the cap of 50% of the present value of the vested benefit is increased to 100% of such present value.

The due date for any repayment by a ñqualified individualò of a participant loan that would occur from the date of enactment through December 31, 2020, is delayed for up to one year. Later repayments for such loan are also adjusted ñappropriatelyò to reflect the prior delayed due date ñand any interest accruing during such delay.ò The delay period is ignored in determining the 5-year maximum period for such loan.

A ñqualified individualò who could be eligible for these expanded loan limits and loan delays is one who could meet the same coronavirus-related tests as discussed above for coronavirus-related distributions.

The IRS has stated that adoption of any of these CARES Act provisions are optional. For instance, an employer may choose to provide for coronavirus-related distributions, but choose not to change its loan provisions or loan repayment schedules.

C. Suspension of Minimum Distribution Requirements

Due to declines in the stock market linked to COVID-19, minimum distributions that account holders must take from defined contribution plans once the individual reaches

age 70½ or 72 (for those who turned 70 on July 1, 2019 or later) are suspended for the calendar year.

Minimum distributions with required beginning dates in calendar year 2020, which have not yet been made by January 1, 2020, and which are required from defined contribution plans, need not be made in 2020.

This waiver is applicable to (i) defined contribution 401(a) qualified plans, (ii) defined contribution 403(a) and 403(b) plans, (iii) governmental defined contribution 457(b) plans, and (iv) individual retirement accounts.

D. Delayed Payments to Single-Employer Plans

Single employer defined benefit plan funding requirements for 2020, including quarterly contributions, may be deferred until January 1, 2021, at which time they must be paid with interest. In determining the application of benefit restrictions in plan years containing the 2020 calendar year, a plan sponsor may elect to apply the plan's 2019 funded status.

E. Reducing or Suspending Discretionary or Safe Harbor Contributions

Not dependent upon the CARES Act, a plan sponsor can suspend its matching or nonelective safe harbor contributions during a plan year if either of the following conditions apply:

1. The annual safe harbor notice included a statement that the plan could be amended during the plan year to reduce or suspend safe harbor contributions; or

2. The plan sponsor is operating at an economic loss for the plan year.

If a plan sponsor satisfies one of these two requirements, supplemental notice that the plan will be amended must be given. The actual suspension or reduction of the contribution cannot be effective until 30 days after the later of i) the date of the supplemental notice, or ii) the effective date of the plan amendment.

The plan document must be amended to reduce or suspend the safe harbor contribution and to add the required nondiscrimination testing provisions for the plan year. Because the plan cannot rely on the top-heavy exemption available to safe harbor plans, the employer may be required to make a top heavy minimum contribution at the end of the plan year.

Safe harbor benefits cannot be suspended retroactively, only future contributions can be suspended, so the plan sponsor is still liable for contributions up to the date of the plan amendment.

III. OTHER BENEFIT PLAN IMPLICATIONS OF COVID-19

A. Tax Free Payments under Section 139

Section 139 of the Internal Revenue Code ï added in 2002 in response to the September 11, 2001 attacks ï allows employers to make tax-free disaster relief payments in cash to any individual if the payment is a ñqualified disaster relief payment.ò

The requirements for making tax-free disaster relief payments are simple and easy to meet. Section 139 applies to any ñfederally declared disasterò defined as any disaster determined by the President to warrant assistance by the Federal Government under the Robert T. Stafford Disaster Relief and Emergency Assistance Act.

When the President invoked Emergency Assistance Act to postpone the April 15th tax deadline, the IRS stated that the COVID-19 pandemic satisfies the requirement of a ñfederally declared disaster.ò As a result, employers may provide tax-free payments to employees, while still claiming a full deduction for the payments, provided the money is intended to reimburse or pay for ñreasonable and necessary personal, family, living, or funeral expensesò incurred as a result of COVID-19.

Section 139 has never before been used for a national pandemic, so the types of expenses that can be treated as deductible are untested. Certainly medical expenses not reimbursed by insurance, the cost of over-the-counter medicines and hand sanitizer,

Section 139 payments are excluded from gross income and from wages and compensation for employment taxes. State tax laws may or may not be the same.

B. Employer Sponsored Student Loan Payments

Section 2206 of the CARES Act provides temporary tax-free status to employer-paid student loan repayment assistance programs (ñLRAPsò). From March 28 through December 31, 2020, an employer may make payments up to $5,250 per year to an employee or direct to a lender, for principal or interest, on any qualified education loan. These payments will not be treated as taxable income to the employee, though borrowers cannot claim a student loan interest deduction based on a tax-free payment of student loan interest from the employer.

Qualified education loans are those that were incurred by the employee for higher education expenses, and they include, but are not limited to, loans for tuition, fees, books, supplies, transportation, equipment, room and board.

Employers interested in making student loan payments for employees should adopt a written plan under IRC Code Section 127.

IV. COVID-19 EXTENDED DEADLINES

The IRS and DOL issued joint guidance extending timelines and deadlines to comply with certain employee benefit requirements: https://www.govinfo.gov/content/pkg/FR-2020-05-04/pdf/2020-09399.pdf.

Effective March 1, 2020, with respect to covered events, plans must disregard the period from March 1 until 60 days after the announced end of the National Emergency (the ñOutbreak Periodò), or other such date announced by the Agencies in a future notification. Given the current state of the pandemic, we do not know how long this period will last or whether it will have different end dates in different parts of the country.

These deadline extension apply to any participant, not just those affected by the COVID-19 pandemicð in other words, there is no ñcertificationò requirement or any steps for an employee to take, the extensions are automatic.

