BENEFITS ADMINISTRATION WORKSHOP

SWBA SouthWest BENEFITS Association

APRIL 20, 2023

HOUSTON

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Session 1 - SECURE Act 2.0 is now Law: RMDs, Automatic Enrollment, and more Updates

Speaker: **Rance Buss,** Partner, Employee Benefit Plan Services, Weaver, LLP

Speaker

Rance Buss serves as the Weaver LLP full time ERISA Partner over the firm's Employee Benefit Plan Services group and has been involved with auditing benefit plans for more than 25 years. Rance regularly participates in the leadership activities of the AICPA's Employee Benefit Plan Audit Quality Center and is a repeat speaker at national conferences and webinars on employee benefit plan audits.

SECURE Act 2.0 is Now Law

RMDs, Automatic Enrollment, and more Updates

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weaver

Assurance • Tax • Advisory

2.0 – How did we get here?

- On December 20, 2019, President Trump signed the "Further Consolidated Appropriations Act, 2020" into law

- This year-end spending package included the most extensive retirement plan legislation in over a decade – "the **Setting Every Community Up for Retirement Enhancement (SECURE) Act**"

2.0 – How did we get here?

- That bill was passed (finally) after numerous bipartisan bills were consolidated into these two congressional bills –

➢ The **Retirement Enhancement and Savings Act** (RESA)of 2016, reintroduced again in 2019, sponsored by Senators Grassley (R) and Wyden (D) of the **Senate Finance Committee**

➢ The **Setting Every Community Up for Retirement Enhancement Act** (SECURE) of 2019, sponsored by the **House Ways and Means Committee** Richie Neal (D) and cosponsored by Ranking Member Kevin Brady (R)

2.0 – How did we get here?

- As with all final bipartisan bills passed, there were provisions that didn't make it into the bill
- So before the virtual ink dried on the SECURE Act, several more retirement plan bills started to spring up on the hill
- By early 2021, the House and the Senate had competing retirement plan bills fighting to be the survivor

2.0 – How did we get here?

On the House side, these two rose to the top

- ***House Bill: SECURE Act 2.0 -*** Late 2020, **House Ways and Means Committee** Richard Neal (D-MA) and Kevin Brady (R-TX) introduced the Securing a Strong Retirement Act of 2020 (SECURE 2.0)

- ***House Bill: RISE -*** The House **Education and Labor Committee** Bobby Scott (D-VA) and Virginia Foxx (R-NC) introduced the Retirement Improvement and Savings Enhancement Act (RISE)of 2021

(On March 29, 2022, the U.S. House of Representatives overwhelmingly approved the Secure Act 2.0 by a vote of **414 to 5**)

2.0 – How did we get here?

On the House side, these two rose to the top

- **Senate Bill: Rise & Shine Act** – On June 14, 2022, the Senate **Health, Education, Labor and Pension Committee** (HELP) unanimously passed the Retirement Improvement and Savings Enhancement to Supplemental Healthy Investments for the Nest Egg Act (RISE & SHINE) sponsored by Patty Murray (D-WA) and Richard Burr (R-NC)
- **Senate Bill: EARN Act** – On June 22, 2022, the **Senate Finance Committee** approved a major bipartisan retirement security package; the Enhancing American Retirement Now Act (EARN) introduced by Ron Wyden (D-Oregon), and Mike Crapo (R-Idaho)

2.0 – How did we get here?

- On December 29, 2022, President Biden signed into law the "**Consolidated Appropriations Act, 2023**," which included a major package of retirement savings provisions known as "**SECURE 2.0 Act**"

- As expected, the final package contained many of the same provisions included in the U.S. House and Senate bills that were previously considered

So what did we get with this bill?

(130 pages, 90 provisions of wonderful retirement plan “reform”)

2.0 – Eligibility & Enrollment

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
ELIGIBILITY AND ENROLLMENT			
Required Automatic Enrollment and Escalation	401(k) and 403(b) plans may, but are not required to, use automatic enrollment and escalation features.	New 401(k) and salary reduction 403(b) plans – meaning those adopted on or after December 29, 2022 – must include automatic enrollment (of at least 3%) and automatic escalation (of at least 1% per year, up to a minimum of 10% and a maximum of 15%). Participants who are automatically enrolled will have 90 days to elect to withdraw those automatic deferrals. Government and church plans are exempt, as are plans sponsored by businesses in existence for less than 3 years and those normally employing 10 or fewer employees.	Plan years beginning after December 31, 2024

2.0 – Eligibility & Enrollment

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
ELIGIBILITY AND ENROLLMENT			
Participation Requirements for Part-Time Employees	The SECURE Act introduced a new requirement that part-time employees with at least 500 hours of service for 3 consecutive years be permitted to make elective deferrals to an employer's 401(k) plan.	SECURE 2.0 shortens the eligibility service requirement for part-time employees from 3 years to 2 years. The eligibility requirements for part-time employees now also apply to salary reduction 403(b) plans that are subject to ERISA.	Plan years beginning after December 31, 2024
Notices to Unenrolled Employees	If an employee is eligible to participate in a defined contribution plan, all legally required notices must be provided to that employee on an ongoing basis, even if the employee never enrolls or receives a contribution.	If a new employee receives a summary plan description and any other notices related to initial eligibility under the plan, but does not enroll or receive a contribution, the plan only has to provide that employee with a single annual reminder notice about the plan. All other notices must be available to the employee, but only have to be provided upon request.	Plan years beginning after December 31, 2022

2.0 – Contributions

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
CONTRIBUTIONS			
Increased Limit and Required Roth Treatment for Catch-Up Contributions	Participants who are age 50 or older may make additional pre-tax and/or Roth contributions to a 401(k) or 403(b) plan known as "catch-up contributions." The catch-up contribution limit is generally subject to annual cost-of-living adjustments, and is $7,500 for 2023.	The catch-up contribution limit for 401(k) and 403(b) plans is increased for participants who are age 60 – 63 to the greater of (i) $10,000, or (ii) 150% of the regular catch-up contribution limit, subject to future cost-of-living adjustments. In addition, catch-up contributions made by participants whose prior year wages exceed $145,000 (as indexed) must be treated as Roth contributions.	The required Roth treatment for catch-up contributions is effective January 1, 2024. The increased limit for catch-up contributions is effective January 1, 2025.

2.0 – Contributions

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
CONTRIBUTIONS			
Optional Employer Matching Contributions on Student Loan Payments	Employers generally are not permitted to make matching contributions to a 401(k) or 403(b) plan for employees paying off student loans instead of contributing to the plan.	Employers are permitted to make matching contributions to a 401(k) or 403(b) plan based on an employee's student loan payments, provided certain requirements are met. Special discrimination testing rules apply.	Permitted for plan years beginning after December 31, 2023
Optional Roth Treatment for Employer Matching and Nonelective Contributions	Employer matching and nonelective contributions to a 401(k) or 403(b) plan may not be contributed on a Roth basis (although they may later be converted to Roth treatment).	401(k) and 403(b) plans may allow participants to elect to have their employer matching and/or nonelective contributions contributed on a Roth basis, as long as those contributions are immediately vested.	**Immediate** – permitted for employer contributions made after December 29, 2022

2.0 – In-Service Withdrawals & Loans

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
IN-SERVICE WITHDRAWALS AND LOANS			
In-Service Withdrawals for Emergency Expenses and Domestic Abuse Victims	Prior to age 59½, in-service withdrawals of 401(k) and 403(b) deferrals are generally limited to hardship withdrawals that are subject to a 10% penalty tax in addition to ordinary income tax.	401(k) and 403(b) plans may allow participants to take (i) up to $1,000 in withdrawals every 3 years for personal or family emergency expenses, and (ii) withdrawals of up to $10,000 (or 50% of the participant's vested balance, if less) if the participant is a victim of domestic violence. These distributions are not subject to the 10% early withdrawal penalty and may be repaid to the plan within 3 years. Personal or family emergency withdrawals may be taken more frequently if the participant repays or contributes the prior withdrawal amount.	January 1, 2024

2.0 – In-Service Withdrawals & Loans

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
IN-SERVICE WITHDRAWALS AND LOANS			
Permanent Relief Provisions for Qualified Federal Disasters	On an *ad hoc* basis, the IRS has acted administratively to allow in-service distributions from 401(k) and 403(b) plans and granted other tax relief for federally declared disasters. However, there were no permanent statutory provisions covering these events.	401(k) and 403(b) plans may allow participants impacted by a qualified federally declared disaster (i) to take distributions of up to $22,000 (with repayment rights and no 10% early withdrawal penalty tax), and (ii) to take higher loan amounts with longer repayment periods.	This provision applies retroactively to disasters occurring on or after January 26, 2021.
Self-Certification for Hardship Withdrawals	IRS regulations allow a plan administrator to rely on a participant's self-certification that other funds were not available to satisfy a financial hardship. The regulations did not address self-certification of the existence of a hardship, although in recent years the IRS has informally accepted this practice.	Plan administrators may generally rely on a participant's self-certification as to both the existence of a hardship and the lack of other available funds. SECURE 2.0 also broadly embraces participant self-certification for distributions in many other contexts.	**Immediate** – plan years beginning after December 29, 2022

2.0 – In-Service Withdrawals & Loans

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
In-Plan Emergency Savings Accounts	In-service withdrawals are generally limited to specific financial hardships.	401(k) and 403(b) plans may allow non-highly compensated employees to make Roth contributions to an emergency savings account within the plan via affirmative election or automatic enrollment. The account must be invested in a capital-preservation fund, and participants may take monthly withdrawals from the account. The balance in the account attributable to employee contributions must be capped at $2,500 (as adjusted for inflation). Employers may match employee contributions to the emergency savings account at the same rate as other matching contributions under the plan. However, the matching contributions may not themselves be deposited into the emergency savings account. Upon the employee's termination, the emergency savings account may be transferred to an IRA or paid to the participant.	Plan years beginning after December 31, 2023

2.0 – Distributions

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
DISTRIBUTIONS			
Increased Required Minimum Distribution Age	The SECURE Act changed the required minimum distribution rules so that distributions to terminated participants must begin after the participant reaches age 72, instead of age 70½.	The required minimum distribution age is again increased to (i) age 73 for participants who reach age 72 on or after January 1, 2023, and (ii) age 75 for participants who reach age 74 on or after January 1, 2033.	**Immediate** – January 1, 2023
Elimination of Pre-Death Required Minimum Distributions for Roth Accounts	Roth accounts in 401(k) and 403(b) plans are subject to pre-death required minimum distribution rules. However, these rules do not apply to Roth IRAs.	The pre-death required minimum distribution rules will no longer apply to Roth accounts in 401(k) or 403(b) plans, establishing consistent rules for IRAs and qualified plans.	January 1, 2024
Increased Cash-Out Limit for Small Accounts	Qualified retirement plans may distribute a terminated participant's benefit without the participant's consent if the value of the benefit is $5,000 or less.	The $5,000 cash-out threshold is increased to $7,000.	January 1, 2024

2.0 – Miscellaneous

Plan Design Feature	Current Law	New SECURE 2.0 Provisions	Effective Date
MISCELLANEOUS			
"Retirement Savings Lost and Found" Database	None	The DOL is required to create an online database of qualified retirement plans that allows individuals to search for the contact information of any plan in which the individual may have a benefit (either as a former participant or as a beneficiary). Plans are required to submit information to the DOL to include in the database.	Directs the DOL to establish the database by December 29, 2024 (*i.e.*, within 2 years of SECURE 2.0's enactment)
Self-Correction of Plan Errors	The IRS correction program for qualified retirement plans – the Employee Plans Compliance Resolution System ("EPCRS") – allows plan sponsors to self-correct plan errors (*i.e.*, without IRS reporting, fees, or approval) only in certain fairly limited circumstances. Under the current version of EPCRS, self-correction is generally available only to correct (i) insignificant operational errors, and (ii) significant operational errors that are corrected within 3 years after the plan year in which the error occurred.	EPCRS is expanded to allow plan sponsors to self-correct all operational errors that occur despite the plan having reasonable compliance practices and procedures in place. To be eligible for self-correction, the error (i) must be corrected within a "reasonable period" after being identified by the plan sponsor, and (ii) cannot be identified by the IRS before the plan sponsor has started correcting the error.	**Immediate** – December 29, 2022

2.0 – Other Considerations

- **Recovery of retirement plan overpayments:**
  Allows retirement plan fiduciaries the latitude to decide not to recoup overpayments that were mistakenly made to participants, including retirees. Certain overpayments may also be treated as eligible rollover distributions. Effective December 29, 2022

- **Reduction in excise tax on certain accumulations in qualified retirement plans:**
  Reduces the penalty for failure to take RMDs from 50% to 25%, with a further reduction to 10% if the RMD failure is corrected in a timely manner. Taxable years beginning after December 29, 2022

2.0 – Other Considerations

- **Performance benchmarks for asset allocation funds:**
  Directs the U.S. Department of Labor (DOL) to update the fee and investment disclosure regulations within two years after the date of enactment so that investments that use a mix of asset classes, such as target date investments, can be benchmarked against a blend of broad-based securities market indices. Effective December 29, 2022

- **Requirement to provide paper statements:**
  Amends ERISA to generally provide that, with respect to defined contribution plans, unless a participant elects otherwise, the plan is required to provide a paper benefit statement at least once annually. Plan years beginning after December 31, 2025

2.0 – Other Considerations

- **Prohibited transaction exemption for certain automatic portability transactions:** Permits a retirement plan service provider to provide employer plans with automatic portability services. Such services involve the automatic transfer of a participant's default IRA (established in connection with a distribution from a former employer's plan) into the participant's new employer's retirement plan, unless the participant affirmatively elects otherwise. Effective for transactions occurring on or after December 29, 2023 (12 months after enactment)
- **Hardship withdrawal rules for 403(b) plans:** Conforms the hardship rules for 403(b) plans to those for 401(k) plans Plan years beginning after December 31, 2023

2.0 – Other Considerations

- **Report to Congress on retirement plan disclosures:** Treasury, DOL, and Pension Benefit Guaranty Corporation (PBGC) are directed to review reporting and disclosure requirements for retirement plans and make any recommendations to Congress within three years of enactment to consolidate, simplify, standardize, or improve the requirements. Upon enactment; report within 3 years

Questions?

BENEFITS ADMINISTRATION WORKSHOP

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Session 2 - Terminating a Retirement Plan: Planning, Announcements, Missing Participants, Distributing Plan Assets

Speakers: **Ed Razim,** Partner, Locke Lord
George Sanders, Sr. Investigator, U.S. Department of Labor, EBSA

Speakers

Ed Razim is a partner in the Houston office of Locke Lord, L.L.P. His practice concentrates on the areas of employee benefits and executive compensation. Ed advises clients on all aspects of qualified retirement plans, welfare benefit plans, nonqualified plans, stock-based plans and deferred compensation and other executive compensation arrangements. He frequently advises clients on ERISA fiduciary and prohibited transaction matters, represents clients before the IRS and DOL on matters related to employee benefits and provides legal counsel on employee benefit and executive compensation matters related to corporate mergers and acquisitions.

Locke Lord

Terminating a Retirement Plan: Key Issues for Plan Sponsors

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April 20, 2023

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Retirement Plan Termination

- Today's key issues
  - Types of plans
  - Basic Issues
  - DC Plan and DB Plan Issues
  - Documentation
  - Process issues
  - Surprises and risks

Types of Plans

- Defined Contribution Plan
  - 401(k) plans
  - Profit Sharing Plans
  - ESOPs
- Defined benefit plans
  - Pension Plans
  - Cash Balance Plans
- Multi-employer plans

Termination 101: What?

- A plan termination is a formal action to "terminate" a qualified retirement plan.
  - Initial result is to discontinue contributions and, in general, fully vest participants.
  - Additional actions must occur to liquidate the plan and satisfy all remaining obligations.

Termination 101: Why?

- This typically occurs due to:
  - Plan sponsor change in business goals, either due to an operational change or cost.
  - An M&A transaction.
    - Buyer may require plan termination before closing.
    - Buyer may determine it does not, or cannot, maintain the plan after closing.

Termination 101: How?

- The plan sponsor will terminate the plan as a corporate action.
  - Identify authority to terminate.
  - Identify how this action is taken, typically this is a written consent.
  - Determine notice obligations.
    - Will participant notices be required and, if so, is there a minimum notice period? This will vary by plan type.
    - Will vendor notices be required?

Termination 101: How?

- Establish the timeline.
- Review plan to determine whether it will need to be amended for change in law and/or regulations.
  - It is common for a plan to be "out of date" during a designated transition period.
  - The "remedial amendment period" typically ends on plan termination.
  - For most plans, this amendment is prepared by the third-party administrator.

Termination 101: How?

- Determine how final funding will occur. This will vary by plan type.
  - For a 401(k) plan, address final payroll period and what occurs with a mid-period plan termination.
  - For a defined benefit plan, address funding issues.
  - Address outstanding plan loans.
  - Talk to the payroll vendor and third party administrator.

Termination 101: How?

- Discuss nondiscrimination testing issues.
  - The plan termination date is the "last day" for a plan's testing year.
  - If this does not occur on December 31st, consider there may be an impact due to the pro-ration of the annual compensation limit.
  - As an example, a "safe harbor plan" with a 4% match can fund up to $13,200 in match based on the full compensation limit of $330,000. A termination after 6 months reduces that amount to $6,600.
  - A similar reduction occurs for the Section 415 maximum contribution limit and can cause a significant limitation on non-safe harbor 401(k) plans.

Termination 101: How:

- Determination Letters.
  - Formal review of plan document by the Internal Revenue Service to confirm qualified status.
    - This is the "gold standard" for a plan termination.
    - Optional for (most) defined contribution plans.
    - Effectively mandatory for defined benefit plans.

Termination 101: How:

- Somewhat burdensome and takes time – typically a year or more – to complete the process.
- There are timing issues due to the "Notice to Interested Parties", which must be provided from 10-24 days before submission.
- The plan is typically not liquidated during this period, which slows the plan liquidation process.

Termination 101: DC Issues

- Defined contribution plan terminations; less complicated:
  - Formal consent to terminate plan taken by plan sponsor as settlor.
  - Additional actions taken by employer as plan administrator in a fiduciary capacity.
  - Most of the “work” is done by the third party administrator.

Termination 101: DB Issues

- Defined benefit plan terminations are complicated
  - It is typical to file with the Internal Revenue Service for a determination letter (IRS Form 5310) and with the Pension Benefit Guaranty Corporation for termination (Form 500)

Termination 101: DB Issues

- The determination letter filing must be submitted first, which extends the time period to liquidate the pension plan until both processes have been completed.
- But there are many more filings with a pension plan termination.

Termination 101: DB Issues

- **Notice of Intent to Terminate** (**NOIT**) issued to affected parties (participants, beneficiaries, alternate payees, union representatives) at least 60 but not more than 90 days before the termination date.
- **204(h) Notice** issued to each applicable individual (participant and alternate payee whose rate of future benefit accrual is affected) and the union representative at least 45 days prior to termination date.