A. Welfare Plans

The following outlines the changes made to plan sponsor obligations and participant rights under COBRA and their HIPAA special enrollment provisions.

1. COBRA
    a. Election Notices. An employer has 30 days from the COBRA qualifying event to notify the COBRA Administrator; the COBRA Administrator then has 14 days to provide a COBRA election notice to the qualified beneficiary. These clocks have been tolled.
    b. Participant Notice of Qualifying Events. Covered employees or qualified beneficiaries have the obligation to notify the COBRA administrator of a qualifying event due to a change in family status (i.e., divorce, ceasing to have a dependent child) or disability (or cessation of a disability) within 60 days of the event. The deadline for individuals to provide such notice is tolled during the Outbreak Period.
    c. COBRA Elections. A qualified beneficiaryôs 60-day period to make the initial election is tolled during the Outbreak Period. As explained in an example provided by the Joint Notice, if an individual was provided with a COBRA

election notice on April 1, 2020, instead of the individual having to elect COBRA coverage within 60 days of the notice, he or she will have 60 days from the last day of the Outbreak Period to make a COBRA election. Depending on how long the Outbreak Period is, that could mean a significant period of time during which individuals may elect retroactive COBRA coverage.

d. COBRA Premium Payments. The dates for making COBRA premium payments, both the initial payment (ordinarily due 45 days from the date of the initial election) and ongoing monthly payments are tolled during the Outbreak Period. As with the tolling of the election period, the tolling of premium deadlines could result in many months of premiums that will be due in a lump sum once the Outbreak Period is over.

Separate from the tolling guidance, the DOL recently issued updated model COBRA notices to explain more about the interaction between COBRA and Medicare. New model documents may be found here: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra. The updated notices do not include any reference to the tolling requirements.

2. HIPAA Special Enrollment Rights

Under HIPAAôs special enrollment provisions, plans must allow employees to change their enrollment in a group health plan within 30 days after the employee experiences a special event (e.g., loss of other group health coverage, change in family status). This timeframe is tolled during the Outbreak Period.

3. Extension of Claims Periods

Both ERISA and the ACA proscribe the timeframes for filing claims, appealing adverse benefit determinations and, for group health plans, pursuing external reviews. All of these timeframes are tolled during the Outbreak Period.

4. Form 5500 and M-1 Filing Relief

Welfare plans with more than 100 participants generally must file a Form 5500 with the DOL by the end of the seventh month after the end of the plan year (for calendar-year plans, July 31 of the following year). The COVID-19 guidance confirms previous relief providing an extension by which any Form 5500 filing that would otherwise be due between April 1 and July 15, 2020, is now automatically due by July 15, 2020, without the need to request an extension. Additionally, the regular two-and-one-half month extension is also available by filing a Form 5558, but this extension is still measured using the original due date instead of July 15.

Finally, this automatic extension also applies if a sponsor previously filed an extension request using Form 5558 and that extension falls within the April 1 to July 15 relief period.

For a calendar-year plan, the 2019 Form 5500 will be due by July 31, 2020, which is outside the relief period.

M-1 filing relief extends for the same period of time as the Form 5500 relief.

5. ERISA-Required Communications and Electronic Disclosure

The COVID-19 guidance states that the Employee Benefits Security Administration (ñEBSAò) will not hold a benefit plan and/or plan fiduciary in violation of ERISA for failure to timely furnish any required notice, disclosure or document during the outbreak period, provided that the fiduciary acts in good faith and furnishes the communication as soon as practicable. For example, this relief would extend to the provision of summary plan descriptions, summaries of material modifications, and notices of adverse benefit determinations and appeals. EBSA states that ñgood faith actsò include use of alternative electronic means of communicating with participants and beneficiaries if the fiduciary reasonably believes they have effective access to those means, such as email, text messaging and continuous access websites. S

B. Retirement Plans

EBSAôs Disaster Relief Notice 2020-01 (*available at* https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2020-01) applies many of the same welfare plan extensions to retirement plans. For instance, retirement plans participants are eligible for the same extensions to make plan claim; plan sponsors will benefit from delayed Form 5500 filings and ERISA-required communications.

1. Fiduciary Relief for Loans and Distributions

In addition to the above, EBSAôs guidance includes relief for plan fiduciaries with respect to retirement plan loans and distributions. If a plan fails to follow procedural requirements for such loans or distributions imposed by the terms of the plan, EBSA will not treat it as a failure if:

- The failure is solely attributable to the COVID-19 pandemic;
- The plan administrator makes a good-faith effort to comply with the procedural requirements; and,

- The plan administrator makes a reasonable attempt to correct any procedural deficiencies, such as assembling missing documentation, as soon as administratively practical.

This relief does not apply to any other requirements under the IRSôs jurisdiction.

2. Fiduciary Relief for Contributions

Additional fiduciary relief is granted for participant contributions and loan repayments to retirement plans. Under ERISA, such contributions and repayments generally must be made no later than 15 business days following the month in which the amounts were withheld from payroll (but the DOL generally takes the position that such amounts must be forwarded to a retirement planôs trust within a few days of payroll). Recognizing that employers and plan service providers may experience difficulties forwarding payments within this timeframe, the DOL provided that it will not take enforcement action with respect to a temporary delay in contributions or repayments to a retirement plan, provided the delay is solely because of the COVID-19 pandemic, occurs during the COVID Period and the plan sponsor forwards such payments as soon as administratively practical.