Termination 101: DB Issues

- **Notice to Interested Parties** (**NTIP**) issued to all participants, alternate payees and beneficiaries at least 10 and not more than 24 days before the determination letter application is filed.
- **Notice of Plan Benefits** (**NOPB**) issued to participants, beneficiaries and alternate payees no later than Form 500 filing date.
- Determination letter application must be submitted before the PBGC Form 500 filing to qualify for extended distribution deadline.

Termination 101: DB Issues

- Form 500 must be filed with the PBGC on or before the 180th day after the proposed termination date.
- PBGC has 60 days after receipt of the Form 500 for review.
- Must distribute plan assets by the later of (a) 180 days after the 60-day PBGC review period, and (b) 120 days after IRS issues a favorable determination letter. Plan liquidation is typically after the determination letter is issued.

Termination 101: DB Issues

- **Notice of Annuity Information** (**NOIA**) issued to affected parties (participants, beneficiaries, alternate payees, union representatives) at least 45 days before distributions occur.
- PBGC Form 501 must be filed no later than 30 days after all plan benefits are distributed.
- Benefit election forms must be provided at least 30 days but no more than 180 days prior to planned distribution date.

Termination 101: Timing

- A plan sponsor has one year to liquidate the plan after termination.
  - If a determination letter was filed, the one year should start on the date of issuance.
  - A "standard" process will take at least 90 days due to the requirement to provide the distribution notice with at least 30 days to consider payment options.
  - Depending on the number of participants, the record keeper, and the need to resolve lost/missing participants, this can easily require 180 days to complete.

Participant Related Issues

- Communication
- Lost participants
- Vesting
- Investment losses/penalties

Communication Issues

- The plan termination process requires many forms of notice
  - Defined contribution vs. defined benefit
- What if people ask questions before you announce the termination?

Lost Participants

- One challenge with a plan termination is the lost/missing participant issue.
  - A plan fiduciary has an obligation to conduct a reasonable and diligent search for lost/missing participants.
- Unclaimed assets must be distributed from the plan to complete the liquidation process.
  - Payment to an IRA is one alternative.
  - Escheat is another alternative.

Lost Participants

- This is a key focus for the Department of Labor
  - FAB 2014-1
    - Search steps: certified mail; employer records; designated beneficiary follow up; electronic search tools
    - Fiduciary considerations
  - DOL Best Practices:
    - https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/retirement/missing-participants-guidance/best-practices-for-pension-plans

Lost Participants

- Defined benefit plan rules
  - The PBGC has separate rules to address lost/missing participants and requires transfer of those assets to the PBGC.
  - The MP-100 for Missing Participants will be filed.
    - Actuarial work is required
    - Separate fees apply
  - The PBGC is willing to accept defined contribution plan assets.

Lost Participants

- Secure Act 2.0 has rules to address this issue
  - There will be a “lost and found” database.

Vesting Issues

- Participants are 100% vested upon plan termination.
  - If a participant has previously terminated and is less than 100% vested but has not forfeited his or her right to return to employment and recommence vesting, that person will also become vested.

Plan Asset Issues

- Liquidation of investments may, at times, cause delays and/or penalties.
  - Common for defined contribution plans with participant investment direction.
  - For stable value funds and similar investments, a "market value adjustment" occurs when the fund is eliminated.
  - That penalty is at the fund level and often cannot be paid by the employer.

Plan Asset Issues

- For plans that hold assets that are not market traded securities, typically defined benefit plans, it may be difficult to liquidate those investments to cash.
- Employer stock held in a defined contribution plan will raise fiduciary issues.

M&A Related Issues

- Special attention should be given to plan termination in a merger & acquisition context.
  - In an asset deal retirement plans typically remain with seller. Steps should be taken to make certain these plans are properly and timely liquidated.
  - In a stock deal retirement plans end up being sponsored by the buyer. If this includes a 401(k) plan, that plan must be terminated before closing or it likely cannot be terminated AND liquidated after closing due to the "successor plan" rule.

M&A Related Issues

- For a 401(k) plan that is terminated immediately before closing, address how to handle compensation if the termination date occurs during a payroll cycle.
  - An ongoing deferral election typically cannot be cancelled mid-payroll period.
  - There can be significant payroll administration challenges.
- Plan loans are a key focus.
  - Can they be transferred to the buyer's plan in an asset deal where the plan is not transferred?
  - Will they be defaulted in a stock deal if the plan is terminated immediately prior to closing?
  - Can loan payments continue after termination?

M&A Related Issues

- Special transition rules apply for an M&A transaction which will allow the "minimum coverage test" to be applied as if the transaction did not occur for a period after closing.
  - Typically covers the year of closing and one more year.
  - The rule is "lost" on the day there is a change in the plan's terms or a material change in the covered employee group.
  - The rule applies on a plan by plan basis, not an employer by employer basis. As such, it can be retained for some plans and lost for others.

Additional Issues

- It isn't over until its over.
  - Once a plan has been liquidated there are still tasks to complete.
    - Final Form 5500s.
    - Returned checks/payments.
  - Plan sponsors should retain records at least 6 years and perhaps longer due to the risk of claims for benefits in future years.

Q&A / Conclusion

Edward A. Razim III, Partner, Locke Lord LLP, erazim@lockelord.com

BENEFITS ADMINISTRATION WORKSHOP

SouthWest BENEFITS Association

APRIL 20, 2023

HOUSTON

Session 3 - Mergers and Acquisitions: Best Practices for In-House Benefits Professionals

Speakers: **Meredith VanderWilt**, Shareholder, Polsinelli
Luis Velez, Sr. Investigator, U.S. Department of Labor, EBSA

Speakers

Meredith VanderWilt is a member of the Employee Benefits and Executive Compensation practice at Polsinelli. She has been working in employee benefits since 2007. She focuses her practice on a variety of employee benefits matters, including the design and implementation of qualified plans, health and welfare plans, and non-qualified compensation arrangements, as well as compliance with the Internal Revenue Code, ERISA, COBRA, HIPAA and PPACA.

Luis Velez is a Senior Investigator in the Dallas Regional Office of the U.S. Department of Labor, Employee Benefits Security Administration (EBSA). He has been an Investigator with EBSA since 2012. He conducts civil and criminal investigations of private-sector pension plans, health care plans, and other employee benefit plans. He earned a Bachelor's Degree in Economics with a Minor in Philosophy from the University of Dayton, and a JD from the University Of New Hampshire School Of Law. He was admitted to the Puerto Rico Bar in October 2011 and has earned the Certified Employee Benefit Specialist (CEBS) designation.

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Mergers and Acquisitions: Best Practices for In-House Benefits Professionals

SouthWest Benefits Association

April 20, 2023

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PRESENTED BY:

- **Meredith VanderWilt**, *Shareholder, Polsinelli PC, Dallas, TX*
- **George Sanders**, *Supervisory Investigator, U.S. Department of Labor, EBSA*

Outline of Presentation

- Basics of Deal Structure
- Retirement Plan Issues
- Welfare Plan Issues
- Executive Compensation Issues

Where to Start

Understand the nature of the transaction

- Acquisition of stock
- Acquisition of assets

Understand the destination:

- **Which plans will the transitioning employees participate in after closing? One year from closing?**

Stock Acquisition

- Buyer purchases the stock of the Company (Target) from the Seller's shareholders.
- Target (and its assets and liabilities) will be owned by Buyer after closing.
- Employee benefit plans often (but not always) remain in place after closing.
  - Do other Seller group employees participate in the plans?
  - Does Buyer have its own plans?

Asset Acquisition

- Buyer purchases some or all of the assets of the company
  - Target company continues to be owned by Seller's shareholders
- Most liabilities generally remain with Target Company
- Employee benefit plans may or may not transfer to Buyer.
  - Do other employees of Seller group participate in the plans?
  - Does Buyer have its own plans?
  - How quickly can employees transfer to new plans?

Deal Timeline

- Potential transaction identified
- Discussions, Letter of Intent (LOI) or Memorandum of Understanding (MOU)
- Due Diligence process
- Negotiation of transaction document
- Closing

Overview of a Purchase Agreement

- Representations – statements of past or present fact (either express or implied) made by one party to induce the other party to enter into the agreement.
- Covenants – a promise to do or not do a particular act
- Indemnification - an undertaking by one party (the indemnifying party – generally seller) to compensate the other party (the indemnified party – generally the buyer) for certain costs and expenses

Benefits Due Diligence - General purpose

- Identify plans
- Understand costs
- Assess risk
- Assist with transition

Retirement Plans Diligence

- When representing Buyer, general request for retirement plan information should include:
  - Copies of all retirement plans
  - Copy of the most recent determination letter
  - Copies of form 5500s with Schedule B for past 3 years
  - Copies of recent actuarial reports for past 3 years
  - Copies of the summary plan description and summaries of material modifications
  - Copies of trust documents
  - Notice of any audit, government investigation or submission to voluntary compliance program
- When representing Seller:
  - Review materials requested by Buyer before providing them to Buyer
  - Relevance of plan information depends on structure of transaction and integration of employees