V. THE SECURE ACT

Prior to the COVID-19 pandemic, The Setting Every Community Up for Retirement Enhancement Act of 2019 (ñthe SECURE Actò) was set to be the hottest topic in Employee Benefit Law for 2020. Signed into law on December 20, 2019 as part of the larger ñFurther Consolidated Appropriations Act, 2020,ò the SECURE Act seeks to satisfy the directive of the October 2018 Executive Order 13847, ñStrengthening Retirement Security in America,ò which states that ñit shall be the policy of the Federal Government to expand access to workplace retirement plans for American workers.ò

This Act represents the most sweeping changes to Americaôs retirement plan regulatory landscape in over a decade. The following endeavors to outline the changes most relevant to employer-sponsored defined contribution plans.

A. Pooled Employer Plans

The Actôs most substantial change will provide the greatest opportunity for more American workers to participate in employer-sponsored benefit plans starting January 1, 2021.

Prior to the passage of the SECURE Act, IRS and Department of Labor (ñDOLò) guidelines made it difficult for small employers to band together to purchase a ñsingle employerò plan. In order for a multiple employer plan (MEP) to be considered a ñbona fide group or association of employersò under IRC § 413 and ERISA § 3(2), the

employer participants are required to have a ñsubstantial business purposeò other than the provision of an employee benefit plan.

Further, the employer members are required to show a ñcommonality of interest,ò historically defined in such a way that effectively limited association participation to employers in the same industry. Although the DOL recently updated its MEP regulations to relax its interpretation of these terms, the Final MEP Regulations did not allow for truly open access MEPs.

The SECURE Act answers the multiple employer plan dilemma by recognizing a new plan type ð the Pooled Employer Plan.

1. What Is a Pooled Employer Plan?

   A Pooled Employer Plan (ñPEPò) allows diverse employers who cannot satisfy the definition of a MEP to establish a single employee pension benefit plan with no common interest required so long as the Plan meets certain requirements. IRC § 413(e)(1)(B), as amended by SECURE Act § 101(a)(1).

   a. The plan must designate a pooled plan provider who is a named fiduciary, the Plan administrator, and the person responsible for performing all administrative duties to ensure the Plan meets its Code and ERISA requirements. IRC § 413(e)(3)(A)(i), as amended by SECURE Act § 101(a)(1).

   b. The pooled plan provider must register with the DOL, acknowledge in writing its status as named fiduciary and Plan administrator, and ensure that all persons who handle Plan assets or who are fiduciaries are bonded in accordance with ERISA § 412. IRC § 413(e)(3)(A)(ii)ï (iv), as amended by SECURE Act § 10(a)(1); ERISA § 3(44), as amended by SECURE Act § 101(c)(1).

   c. The Plan must further designate trustees and each employer in the plan must retain fiduciary responsibility for monitoring the pooled plan provider, ensure participants and beneficiaries are not subject to unreasonable restrictions or fees, and require the pooled plan provider to supply the participating employers any necessary disclosures. ERISA § 3(43)(B), as amended by SECURE Act § 101(c)(1).

   PEPs will be available for plan years beginning after December 31, 2020, with the Secretary instructed to publish guidance and model plan language that meets both Code and ERISA requirements.

2. Relief from the ñOne Bad Appleò Rule for MEPs and PEPs.

   Multiple employer plans, as well as new pooled employer plans, will want to be sure Plan terms are written to take advantage of the Actôs relaxation of the disqualification rules currently applied when one employer fails to meet Plan requirements.

   26 CFR § 1-413-2(a)(3)(iv) states that the qualification of plan ñis determined with respect to all employers maintaining the section 413(c) plan. Consequently, the failure by one employer maintaining the plan (or by the plan itself) to satisfy an applicable qualification requirement will result in the disqualification of the section 413(c) plan for all employers maintaining the plan.ò

   In order to prevent this loss of qualified status, the Plan should provide that if one employer fails to meet the requirements, the assets of the Plan attributable to the employees of that employer would be transferred to a Plan maintained only by that employer, or to another eligible retirement plan for each individual (unless determined otherwise by the Secretary). The noncompliant employer would be liable for any plan liabilities attributable to its employees. IRC § 413(e), as amended by SECURE Act § 101(a)(1).

3. Simplified Annual Reporting Requirements for MEPs and PEPs.

   As of plan years beginning after December 31, 2020, multiple and pooled employer plans may take advantage of the simplified annual reporting currently only extended to plans covering fewer than 100 participants. So long as the MEP or PEP covers fewer than 1,000 participants, where no single employer has 100 or more participants, the Plan may use Form 5500-SF, Short Form Annual Return/Report of Small Employee Benefit Plan. 29 U.S.C. § 1024(a)(2)(A)(ii), ERISA § 104(b), as amended by SECURE Act § 101(d).

4. Combined Annual Reporting for Groups of Plans.

   The SECURE Act directs the IRS and DOL to work together to create a revised Form 5500, Annual Return/Report of Employee Benefit Plan, that will allow all employer members of a group of plans fulfilling certain requirements to file a single aggregated annual return. This grouping of plans may include IRAs or defined contribution plans so long as they have the same trustee, the same one or more named fiduciaries, the same administrator, plan years beginning on the same date, and that provide the same investment options to participants. The SECURE Act, § 202(c).