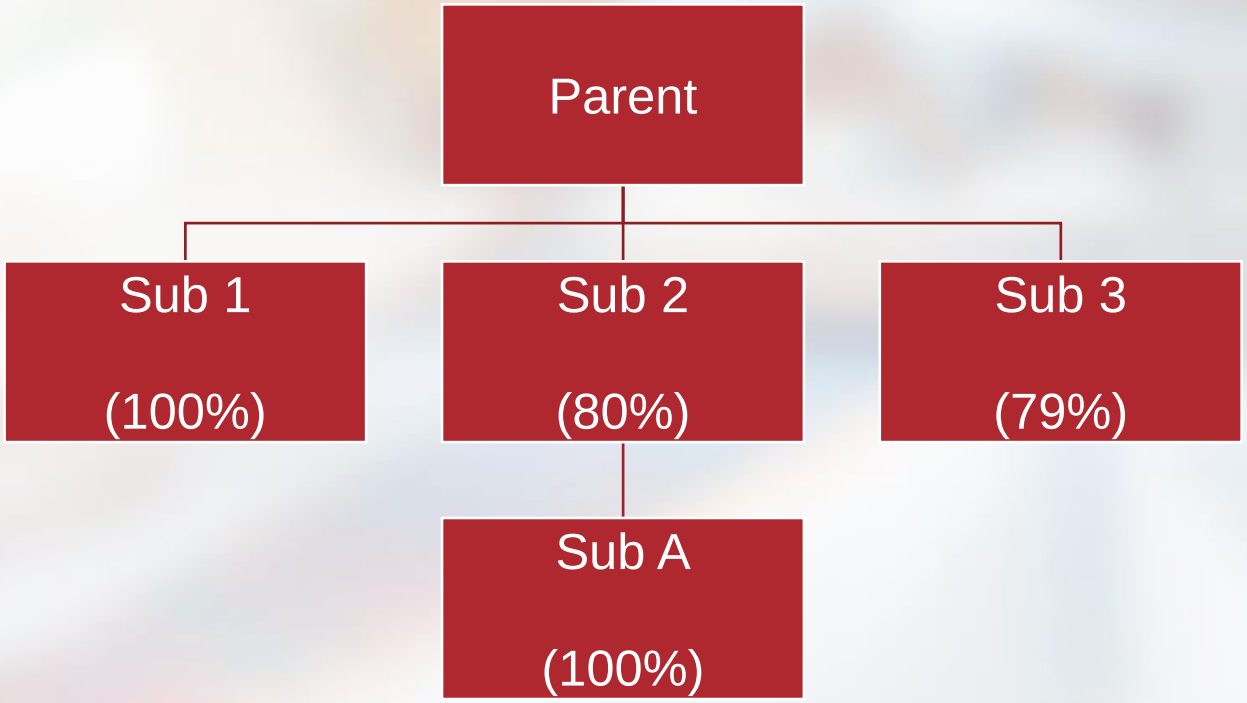
Retirement Plans - Qualification

- A high priority should be placed on confirming that plan is qualified:
  - Is there a determination letter?
  - Does the timing of required amendments comply with law?
  - Proper signatories on documents?
  - Is there any evidence the plan has NOT operated in a manner that its tax qualified status is not jeopardized
  - Confirm proper coverage and discrimination testing has been conducted
- Request whether plan is participating in a voluntary correction program

Understanding the Controlled Group

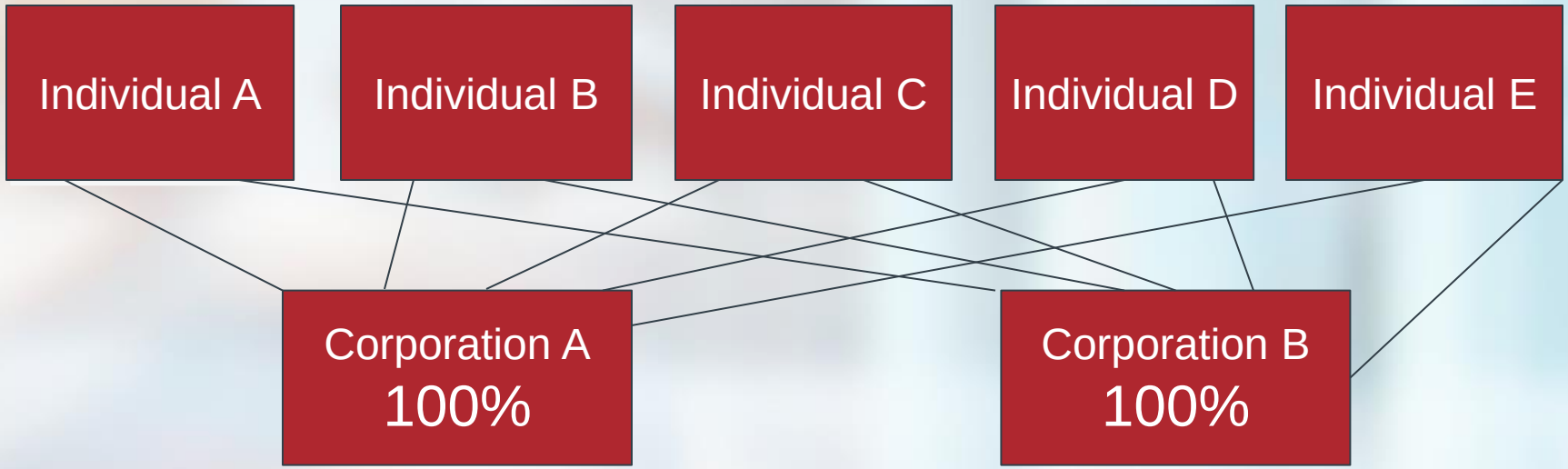
- A group of employers will be treated as the same employer if certain criteria are met.
  - Will impact nondiscrimination testing
  - Could give rise to operational issue if correct employer is not listed as a participating employer in plan document, or if an employer that is not participating is not included
- Lack of Controlled Group can cause problems too
  - Unrelated employers can give rise to “multiple employer plan,” which must meet special rules

Types of Controlled Groups



- **Parent – Subsidiary**
  - One business (the “common parent”) owns at least 80% of one or more other business entities (the “subsidiaries”)
  - Can have multiple tiers of ownership
  - For §415 purposes only, substitute “more than 50%” for “at least 80%”.

Brother/Sister Controlled Group



The same five or fewer shareholders, who are individuals, estates, or trusts, own at least an 80% controlling interest in each business entity; AND
The same five or fewer shareholders have an identical ownership among all business entities which, in the aggregate, is more than 50%.

Affiliated Service Group

- Service organizations linked through common ownership or joint activity or combination of both.
  - Service organization: Capital is not material income-producing factor
  - Common services provided: health, law, engineering, accounting
- Services may be rendered between the combined entities or to third parties.

Defined Contribution Plan – Plan Investments/Trustee

- Is the plan invested solely in mutual funds?
  - Some stable value funds and guaranteed investment contracts have a notice period requirement
- Does the plan hold employer stock?
- Who is the plan trustee?
  - If not a professional trustee, does the individual have access to assets?
- Is there a (proper) bond in place?

Defined Contribution Plans – What Happens at Closing?

- Timing issues
  - Participant loans and default rules
  - Watch payroll dates in connection with closing (especially in asset deal)
  - Consider impact on nondiscrimination testing
- Will the plan continue or will it be terminated?
  - Buyers often want plan terminated prior to closing to limit liability
- If Plan is terminated, who will be responsible for the wind down? Should Buyer be involved?
  - Plan amendments may be required
  - Will want to consider filing with the IRS for a determination letter

Defined Contribution Plans – What Happens at Closing?

- Who will have potential liability for issues prior to the termination?
- Will rollovers be allowed to Seller's plan? What about participant loans?
- Will assets be transferred to buyer's plan?
  - Certain benefits will need to be "protected"
    - Distribution forms and timing
    - Vesting (!!!)
- What if Buyer in asset deal wants to "borrow" the plan for a short period of time?
  - Multiple employer plan issues

Defined Benefit Plans

- Defined Benefit Plans represents a potential high-risk area for the Buyer
  - Liability for funding falls on the employer
  - ERISA sets minimum funding standards based on assumption that plan will continue indefinitely
    - Funding on a termination basis could require a significant contribution
- Controlled group liability
- Diligence:
  - Review 5500s, actuarial reports, Annual Funding Notices to participants
  - Request that actuary calculate funding on a termination basis

Defined Benefit Plans – What Happens at Closing?

- Will the plan continue or will it be terminated?
  - Buyers (really) want plan terminated prior to closing to limit liability
    - Participant notice deadlines make it difficult
- If Plan is terminated, who will be responsible for the wind down? Should Buyer be involved?
  - Termination of defined benefit plan is an extended process - PBGC filings, dealing with annuity distribution rules, etc.
- Who will have potential liability for issues prior to the termination?
- Will rollovers be allowed to Seller's plan?
- Buyers typically do not allow assets be transferred to Buyer's plan

Multiemployer (Union) Retirement Plans

- Potential high-risk area for Buyer
  - Many Union plans are under funded
- Participating employers can be subject to significant liability upon withdrawal
  - Triggering of withdrawal liability depends upon the nature of the transaction and special rules
  - Withdrawal liability may bear no relationship to the level of contributions an employer was making
  - Best practice is to request an estimate from the plan of any potential withdrawal liability
- Potential liability runs to all controlled group members
- Withdrawal from the plan or a change in benefits provided by the plan may require negotiation with the collective bargaining unit

Health & Welfare Plans

- Includes:
  - Medical
  - Dental
  - Prescription drug
  - Life insurance
  - AD&D
  - Severance
  - Disability
  - Long-Term Care

Health & Welfare Plans – Due Diligence

- When representing Buyer, general request for health & welfare information should include:
  - Documentation of ACA Compliance since 2015 (longer than 3 years)
  - Copies of all plan documents
  - Copies of IRS Form 5500 for past 3 years
  - Copies of most recent actuarial reports for past 3 years
  - With respect to retiree health and life insurance plans, internal correspondence and memoranda regarding benefits
  - Form COBRA notice
  - HIPAA business associate agreements, privacy notice and plan amendments
  - Insurance policies or arrangements
- When representing Seller:
  - Review materials requested by Buyer before providing them to Buyer
  - Relevance of plan information depends on structure of transaction and integration of employees

Health and Welfare Plans – Risk Areas

- Retiree health or other welfare benefits
- ACA compliance (often can be biggest liability exposure)
- Self funded vs fully funded arrangements
  - Claims history, stop loss policy
- The hidden Multiple Employer Welfare Arrangement (MEWA)
  - Special rules apply to MEWAs, including specific reporting requirements
  - MEWAs are illegal in some states unless they meet stringent laws generally applicable to insurance companies
- Form 5500 issues
- Cafeteria plans

COBRA Issues

- COBRA is often overlooked by the parties (although the transaction document may address it)
- Cost is (generally) not significant, since employee generally bears the burden, but cost to the employer of noncompliance can be significant
- General rule of law – Seller has responsibility to provide COBRA unless Seller no longer maintains a group health plan
  - Buyer would then have responsibility to provide COBRA, including Seller employees who terminated prior to the transaction
- Buyer and Seller can override this general rule and negotiate who will provide COBRA

Health and Welfare Plans – What Happens at Closing?

- Will Buyer keep plans?
  - Need to coordinate with/obtain permission of service providers, stop loss carrier
  - How do benefits compare to other Buyer benefits, i.e., will there be any nondiscrimination testing issues?
- Will transitioning employees participate in Buyer's plans?
  - How quickly can employees be set up on new plan/payroll?
  - How will deductibles, out-of-pocket maximums and other amounts incurred under Seller's plan be treated?
  - Will flexible spending accounts continue for the year of the transaction? How will amounts paid into Seller plan be transferred or "credited" to Buyer?
  - What if Buyer in asset deal wants to 'borrow" the Seller's plans until employees can be transitioned to Buyer's plan?
    - MEWA issues

Executive Compensation – Due Diligence

- When representing Buyer, general request for executive compensation information should include:
  - Copies of all employment, offer, change in control, severance, retention, incentive, bonus, deferred compensation, consulting or other similar agreements or arrangements with directors, employees, independent contractors and consultants.
  - Copies of all separation or termination agreements for which obligations remain outstanding.
- When representing Seller:
  - Review materials requested by Buyer before providing them to Buyer
  - Relevance of plan information depends on structure of transaction and integration of employees

Executive Compensation Issues

- Executive compensation documents should be reviewed for compliance with section 409A of the Internal Revenue Code (“Code”)
  - Special rules that apply to deferred compensation (i.e., promise made in one year to pay amounts in a subsequent tax year)
  - Failures to Comply result in:
    - 20% penalty tax to the employee (not the employer), in addition to the regular taxes due
    - Potential penalties and interest assessed against employer for improper payroll tax reporting
  - Transaction may trigger payments, accelerated vesting or other benefits

Executive Compensation - Golden Parachute Rules

- Special rules under the Code that apply if certain payments or vesting is triggered by transaction
  - Generally, only applies if there is a C corporation in the related group or the deal structure
  - Employee taxed on “parachute payments” if compensation that is contingent upon the transaction exceeds a certain threshold
  - Employer loses related deduction
  - May be able to avoid consequences if shareholders approve the payments

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Questions?

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BENEFITS ADMINISTRATION WORKSHOP

SWBA SouthWest BENEFITS Association

APRIL 20, 2023

HOUSTON

Session 4 - Transparency Updates: Fee Disclosure Requirements for Brokers and Consultants

Speakers: **Emily Stutts,** Health and Benefits Compliance Attorney, WTW

Tina Godfrey, Sr. Advisor for Health Investigations, U.S. Department of Labor, EBSA

Speakers

Emily Stutts Emily is an attorney in the Health & Benefits line of business with Willis Towers Watson. She works in the areas of health and welfare benefit plan design and strategy and legal compliance (including the ACA, ERISA, the Internal Revenue Code, COBRA, HIPAA, the FMLA, USERRA, and state insurance laws). She delivers presentations on changing laws and the impact on employers and their benefit plans and other topics of interest to employers, and she conducts nondiscrimination testing. She also works on compliance audits and benefits administration/process improvement reviews.

Prior to attending law school and joining WTW, Emily was a high school English and Psychology teacher.

Tina Godfrey joined the Department of Labor in September 2000. Since then, she has held various positions within the agency to include: Investigator, Senior Investigator, Supervisory Investigator and her current position of Senior Advisor for Health Investigations. She has conducted numerous civil investigations involving a variety of complex Pension and Welfare Plans. She has also been involved in conducting various criminal investigations working jointly with FBI, Health and Human Services Agents, the Office of the Inspector General and Assistant United States Attorneys. She has served as the Dallas Regional Office Coordinator for the Voluntary Fiduciary Correction Program, the Consultant/Advisor, Service Provider Project and the Abandoned Plan Program. She has participated in numerous seminars as a panel member on behalf of the Department.

Transparency in Coverage and Consolidated Appropriations Act

Broker and Consultant Fee Disclosure Requirement

April, 20 2023

Today’s speakers

Emily Stutts

Director
Compliance & Audit

emily.stutts@wtwco.com

Tina Godfrey

Employee Benefits Security Administration (EBSA)

For questions or assistance:
1-866-444-3272

Overview of the Transparency in Coverage final rule and Consolidated Appropriations Act legislation

TiC final rule

- President Trump's Executive Order 13877 ("Improving Price and Quality Transparency")
- Final rule on transparency in health coverage requirements of §1311 of the Affordable Care Act (ACA) issued November 2020
- Requirements
  - **2022: Negotiated prices* (delayed until July 1, 2022)** – public release of negotiated rates via machine-readable files (MRFs)
  - **2023/2024 Cost-sharing information** – disclosure of cost-sharing estimates by group health plans and health insurance issuers at enrollee request (via online tool)

CAA

Legislation passed in late 2020 includes:

No Surprises Act (Title I)

- Surprise medical billing protections
- In-network deductible/Out-of-pocket maximum (OOPM) on ID card
- Continuity of care
- Accuracy of provider directories
- Price comparison tool
- Advance explanation of benefits (EOB)

Transparency (Title II)

- Removal of plan/provider gag clauses
- **Broker/Consultant fee disclosure**
- Mental Health Parity and Addiction Equity Act (MHPAEA) non-quantitative treatment limitation (NQTL) comparative analysis requirement
- RxDC reporting

*Complements a similar hospital transparency rule issued by the Department of Health and Human Services (HHS) (effective January 2021) requiring hospitals to post standard charge amounts based on negotiated rates for common or shoppable items or services.

Broker and Consultant Fee Disclosure Requirement

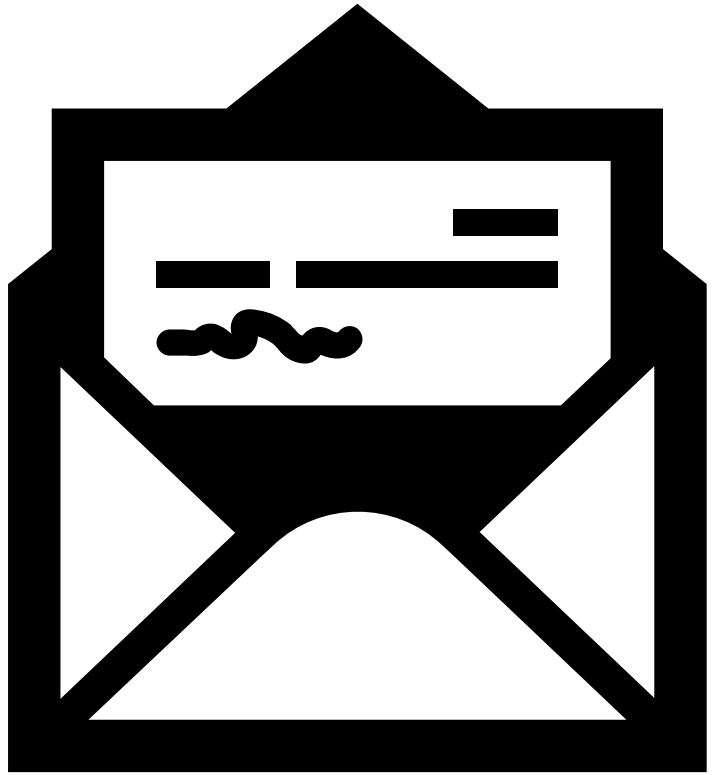
Overview

The Consolidated Appropriations Act (CAA) requires new disclosure requirements for brokers and consultants engaged by plan fiduciaries to provide services to ERISA group health plans

- Will apply to contracts for services executed, extended or renewed on or after December 27, 2021
- Applies to brokers and consultants who are reasonably expected to receive at least $1,000 (adjusted for inflation) direct or indirect compensation for applicable services

Disclosed Information

- Description of services to be provided
- If applicable, statement that fiduciary services will be or expected to be provided to the plan
- Description of direct and indirect compensation and how will it be paid
- Termination of agreement provisions
- Transaction basis payments (e.g., commissions)
- Certain information on indirect compensation
- Disclose to plan fiduciary before contract or arrangement is entered into
- Must notify plan fiduciary of disclosure changes generally no later than 60 days after informed of change
- Plan fiduciaries coordinate with brokers and consultants on the extent the disclosures will apply and what indirect compensation must be disclosed