B. Expansion of 401(k) Safe Harbors

Starting with the first plan year after December 31, 2019, employers *may* take advantage of the expansion of the automatic enrollment safe harbor or nonelective safe harbor rules.

a. Increase in Cap for Automatic Enrollment Safe Harbor. In the past, Plans that include a qualified automatic contribution arrangement were capped at a 10% default rate. Plans may be amended as of the new plan year to allow for a 15% default rate (after a 10% cap during an employeeôs first enrolled plan year). IRC § 401(k)(13)(C)(iii), as amended by SECURE Act § 102(a).

b. Timing of Employee Notice for Nonelective Contributions. Prior to the Actôs passage, an employer could amend its Plan after the first day of the plan year (but no later than 30 days before the end of the plan year) to include a 3% nonelective employer contribution, *but only on the condition that employees received a contingent notice of the intended amendment in writing prior to the beginning of the plan year*. The SECURE Act removes this notice requirement, thereby accelerating an employerôs ability to add this nonelective employer contribution safe harbor. IRC § 401(k)(12)(A), as amended by SECURE Act § 103(a)(1).

c. Timing of Plan Amendment for Nonelective Contributions. If an employer wishes to amend its Plan to take advantage of the nonelective safe harbor *and* makes at least a 4% contribution (rather than 3%), the employer can postpone amending the Plan until the last day for distributing excess contributions for the plan year (generally, not until the close of the following plan year.) IRC § 401(k)(12)(F), as amended by SECURE Act § 103(b); § 401(k)(13)(F), as amended by SECURE Act § 103(c).

C. Changes to Distribution Rules

a. Penalty-Free Withdrawals for Birth or Adoption of Child. Effective January 1, 2020, an individual may take a $5,000 disbursement without incurring the 10% tax penalty for early distribution provided the withdrawal is made during the one-year period beginning on the date a child is born or date a legal adoption is finalized. 26 U.S.C. § 72(t)(2)(H), as amended by SECURE Act § 113.

b. Increase in Age for Mandatory Distributions. The Act recognizes that life expectancies have increased since the mandatory distribution rule was set at age 70½ in the 1960s. Accordingly, any mandatory distributions after December 31, 2019 with respect to individuals who attain the age of 70½ after such date, shall begin April 1 of the calendar year following the calendar year in which the employee attains age 72. Individuals who turned 70½ in 2019 will still need to

withdraw their required minimum distributions in April 2020. IRC § 401(a)(9)(C)(i)(I), as amended by SECURE Act § 114(a).

c. Change to Required Minimum Distribution for Non-Spouse Inheritors. Prior to the signing of the SECURE Act, if an employee died before his or her retirement account was exhausted the minimum distribution rules for designated and non-designated beneficiaries varied based on the timing of the ownerôs death vis-à-vis plan distributions.

Now, for distributions made with respect to account owners who die after December 31, 2019, the general rule is the account balance must be paid out within 10 years (previously five) after the date of death. The SECURE Act § 401(b).

There is, however, an exception for *eligible* designated beneficiary defined as the surviving spouse, a minor child, a chronically ill individual, or any other individual who is not more than 10 years younger than the decedent. For these eligible designated beneficiaries, the minimum distribution rules remain similar to pre-Act law, allowing the payout over the life or life expectancy of the beneficiary. IRC §§ 401(a)(9)(H), 401(a)(9)(E), as amended by SECURE Act §§ 401(a)(1) ï (2).

D. Decrease in Age for In-Service Distributions

Although not part of the SECURE Act, but rather found elsewhere in the omnibus appropriations bill, the in-service distribution age for defined-benefit and government plans has been lowered from age 62 to 59½ for plan years beginning after December 31, 2019. IRC §§ 401(a)(36), 457(d)(1)(A), as amended by the ñBipartisan American Miners Act of 2019,ò H.R. 1865, Public Law 116-44, Division M.

E. Expanded Employer Tax Credits for Small Business

In another step toward the Presidential mandate to find ways to expand retirement savings plans to more Americans, the IRS will award new and increased tax credits to small businesses wishing to host a Plan beginning with the first tax year after December 31, 2019.

a. Increase in Tax Credit for Small Employer Startup Costs. Rather than being capped at $500 for three tax years, small employers (with at least two (unless a state law allows for one) but not more than 50 employees) are now eligible for the greater of 50% to $500 *or* the lesser of $250 per each non-highly compensated employee or $5,000. IRC § 45E(b), as amended by SECURE Act § 104(a).

b. Small Employer Automatic Enrollment Credit. For Plans that implement an automatic enrollment provision, an employer will receive a tax credit of $500 for three years. 26 U.S.C. Subpart D § 45T, as amended by SECURE Act § 105(a).

F. Increased Penalties for Failure to File

In addition to increasing the minimum penalty for failure to file a tax return from $330 to $435, the Act dramatically increases penalties for failure to file retirement plan returns. IRC § 6651, as amended by SECURE Act § 402.

a. The fine for failure to file a Form 5500 has increased from $25/day to a $15,000 maximum to $250/day with a $150,000 maximum.

b. The fine for failure to file the annual registration statement (for plans subject to ERISAôs vesting requirement) has increased from $1/day to a $5,000 maximum to $10/day to a $50,000 maximum.

c. The fine for failure to file a notification of change of status has increased from $1/day to a $1,000 maximum to $10/day to a $10,000 maximum.

d. The fine for failure to provide a participant notice of the right to elect no withholding from plan distributions has increased from $10/day to a $5,000 maximum to $100/day to a $50,000 maximum.

These new fines apply to returns, statements, and notifications required to be filed/provided after December 31, 2019. IRC §§ 6652(d), (e), (h), as amended by SECURE Act § 403.

G. Relaxation of Rules on Retroactive Amendments.

Effective for Plans adopted for taxable years beginning after December 31, 2019, if an employer adopts a Plan after the close of a taxable year but before the time prescribed by law for filing the employerôs return, the employer may elect to treat the Plan as having been adopted as of the last day of the taxable year. IRC § 401(b)(2), as amended by SECURE Act § 201.

H. Plan Loans via Credit Card

Any new plan loan made after December 20, 2019 disbursed via the use of a credit card ñor other similar arrangementò shall be treated as a deemed distribution subject to normal taxation plus the 10% early distribution tax (if applicable). IRC § 72(p)(2)(D), as amended by SECURE Act § 108.

I. Modification of Nondiscrimination Testing Rules

The SECURE Act adds an extensive new subsection (o) to IRC § 401 that reimagines the nondiscrimination testing rules for closed-class defined benefit plans in order to protect older, longer-service participants. For defined benefit aficionados, an entire article could be dedicated to this new and long-overdue guidebook. In short, however, this new subsection addresses the nondiscrimination testing problems many employers have faced since closing their pension plans in favor of defined contribution plans.

As employees grandfathered into the closed DB plan have aged and (theoretically) become more highly compensated (or have seen lesser compensated participants turnover), the plans struggle to meet the threshold conditions the IRS requires to test the DB and DC plans on an aggregate equivalent basis.

Under the new modifications, defined benefit participants may continue to accrue benefits, and Plans receive nondiscrimination relief with respect to benefits, rights, features and benefit accruals. SECURE Act § 205.

J. Annuities – Safe Harbor and Portability

Few workplace retirement plans offer annuities (ñlifetime income optionsò) as an investment option for several reasons. First, they are complicated to understand and their fees more costly than other investment alternatives. Second, because they are underwritten by insurance companies, there is an inherent risk the insurer will become insolvent with the result the employer is sued for abrogating its fiduciary responsibility to offer financially sound products. Finally, annuities are difficult to liquidate and participants may face substantial surrender charges if a plan amendment or change in eligibility forces a cancellation. The SECURE Act addresses the second and third of these risks.

a. Fiduciary Safe Harbor for Selection of Annuities: Effective immediately, employers who wish to offer annuities as an investment option may take advantage of a new safe harbor for the selection of the lifetime income provider so long as the employer ñengages in an objective, thorough, and analytical searchò that considers the insurerôs financial capabilities and the productôs costs. ERISA § 404(e), as amended by SECURE Act § 204.

b. Portability of Lifetime Income Options: Effective in the plan year beginning after December 31, 2019, a Plan will no longer be disqualified for allowing a qualified distribution (a trustee-to-trustee rollover to another employer-sponsored plan or IRA) or distributions of a lifetime income investment in the form of a qualified plan distribution annuity contract so long as the distribution takes place in the 90

days prior to the date the annuity investment option may no longer be held in the Plan. IRC § 401(a)(38), as amended by SECURE Act § 109(a).

K. Eligibility of Long-Term Part-Time Workers in 401(k) Plans

Employers have long been allowed to exclude part-time employees (those who work less than 1,000 hours per year), as well as delaying participation based on attainment of age (but not beyond 21) or years of service (but not beyond the completion of a 12-month period with at least 1,000 hours of service). Now, effective with plan years beginning after December 31, 2020, 401(k) plans must open eligibility for certain long-term part-time employees. Collectively bargained plans are not subject to this requirement.

These part-time employees shall be eligible after the first period of three (3) consecutive 12-month periods wherein the employee has at least 500 hours of service and so long as the employee has met the age requirement by the close of the last of the 12-month periods. Employers do not have to take into account any 12-month period beginning before January 1, 2021. IRC §§ 401(k)(2)(D), 401(k)(15)(A), as amended by SECURE Act § 112.

Employers do not have to make nonelective or matching contributions to these participants and may exclude the part-time employees from nondiscrimination and top-heavy rules. If the employer chooses to make employer contributions, for vesting purposes one year of service equals a 12-month period wherein the employee has at least 500 hours of service. IRC § 401(k)(15)(B), as amended by SECURE Act § 112(a).

L. New Lifetime Income Disclosure

The DOL issued an advance notice of proposed rulemaking in 2013 that would require, as part of the ERISA required annual (or quarterly) benefit statements, information about the lifetime income that might be provided by the accrued funds in the Plan. The requirement comes to fruition in the Act, requiring such lifetime income disclosures at least once during any 12-month period. 29 U.S.C. § 1025(a), as amended by SECURE Act § 203(a).

No later than December 20, 2020 the DOL is required to issue a model lifetime disclosure that explains that the information is only meant as an illustration and will depend on many financial factors. The DOL shall prescribe the assumptions the plans must use to make the calculations. No plan fiduciary, sponsor, or other person shall have any liability due to providing such predictions so long as they are made according to the assumptions and rules provided and include the explanations found in the model lifetime income disclosure.

VI. NEW DEFINED CONTRIBUTION HEALTHCARE PLANS

The ACAôs rules regarding health reimbursement arrangements (HRAs) have long required an HRA to be ñintegratedò with other employer group coverage. This determination was based in the language found in Section 2711 of the Public Health Service Act that prevents a group health plan from placing an annual or lifetime dollar limit for any essential health benefit. Only insofar as an HRA is paired with another group health plan can the combined arrangement comply with the ACA.

As a consequence, employees who waive the employerôs group health coverage cannot benefit from the HRA. Further, because the HRA must be integrated with a group health plan, an HRA participant was not allowed to use HRA money to purchase individual health insurance.

In response to the Presidentôs Executive Order 13813 requiring HHS to expand access to alternate forms of insurance coverage, the IRS and DOL issued new rules on June 20, 2019 allowing for two new HRA formats.