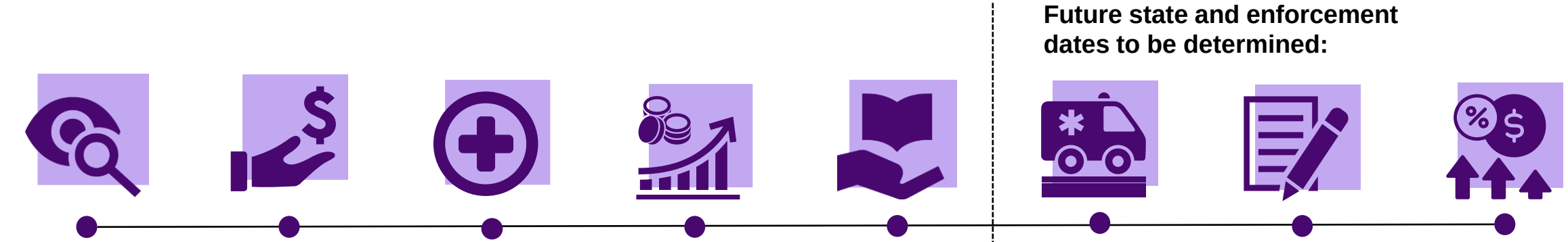
Broker and Consulting Services

- Brokerage services provided to a group health plan with respect to certain activities (e.g., selection of insurance products, benefit administrators, Rx benefit administration services)
- Consulting services to a group health plan with respect to certain activities (e.g., plan design development, insurance product selection, disease management provider selection)
- Also applies to affiliate or subcontractor of broker or consultant

Timing and Next Steps

- Disclose to plan fiduciary before contract or arrangement is entered into
- Must notify plan fiduciary of disclosure changes generally no later than 60 days after informed of change
- Plan fiduciaries coordinate with brokers and consultants on the extent the disclosures will apply and what indirect compensation must be disclosed

Transparency in Coverage (TiC) and Consolidated Appropriations Act (CAA): 2022 and 2023 effective dates



No Surprises Act provisions (CAA)
January 1, 2022

Price disclosure via machine-readable files for in-network and out-of-network medical (TiC)
July 1, 2022

Healthcare and prescription drug reporting for calendar year (CY) 2020 and 2021 (CAA)
January 31, 2023[1]
CY 2022 reporting
June 1, 2023

Price comparison tools or cost-sharing estimate (CAA and TiC)
January 1, 2023

Gag Clause Prohibition Compliance Attestation (GCPCA)
December 31, 2023

Future state and enforcement dates to be determined:

Air ambulance reporting by group health plans (CAA; proposed regulations)
TBD until final regulations released[2]

Price disclosure via machine-readable file for prescription drug (TiC)

Advance explanation of benefits from plan based on provider's good faith estimate (CAA)

[1]On December 23, 2022, the government provided a grace period through January 31, 2023, to submit the prescription drug data collection reporting.
[2]Proposed regulations had a deadline of March 31, 2023, to report on 2022 calendar-year data.

BENEFITS ADMINISTRATION WORKSHOP

SouthWest BENEFITS Association

APRIL 20, 2023

HOUSTON

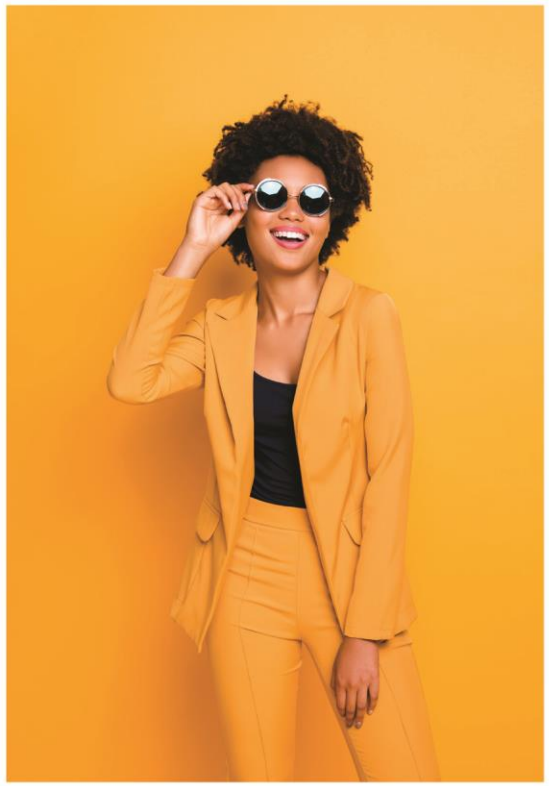
Session 5 - Plan Administration Issues: The End of the COVID-19 Outbreak Period and Public Health Emergency Period

Speaker: **David LeFevre**, Chief ERISA Geek, ERISAfire LLC

Speaker

David LeFevre's area of focus is employee benefits—"ERISA" to those in the know. Primarily a health and welfare benefits lawyer, David also works on retirement plan compliance matters. Things he typically works on include: self-insured medical, HRAs, FSAs, Obamacare, defined contribution plans like 401(k)s and defined benefit plans. David has been advising brokers, small business owners and multinational employers alike for more than 10 years with experience in both private practice and as in-house counsel.

End of the COVID-19 Outbreak Period and Public Health Emergency



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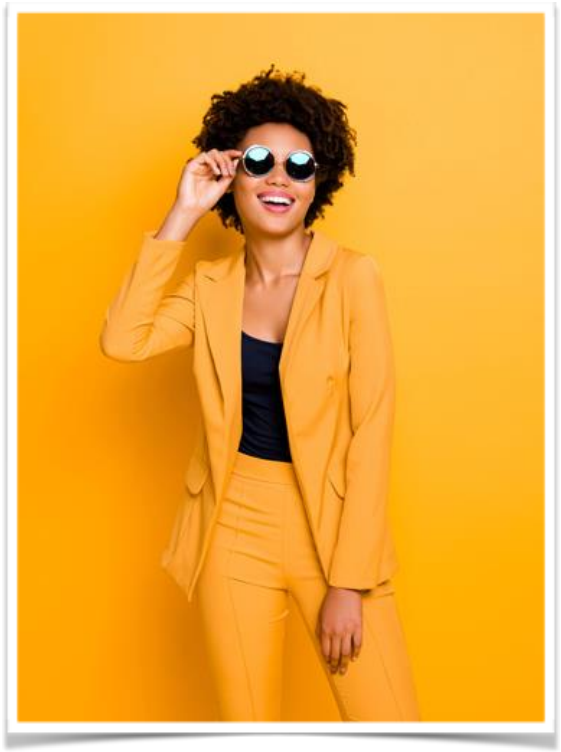
End of the COVID-19 Outbreak Period and Public Health Emergency



Outbreak Period deadline extensions phase out July 10-September 9

Coverage mandates end July 10

Other important stuff

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A	B	C	D	E	F	G	H	I
L	R	L	T	R	R	L	T	R

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End of the DOL Outbreak Period

Refresher

- May 2020: DOL extends numerous deadlines under ERISA for a period of time measured by the National Emergency called the "Outbreak Period"
- a.k.a. worst thing to happen to adverse selection since 1986
- February 2021: DOL reinterpreted the guidance so that the statutory 1-year limit on extensions applies to each individual and each deadline
- Clock on X-day timeframe does not start to tick until after 1 year or end of Outbreak Period

End of the DOL Outbreak Period

Refresher

- HIPAA special enrollment mid-year election changes (e.g., loss of other coverage, marriage, birth, adoption)
- COBRA election
- COBRA premium payment
- ERISA claims and appeals

End of the DOL Outbreak Period

Update

- January: White House says National Emergency will end May 11
- Implication: Outbreak Period will end July 10
- February: DOL issues FAQs on July 10 end of Outbreak Period
- March: Congress passes a resolution ending the National Emergency immediately
- April 10: President Biden signs the legislation
- Implication: Outbreak Period will end June 9
- April 12: DOL floats rumors that it will end the Outbreak Period when it pleases, and the end will be July 10

End of the DOL Outbreak Period

HIPAA Special Enrollment

- Special enrollment for events < July 10, 2022 must be initiated 1 year and 30 days after the event*
- Special enrollment for events July 10, 2022-July 10, 2023 must be initiated by August 9, 2023*
- Normal deadline applies to events > July 10, 2023

* Or after such other date as is provided in the plan (e.g., 31 days or August 10, 2023)

End of the DOL Outbreak Period

HIPAA Special Enrollment

Example:

- EE got married March 15, 2023
- Mid-year election change opportunity open March 15
- 30-day period to notify HR and enroll in the plan doesn't start until after July 10, 2023
- Day 1 of 30-day period is July 11, 2023
- 30-day period ends August 9, 2023
- Election change request received on/after August 10, 2023 would be ineffective

End of the DOL Outbreak Period

HIPAA Special Enrollment

Example:

- EE gets married July 1, 2023
- Mid-year election change opportunity open July 1
- 30-day period to notify HR and enroll in the plan doesn't start until after July 10, 2023
- Day 1 of 30-day period is July 11, 2023
- 30-day period ends August 9, 2023
- Election change request received on/after August 10, 2023 would be ineffective

End of the DOL Outbreak Period

HIPAA Special Enrollment

Example:

- EE loses Medicaid effective January 1, 2023
- Mid-year election change opportunity open January 1
- 60-day period to notify HR and enroll in the plan doesn't start until after July 10, 2023
- Day 1 of 60-day period is July 11, 2023
- 60-day period ends September 8, 2023
- Election change request received on/after September 9, 2023 would be ineffective