A. Individual Coverage HRA

An Individual Coverage HRA, or ICHRA, is a group health plan, subject to ERISA and COBRA that is integrated with an individual insurance policy, including Medicare. Uniquely, the individual policies a participant chooses to purchase do not become part of the ICHRA and do not themselves become a group health plan.

In order to prevent a plan sponsor from intentionally or unintentionally steering any participants with adverse health factors away from the employerôs traditional group health plan, the ICHRA must satisfy several safe harbor rules.

1. Employees must enroll in individual health insurance (including Medicare or student health plans) for each month they are covered by the ICHRA, and they cannot be reimbursed for any expenses incurred after individual coverage ceases.

2. Enrollment in other group health coverage, such as a spouseôs group plan, does not meet ICHRA eligibility requirements and these individuals would not be allowed to participate.

3. An employer cannot offer employees a choice between a group health plan and an ICHRA. However, an employer can create classes of employees based on a given set of employment distinctions (i.e., salaried, hourly, geography, full-time, part-time, etc.) and offer an ICHRA to some classes and a more traditional group health plan to others.

4. Employer size determines the minimum class size for the ICRHA: 10 employees for groups under 100 lives, 10% for employers sized 100-200 lives, and at least 20% for larger employers.

5. Within each class, the ICHRA must be offered on the same terms to each employee.

6. An employer may fund differing amounts to account for premium variances due to age (individual polices are age rated). An ICHRA is deemed non-discriminatory so long as the amount made available to the oldest participant(s) is not more than three times the amount made to the youngest participant(s).

7. An employer may provide larger contributions based on family size.

8. Employees must be given a 90-day advance written notice of the employerôs decision to implement an ICHRA so the employee has time to shop for the individual coverage needed in order to receive the benefit.

Unlike a Qualified Small Employer HRA (ñQSEHRAò) that has a maximum annual contribution limit, there is no maximum funding limit for an ICHRA. However, in order to meet the ACAôs affordability test for the purpose of the employer shared responsibility payment, an employer of 50 or more full-time equivalent employees subject to the ACAôs employer mandate will have to fund a minimum contribution.

An ICHRA is ñaffordableò if, after expending the ICHRA money, an employee can purchase the lowest-cost silver plan available through the Exchange without spending more than 9.78% of the employeeôs household income.

B. Excepted Benefit HRA

The same revenue rule that paved the way for the Individual Coverage HRA also created a new limited Excepted Benefit HRA (ñEBHRAò).

Despite its name, an Excepted Benefits HRA may reimburse eligible medical expenses, COBRA premiums, and premiums for excepted benefit coverage such as vision and dental insurance, long-term disability insurance, and short-term limited-duration medical policies.

The EBHRA cannot be used to reimburse individual health insurance, Medicare premiums, or employee contributions toward an employerôs group health plan.

In order to offer an Excepted Benefit HRA an employer must offer an underlying group health plan except the EBHRA is in addition to the group plan. Employees who waive group coverage remain eligible for EBHRA benefits.

An EBHRA must be offered on the same terms to all similarly situated individuals. In other words, an employer cannot provide more (or less) money to individual employees who may have greater medical expenses than others.

The EBHRA is not meant to be a replacement for primary coverage. It is limited to $1,800 per plan year, though amounts can roll over from one plan year to the next and accumulate more than $1,800. If the employer offers other HRAs, the amounts are aggregated for the purposes of determining whether the EBHRA meets the $1,800 limitation.

VII. OTHER ACA DEVELOPMENTS

A. The Further Consolidated Appropriations Act of 2020

In addition to the SECURE Act, the December 20, 2019 omnibus spending package (H.R. 1865) included other changes to the ACA:

1. Repeal of the ñCadillacò Tax

   Originally intended to take effect in 2018, this extremely controversial portion of the Affordable Care Act was intended to levy a 40% excise tax on employer health plans that cost more than $11,200 for individual coverage or $30,150 for family coverage. Congress had already delayed its implementation twice and, with this Appropriation Act, repealed it permanently.

2. Repeal of the Medical Device Tax

   Enacted in 2013, the ACAôs medical device tax imposed a 2.3% tax on the domestic sale of medical devices, to be paid by the manufacturer or importer. The tax was suspended in 2016 (except for two weeks in 2018). The Appropriation Act repealed it permanently.

3. Repeal of the Health Insurance Industry Fee

   The ACA created this annual fee on health insurers in order to fund the implementation of marketplace exchanges. The tax, based on an insurerôs total premiums and market share, was first payable in 2014 though the IRS put a moratorium on the fee for 2017, and suspended it again 2019. The Appropriation Act repeals it for calendar years beginning January 1, 2021.

4. PCORI program fee extended 10 years

   The one tax that was set to permanently expire without intervention was actually extended another 10 years, until September 30, 2029. The Patient-Centered Outcomes Research Trust Fund is a fee on insurers and self-funded health plans meant to fund the Patient-Centered Outcomes Research Instituteð a think tank dedicated to advancing the quality and relevance of evidence-based medicine. The 2019/20 fee is a flat rate of $2.54 per enrollee per year.

B. *California v. Texas (*a.k.a. *Texas v. U.S.*)

The ACA survived its first constitutional challenge in 2012 when SCOTUS declared in *NFIB v. Sebelius* that the individual mandate was a constitutional exercise of Congressô taxing power.

Subsequently, the 2017 Tax Cuts and Jobs Act set the shared responsibility payment at zero dollars for January 1, 2019. A group of 20 states (Wisconsin and Maine have sense withdrawn), led by Texas, sued the federal government declaring that, because the individual mandate no longer resulted in ñat least some revenueò for the federal government, it was no longer constitutional. Further, Texas argued that the ACA cannot survive without the individual mandate, so the entire law should be struck down. In December 2018 the Texas trial court invalidated the entire ACA.

In March 2019 the United States agreed that the entire ACA should be invalidated, so 17 states (expanded to 21), led by California, were permitted to intervene in the case and defend the ACA on appeal. In a 2:1 decision in December 2019 the 5th Circuit agreed with the trial courtôs decision that the individual mandate is no longer constitutional, but sent the case back to the trial court for additional analysis on the matter of severability of the individual mandate.

California filed for *certiorari* and the Supreme Court agreed to review three issues: whether Texas and the individual plaintiffs have standing to bring the lawsuit to challenge the individual mandate; whether the 2017 Tax Cuts and Jobs Act rendered the individual mandate unconstitutional; and, if the mandate is unconstitutional, can the rest of the ACA survive.

The Court has not yet set a date for oral argument. Even if the case is argued before the 2020 election, the chances of the Court issuing a decision before the election are very slim. Many feel the decision could come as late as June 2021.

VIII. NEW ELECTRONIC DISCLOSURE RULE

The Department of Labor announced a final rule on May 21, 2020 that will allow employers to post retirement plan disclosures online or to deliver them to workers by email or smart phone, as a default. This new safe harbor, which may be relied upon immediately, allows employers much greater latitude to provide ERISA-required documents in an electronic format than afforded in the 2002 safe harbor found at 29 CFR § 2520.104b-1(c).

While employers may continue to rely on the 2002 safe harbor, the new rules allow for retirement plan disclosures (welfare plans are specifically excluded from the regulation) to be posted on an internet website or to be delivered electronically (to an email address or smart phone number) without a ñcovered individualôsò affirmative consent.

A. Covered Individuals

This new safe harbor applies only to one category of plan beneficiariesð the covered individual. A covered individual is any participant, beneficiary or other individual entitled to ERISA documents who provides the plan administrator with an electronic address. If an employer assigns an employee an electronic address, then the employee is deemed to have provided an electronic address. If a covered individual terminates employment, the plan administrator must take reasonable measures to obtain a new electronic address.

The plan administrator must have a system to identify invalid or inoperable electronic addresses and, if such cannot be promptly corrected, the individual is deemed to have opted out of electronic delivery.

B. Initial Notice of Default Electronic Delivery

Before switching to the online/electronic default, each affected individual must be given a one-time <u>on paper</u> initial notice explaining the new electronic default and that the individual has the right to 1) receive a paper version of any document free of charge, and 2) completely opt out of electronic delivery. The notice should explain how an individual can exercise those rights.

C. Notice of Internet Availability ("NOIA")

For each disclosure posted on an internet website, the plan administrator must send covered individuals an electronic NOIA with a brief description of the document, instructions on how to access information on the website, and other prescribed content. The NOIA must also adhere to certain readability and formatting standards.

Certain disclosures can be listed on a combined annual NOIA. For instance, an annual NOIA can notify participants of the delivery of summary plan descriptions and other

annually furnished documents that do not require action by the individual by a specific deadline.

Documents that are not furnished annually (e.g., a blackout notice) must be accompanied by a separate NOIA.

D. Website Requirements

A ñwebsiteò that hosts retirement plan disclosures may include electronic-based repositories, such as mobile applications. Whether internet or app-based, the plan administrator must take measures reasonably calculated to ensure that:

- the covered document is available on the website no later than the date on which the covered document must be furnished under ERISA;
- the covered document remains on the website for at least one year, or until it is superseded by a new version of the covered document if later;
- the website presents the covered document in a manner that can be understood by the average plan participant;
- the covered document is presented on the website in a common format or formats that can be both read online and printed on paper and that can be downloaded and permanently retained in electronic format (such as PDF);
- the covered document can be searched electronically by numbers, letters or words;
- the website protects the confidentiality of personal information relating to any covered individual.

E. Disclosures via Email or Smart Phone Systems

Instead of posting disclosure documents on the internet and furnishing participants with an NOIA, plan administrators may choose to send an email that includes the NOIA disclosure language in the body of the email or as an attachment. The email must satisfy several content requirements, including a brief description of the document and a statement of the right to request a paper copy.

IX. ERISA LAWSUITS

A. Standing to Sue for Fiduciary Breach

Thole v. U.S. Bank, 590 US ____ (2020)

Background

James Thole and others brought a class action against US Bank over the Bankôs management of a defined benefit pension plan. Thole claimed the bank engaged in prohibited transactions, causing the plan to be underfunded. The Bank sought to dismiss the case for lack of right to sue and ERISAôs statute of limitations. During litigation, the plan righted itself, the plaintiffs suffered no loss, and the court dismissed the case as

moot. Thole appealed to the 8th Circuit that upheld the district courtôs dismissal. Plaintiff petitioned SCOTUS arguing the 8th Circuitôs decision conflicted with other circuits.

Dispute

Can an ERISA plan participant seek relief for fiduciary misconduct without demonstrating actual financial loss or imminent risk thereof? If so, may the participant seek restoration of plan losses caused by fiduciary breach without demonstrating any financial loss? Did Thole have Article III standing?

Holding

In a 5-4 decision, the Court held the plaintiff did not have Article III standing because they would still receive the same amount of monthly benefits regardless of the caseôs outcome. The poor decisions by the fiduciaries did not cause any actual injury.