End of the DOL Outbreak Period

HIPAA Special Enrollment

Practical Considerations

- Who thought the outbreak was already over?
- Employee-facing mid-year election change language, internal P&Ps and automated systems should be reviewed
- Below-the-fold mention in materials for next open enrollment would be prudent

End of the DOL Outbreak Period

COBRA Elections and Premium Payments

- Election opportunities arising < July 10, 2022 open for 1 year and 60 days*
- Election opportunities arising July 10, 2022-July 10, 2023 open through September 8, 2023*
- Normal 60-day deadline applies to election opportunities arising > July 10, 2023

* 60-day period runs from *later of* loss of coverage and receipt of notice

End of the DOL Outbreak Period

COBRA Elections and Premium Payments

Translation (generally speaking):

- Elections where first month of COBRA would be June 2022 and prior open for 1 year and 60 days
- Elections where first month of COBRA would be July 2022-July 2023 open through September 8, 2023*
- Normal 60-day deadline applies where first month of COBRA would be August 2023 or after

* Potentially later, depending on date of notice receipt

End of the DOL Outbreak Period

COBRA Elections and Premium Payments

- All premiums for months 2+ normally due ≦ May 31, 2022 due 1 year after normal due date*
- All premiums for months 2+ normally due June 30, 2022-June 30, 2023 come due August 9, 2023*
- No more extensions for premium bills due ≧ July 31, 2023

* Assuming COBRA premium "due" first of the month with 30-day grace period—effectively end of the month

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End of the DOL Outbreak Period

COBRA Elections and Premium Payments

- First month premiums normally due < August 24, 2022 get 1-year extension
- All first month premiums normally due August 24, 2023-August 24, 2023 come due August 24, 2023
- Normal deadlines thereafter

End of the DOL Outbreak Period

COBRA Elections and Premium Payments

Practical Considerations

- Is notice to COBRA enrollees of August 9 deadline required?
- Is notice required to COBRA QBs who lost coverage June 2022-June 2023 (i.e, first month of COBRA would be July 2022-July 2023)?
- Even if technically required, is notice a good idea?
- Will your COBRA TPA be prepared by July?
- What if COBRA TPA has changed since July 2022?

End of Public Health Emergency

Refresher

- March 2020: FFCRA and CARES Act impose coverage mandates for COVID-19 vaccines and tests during HHS-declared Public Health Emergency
- January 2022: DOL guidance expanded mandate to OTC tests
- January 2023: White House announces Public Health Emergency will end May 11, 2023

End of Public Health Emergency

COVID Testing

- Mandate ends for all *dates of service* on/after May 11
- OTC no longer needs to be covered
- Normal pre-pandemic network coverage and cost-sharing can resume
- Carrier/TPA implementation processes and options do vary

End of Public Health Emergency

COVID Vaccines

- CARES Act required coverage of COVID vaccines without cost-sharing during PHE
- ACA-required preventive service, so largely a moot point *
- Out-of-network vaccines not required to be covered without cost-sharing or at all

* Federal district court case invalidated preventive service mandates based on USPSTF recommendations, but not ACIP recommendations

End of Public Health Emergency

Expanded EAPs for COVID-19 Testing and Vaccines

- DOL created a loophole so employers could broadly provide testing and/or vaccines to employees without creating ACA-covered medical plans
- DOL used an EAP exception for its loophole
- The loophole closes May 11

End of Public Health Emergency

Mental Health Parity

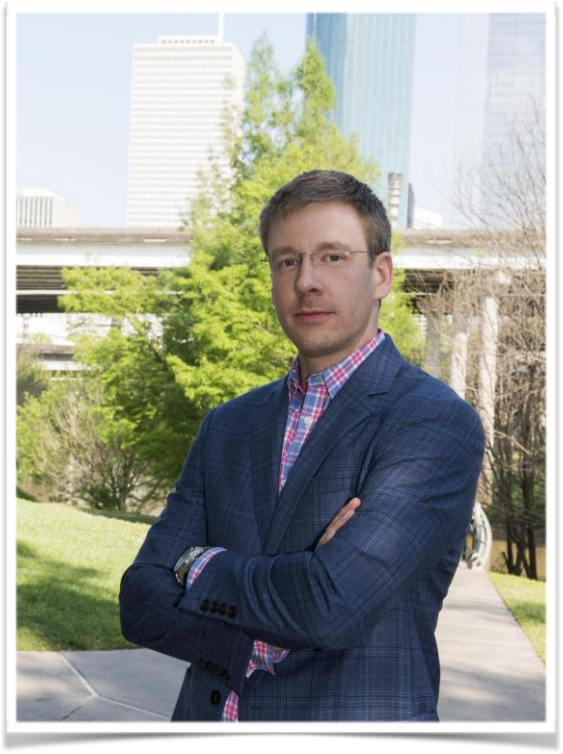
- Coverage of COVID-19 testing services and over-the-counter tests would not be held against a plan for MHPAEA QTL or NQTL purposes
- Does anyone do mental health parity testing to begin with?

Temporary Telehealth/HSA Rules

Pre-Deductible Coverage by HSA-Qualified HDHP

- CARES Act changed HSA rules to permit coverage of telemedicine and telebehavioral health services inside HDHP deductible while preserving eligibility to make HSA contributions
- Extended twice by Congress
- Relaxed HSA qualification rule for telehealth runs through plan years beginning in 2024 (December 31, 2024 for calendar year plans)
- Unaffected by NE or PHE

Thank You



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Published in:

Bloomberg Law

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APRIL 20, 2023

HOUSTON

Session 6 - Mental Health Parity and Addiction Equity Act: DOL Perspectives and Employer Guidance

Speakers: **Nicole Bitter**, Senior Director, WTW
Tina Godfrey, Sr. Advisor for Health Investigations, U.S. Department of Labor, EBSA

Speakers

Nicole Bitter is a Senior Director at WTW where she serves as the co-leader of the MHPAEA solution. She has twelve years of experience in the consulting industry, including 11 years at WTW. She focuses extensively on health and benefits matters. Nicole has significant experience delivering presentations on changing laws and the impact on employers and their benefit plans. She also performs compliance audit workgroups and works on compliance audits and benefits administration/process improvement reviews. Nicole previously served as the general counsel for a health care company in Dallas, which provided her with a comprehensive understanding of the intricacies and implications associated with client benefit and compliance concerns.

Tina Godfrey joined the Department of Labor in September 2000. Since then, she has held various positions within the agency to include: Investigator, Senior Investigator, Supervisory Investigator and her current position of Senior Advisor for Health Investigations. She has conducted numerous civil investigations involving a variety of complex Pension and Welfare Plans. She has also been involved in conducting various criminal investigations working jointly with FBI, Health and Human Services Agents, the Office of the Inspector General and Assistant United States Attorneys. She has served as the Dallas Regional Office Coordinator for the Voluntary Fiduciary Correction Program, the Consultant/Advisor, Service Provider Project and the Abandoned Plan Program. She has participated in numerous seminars as a panel member on behalf of the Department.

A timeline of Mental Health and Substance Use Disorder Parity

1996

Mental Health Parity Act (MHPA) passed

- Requires parity between lifetime and annual dollar limits on mental health (MH) and medical/surgical (M/S) benefits
- Applies to large group health plans (GHPs)

2008

Mental Health Parity and Addiction Equity Act (MHPAEA) passed

- Prohibits GHPs offering MH and substance use disorder (SUD) benefits from imposing more stringent benefit limitations on those benefits than on M/S benefits

2010

Affordable Care Act (ACA) passed

- Extends parity requirements to individual and small group plans
- Mandates mental health and substance use disorder services as an essential health benefit required for all plans sold through federal health insurance marketplace or state exchange

2013

Final regulations implementing **MHPAEA** issued

- Require parity testing for QTLs and NQTLs

2020

Consolidated Appropriations Act (CAA) passed

- Requires GHPs and issuers covering MH/SUD and M/S benefits to prepare a comparative analysis of any NQTLs that apply. Analysis must be provided, at the request of the Department of Labor (DOL) for ERISA plans, beginning February 10, 2021

CAA in a nutshell: Adds two new requirements to health plans' existing MHPAEA obligations – A comparative analysis and the duty to disclose this analysis and related information to the DOL on request.

CAA: What do we know?