B. Statute of Limitations and "Actual Knowledge"

Intel Corp. Investment Policy Committee v. Sulyma, 589 U.S. ____ (2020)

Background

Employee Sulyma brought a class action against plan fiduciaries for overinvestment in hedge funds and private equity, resulting in substantial losses and excess fees. The district court granted summary judgment for Intel because Sulyma had access to the documents describing plan investments more than 3 years before he filed suit. In general, fiduciary breach claims are covered by the 6-year statute of limitations, but if there is ñactual knowledgeò of the breach the limitation period is 3 years. The 9th Circuit reversed, holding Sulyma did not have ñactual knowledgeò of where his retirement funds were invested.

Dispute

Does ERISAôs 3-year limitation period begin to run when the plaintiff has access to documents needed to determine that a breach of fiduciary duty occurred but has no ñactual knowledgeò of the breach because plaintiff hasnôt read the documents?

Holding

In a unanimous opinion, SCOTUS sided with Sulyma, indicating making documents available to plan participants is not enough to prove actual knowledge. Providing a URL link to a document is not the same as actual knowledge of the contents of the document, it is merely constructive possession of documents. In the past, plan fiduciaries had to worry about participants receiving a paper disclosure in the mail and throwing it away without reading it. Today, plan administrators may need to worry about a participant who receives an e-mail Notice of Availability, but never opens the e-mail or clicks on the enclosed link.

Going forward, plan fiduciaries may want to consider requiring employees to electronically acknowledge that they have received and understood important disclosures. Plan fiduciaries may consider discussing with their service providers ways to track whether participants have accessed electronic disclosures.

C. Pre-emption

Gobeille v. Liberty Mutual Insurance Co., 577 US ____ (2016)

Background:

Vermont law requires issuers of group health plans (insurers and self-funded plan sponsors) to report payments related to health care claims for compilation in a state health care database. Liberty Mutualôs employee health plan advised its TPA, Blue Cross, to not disclose confidential claims information. Blue Cross sought a declaratory opinion whether ERISA preempts Vermontôs statute. The 2nd Circuit reverse the lower courtôs summary judgment in favor of Vermont.

Dispute:

Does a stateôs mandatory reporting schema have an ñimpermissible connectionò with ERISA plans? In other words, does the law govern or interfere with the uniformity of, ERISA plan administration?

Holding:

In a 6-2 opinion, ERISA invalidates Vermontôs all-payer claims database reporting requirements for self-funded employee health plans because to do otherwise would ñimpinge upon reporting, disclosure, and recordkeeping [requirements that] are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA.ò The Court did not demand a plan show a burden imposed by the state law, it was enough to show the possibility of disuniform state reporting laws or to accommodate multiple governmental agencies.

NEW *Rutledge v. Pharmaceutical Care Management Association,* recently accepted by SCOTUS, asks whether ERISA preempts an Arkansas state law that requires PBMs--who are regulated by state statuteð to reimburse pharmacies for a generic drug at a rate that is at least what the pharmacy paid for the drug. The PBMs, because they service ERISA plans, claim the state does not have authority to regulate them at all.

D. ESOP Valuation

Lee v. Argent Trust Company, Case No. 19-2485, U.S. Court of Appeals, 4th Circuit, December 30, 2019

Background

Sharon Lee, an ESOP participant, challenged the price the ESOP paid for shares of Choate Construction in a leveraged ESOP transaction. The plaintiff claims that ESOPs are inherently risky and vulnerable to abuse and that, in this instance, the ESOP paid Choate $198 million on stock valued at $64.8 million.

Dispute
The lower court dismissed the case for lack of standing, stating the plaintiff had not demonstrated any concrete or particularized injury. The National Center for Employee Ownership and the American Society of Appraisers have taken the rare step of filing amicus briefs on this case at the 4th Circuit due to their fear this case could set a precedent for ESOPs based on imperfect understanding of ESOP pricing methodology and ESOPs in general.

E. Duty to Monitor
Tibble v. Edison International, 575 US ____ (2015)

Background:
Edison Intôl is a holding company for electric utilities that offers retail-class mutual funds as part of its 401(k) plan, even though otherwise identical institutional-class funds that charged lower fees were available. Tibble sued under ERISA arguing that including the higher-cost funds in the plan was a continuing violation. The district court and 9th Circuit affirmed ERISA did not recognize a ñcontinuing violationò theory and that the 6 year statute of limitation for bringing claim had tolled.

Dispute:
Does the 6-year statute bar a claim of breach of fiduciary duty when fiduciaries made the choice more than 6 years before a claim was filed?

Holding:
A unanimous court said NO STATUTE of REPOSE because the nature of fiduciary duty under trust law creates a continuing obligation to monitor investments and remove imprudent ones. Because this continuing duty is separate from the initial duty to choose investments carefully, violation of the continuing duty counts as a breach of fiduciary duty.

F. Subrogation
Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan, 577 US ____ (2016)

Background:
Montanile was in a car accident resulting in significant injuries. The plan dispersed over $120,000 to cover his bills. He later sued the driver, eventually obtaining a $500,000 settlement. The Plan then demanded reimbursement of its $120,000. Montanile appealed claiming his reimbursement had already been spent and disbursed to other parties. The 11th circuit held that, because the Plan had subrogation rights, its lien attached before Montanile spent the funds and therefore he could not evade the repayment by claiming the money was gone.

Dispute:
Is a reimbursement to an ERISA plan ñappropriate equitable reliefò if the identified source of the reimbursement has already been spent?

Holding:
If a third-party payment has been wholly disbursed on non-traceable items (e.g., services), ERISA does not allow for suit to recover reimbursement [8-1]. While the Plan had a claim under ERISA while the settlement money was in the employeeôs possession, the claim does not extend beyond the dissipation of the fund.