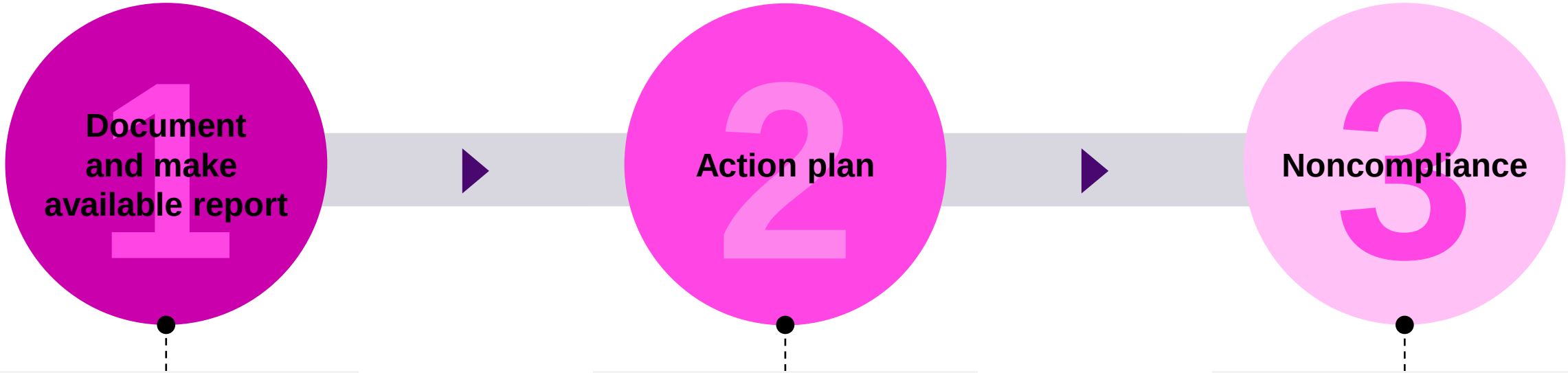
CAA FAQs

- On April 2, 2021, the Departments of Labor, Health and Human Services and the Treasury (the Departments) issued FAQs related to the implementation of the MH/SUD parity provisions under the CAA and MHPAEA
  - Part 45 provides guidance on the following issues regarding the NQTL analysis:
    1) Documentation requirements
    2) Initial focus on certain NQTLs by the Departments
    3) Departmental review procedures
    4) Disclosure to states, as well as plan participants and beneficiaries

NQTL Analysis — FAQs Part 45

- Provide “sufficient information” and include “robust discussions” of various elements:
  - Comparative analyses that consist of conclusory or generalized statements of compliance without specific supporting evidence and detailed explanations are insufficient
- Requires gathering and ***analyzing*** NQTL factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL
- Must describe and provide guidelines and policies used in administration
- Formal report upon request from the Departments
- 20 requests per year is required under law

Breaking it down: Group health plan has received a DOL NQTL analysis request



- Upon request by the DOL, provide NQTL analysis required for Part 1 (10-day turnaround)
- Followed by Part 2 request (10-day turnaround)

- If a GHP is found to be in noncompliance, the plan must submit an action plan to the DOL within 45 days

- If the GHP continues to be in noncompliance after the corrective period, the GHP must notify all GHP participants within seven days

*The DOL will specify any additional information needed

MHPAEA enforcement statistics

Congressional report findings

Under the Consolidated Appropriations Act, 2021 (CAA), the DOL was required to review 20 comparative analyses.

Between April 16, 2021, and October 31, 2021, Employee Benefits Security Administration (EBSA) received and began reviewing responses from 156 plans.

This substantially exceeds the amount required, showing the emphasis and prioritization of MHPAEA compliance under the Biden administration.

Top five NQTLs requested in a comparative analysis

- Pre-authorization requirements
- Network provider admissions standards
- Concurrent care review
- Limits on applied behavior analysis or treatment for autism spectrum disorder
- Out-of-network reimbursement rates

Top NQTLs with non-compliance findings

- Limitation or exclusions of ABA therapy or other services to treat autism
- Billing requirements: Licensed MH/SUD providers can bill the plan only through specific types of other providers
- Limit or exclusion of medication-assisted treatment for opioid use disorder
- Pre-authorization
- Limitation or exclusion of nutritional counseling for MH/SUD conditions
- Provider experience requirement beyond licensure

MHPAEA enforcement

- Employee Retirement Income Security Act of 1974 (ERISA) contains no specific penalty or enforcement rule for violations of MHPAEA
- IRS may impose excise taxes of $100 per day for each individual to whom a failure relates for a group health plan's failure to comply with the MHPA's and the MHPAEA's requirements
- Participants, beneficiaries and the Department of Labor (DOL) may use ERISA's civil enforcement provisions to file lawsuits to enforce MHPAEA's requirements
- Affected parties can seek damages for unpaid benefits, interest and attorney's fees under ERISA § 502
- MHPAEA provisions applicable to group insurers are enforced in the first instance by state insurance regulators; nevertheless, Health and Human Services (HHS) may enforce these provisions where a state fails to substantially enforce them

MHPAEA rules

Overview	Requires health plans providing Mental Health/Substance Use Disorder (MH/SUD) benefits to provide those benefits in parity with Medical/Surgical (M/S) benefits.
Financial requirements/ Quantitative treatment limitations	Group health plans offering M/S benefits and MH/SUD benefits that impose **"financial requirements"** (e.g., deductibles, copayments, coinsurances, out-of-pocket maximums) or **"quantitative treatment limitations" (QTLs)** (e.g., number of visits, days of coverage, days in a waiting period) must apply these requirements/limitations to MH/SUD benefits no more restrictively than the **"predominant"** financial requirements or quantitative treatment limitations applied to **"substantially all"** M/S benefits in the same classification.
Non-quantitative treatment limitations	Group health plans may not impose **"non-quantitative treatment limitations" (NQTLs)** (e.g., prior authorization, utilization review) on MH/SUD benefits unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA) which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.

MHPAEA classifications

- The test must be applied on a classification-by-classification basis
- There are six classifications of benefits (and a couple of sub-classifications):

1	2	3	4	5	6
Inpatient in-network	**Inpatient out-of-network**	**Outpatient in-network**	**Outpatient out-of-network**	**Emergency**	**Prescription drug**
		• Office visit • All other services	• Office visit • All other services		

- Other classifications and sub-classifications are not allowed
- Intermediate levels of care in MH/SUD must be classified correctly (e.g., Residential Treatment Center [RTC] as inpatient if Skilled Nursing Facility [SNF] is considered inpatient on M/S side)

Clinical and legal/regulatory compliance support is required for this review, with data extracts from the vendor or claims administrator.

Quantitative requirements and treatment limitations

Compliance steps

1

Determine if a particular type of financial requirement or quantitative treatment limitation applies to substantially all (two-thirds) M/S benefits in the relevant classification of benefits

Two-thirds calculation is based on the dollar amount of plan payments expected to be paid for the plan year (any reasonable method can be used).

2

Determine the predominant level (more than 50%) of that requirement or treatment limitation that applies to M/S benefits in the classification being tested

The predominant level of this requirement or limitation applicable to M/S benefits within that classification is the most restrictive that can be imposed on MH/SUD benefits within that same classification.

Must use plan-specific data when credible. If plan-specific data is not credible, then request testing results from claims administrator's book of business for similar plan designs with similar demographics.

Non-quantitative treatment limitations

Precertification, exclusions and limitations

- No NQTL on a MH/SUD benefit in any classification (or sub-classification) unless:
  - Any processes, strategies, evidentiary standards or other factors used are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to M/S benefits in the same classification

- No requirement to use the same NQTLs for both MH/SUD and M/S benefits, but processes, strategies, evidentiary standards and other factors must be comparable
- Disparate results alone do not mean that the NQTLs do not comply with MHPAEA
  - Identify non-compliant additional NQTLs
    - For example, requiring access to MH/SUD care through the Employee Assistance Program (EAP) (not permissible)
    - For example, requiring failure of outpatient SUD before approving admission to 24/7 facility

Clinical and legal/regulatory compliance support is required for this review, with data extracts from the vendor or claims administrator.

Evaluating compliance with MHPAEA regulatory activities

Potential indicators of a NQTL compliance conflict

Practice examples: Overly stringent benefit requirements

- Overly stringent preauthorization requirements applied to MH/SUD benefits
- Specific, restrictive requirements for MH/SUD treatment
- Written treatment plan requirements
- Must be for a condition that can be favorably changed
- SUD means a disease that is characterized by a pattern of pathological use of alcohol or drugs with repeated attempt to control its use, and with negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social
- Follow-up program directed by a behavioral health provider on at least a monthly basis
- Residential programs must be headed by an addiction specialist
- Applied behavioral analysis is tied to age versus medical necessity
- More restrictive definition of experimental/investigational for MH/SUD benefits
- More restrictive definition of medically necessary for MH/SUD benefits
- State licensing requirements
- MH/SUD providers must be licensed by the state, but requirement not applied to M/S providers
- Exclusions for court ordered treatment for SUD, but not excluding it for M/S conditions
- Covering autism-related benefits, but excluding ABA (i.e., not providing benefits in all six classifications)

Evaluating compliance with NQTL

Comprehensive evaluation is required to ensure NQTL compliance (continued)

Identify the individuals who are making claim denial determinations with respect to MH/SUD claims

- Consider whether decision makers have comparable expertise respecting MH/SUD and M/S benefits and claim reviews

Performance of a claim review/audit is a threshold and required activity

- Assess average claim denial rates
- Assess claim appeal overturn rates
- Assess parity respecting claim denials and overturned appeals for MH/SUD benefits as compared to M/S benefits

There is no requirement to utilize the same NQTL for MH/SUD benefits and M/S benefits to establish parity

- Focus on the underlying processes, strategies, evidentiary standards and other factors used in applying the NQTLs (not necessarily the results)

Document and archive any plan analysis or audit that is performed

- Participant disclosure of certain analytic points may be required
- Federal agencies (DOL and HHS) may request an inspection of audit findings
- Report should contain evidence to demonstrate the plan is compliant with respect to MHPAEA's requirements, which may include charts, graphs, and other documents comparing the processes, strategies, evidentiary standards and other factors used in applying NQTLs to MH/SUD benefits versus M/S benefits *(along with supporting documentation demonstrating compliance)*

What areas of NQTLs will the DOL focus on in 2023?

- **Potential NQTL focus in 2023**
  - Eating disorders
  - Network adequacy
  - Impermissible exclusions; and
  - Continued focus on 2022 areas of compliance
    - ABA therapy
    - Nutritional counseling
    - Opioid use disorder medication limits or exclusions
- **What to watch for in 2023?**
  - Consolidated Appropriations Act (CAA) elimination of MHPAEA opt-out for nonfederal governmental plans