Agenda

7:30 – 8:15 am - Registration and Breakfast
8:15 – 8:30 am - Welcome and Opening Remarks

8:30 – 9:30 am

Session 1 - What's Next with SECURE 2.0: Compliance Issues and Voluntary Provisions Update

Speaker: **Brian Giovannini**, Counsel, Haynes Boone

9:35 – 10:35 am

Session 2: The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities

Speakers: **Robert Massa,** Managing Director, Qualified Plan Advisors
Ed Razim, Partner, Locke Lord LLP

10:35 – 10:50 am - BREAK

10:50 am – 11:50 am

Session 3: Mergers and Acquisition Issues for Retirement and Health & Welfare Plans

Speaker: **Barbara Klepper**, Shareholder, Winstead PC

12:00 – 1:00 pm - LUNCH

Afternoon Schedule
1:00 – 2:00 pm

Session 4: Mental Health Parity: How to Comply with DOL Regulations

Speakers: **Beth Allen**, Attorney, Allen Benefits Law
Tina Godfrey, Sr. Advisor for Health Investigations, U.S. Department of Labor, EBSA

2:00 – 2:15 pm - BREAK

2:15 – 3:15 pm

Session 5: How Will that Impact my Plan?: Plan Document Compliance, Updating SBCs and other Participant Communications

Speakers: **Felicia Finston**, Partner, Finston Friedman Fisher Law Group
Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

3:20 – 4:20 pm

Session 6: COBRA Administration: Compliance Pitfalls and Successfully Partnering with your Vendor

Speakers: **Angela Stockbridge**, Of Counsel, Steptoe and Johnson, PLLC
Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

4:20 pm - ADJOURNMENT

Continuing Education Credit Requirements

Texas Group I Insurance Licensees **6.0 General Hours**

Complete the generic attendance form enclosed in your packet and return it to the Registration Desk at the end of the Conference. SWBA will send a certificate of attendance for your records in the following weeks. Under a new rule, insurance agents must also sign the attendance register (at the Registration Table) at the beginning of each morning and afternoon session. All sessions have been approved for credit, SWBA will submit your attendance record directly to the Texas Department of Insurance.

- Course Title: SWBA 2024 Benefits Administration Workshop
- Course Number: 137860
- Sponsor Number: 117791

Attorneys - Texas **6.00 Total CLE Hour including 0.00 Ethics Hours**

Complete the State Bar of Texas Course Attendance Form and return it to the Registration Desk at the end of the conference. SWBA will submit your signed and completed attendance form to the State Bar of Texas MCLE Department.

- Course Title: SWBA 2024 Benefits Administration Workshop
- Course Number: 174224560
- Sponsor Number: 1530

Texas CPAs **7.2 Hours**

Complete the generic attendance form enclosed in your packet and return it to the Registration Desk at the end of the Conference. SWBA will send a certificate of attendance for your records in the following weeks. Each licensee is responsible for reporting to the Texas State Board of Public Accountancy.

- Course Title: SWBA 2024 Benefits Administration Workshop
- Course Number: 2024-1
- Sponsor ID Number: 04850

Attorneys - Oklahoma **7.00 Total CLE Hour including 0.00 Ethics Hours**

Complete the State Bar of Texas Course Attendance Form and return it to the Registration Desk at the end of the conference. SWBA will submit your signed and completed attendance form to the State Bar of Texas MCLE Department.

- Course Title: SWBA BENEFITS ADMINISTRATOR WORKSHOP
- Course Number: 98795
- Instance ID: 100484
- Sponsor Number: 365

HRCI **6 Hours**

Complete the generic attendance form enclosed in your packet and return it to the Registration Desk at the end of the Conference. SWBA will send a certificate of attendance for your records in the following weeks. Each licensee is responsible for reporting to HRCI.

- Course Title: SWBA Benefits Administration Workshop – Houston
- Program Activity ID: 647805
- Provider Number: 603819

SHRM **6 Hours**

Complete the generic attendance form enclosed in your packet and return it to the Registration Desk at the end of the Conference. SWBA will send a certificate of attendance for your records in the following weeks. Each licensee is responsible for reporting to HRCI.

- Course Title: SWBA Benefits Administration Workshop – Houston
- Program Activity ID: 24-QGSS4
- Provider Number: 603819

Other Disciplines and Jurisdictions

Complete the generic attendance form enclosed in your packet and return it to the Registration Desk at the end of the Conference. SWBA will send a certificate of attendance for your records in the following weeks. The certificate will reflect the particular requirements of each group insofar as we are aware of them. Each licensee is responsible for reporting to the appropriate state or professional authority.

Continuing Education Attendance Form

Please record your name, type of continuing education requested, sessions you attended and total hours. After the conference, please turn this form in to the registration desk.

Name: _____

Type of CE requested (circle all that apply):

Attorney State_____Bar#: _____

CPA State: _____

Enrolled Agent Actuary

HRCI/SHRM_____ IRS Enrolled Agent_____

Insurance: ***License number required for credit in Texas.***

- ☐ Texas License#: _____
- ☐ Other State_____ License #_____

Please circle all sessions you attended:

GENERAL SESSION I (60 Minutes)
What's Next with SECURE 2.0: Compliance Issues and Voluntary Provisions Update

GENERAL SESSION II (60 Minutes)
The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities

GENERAL SESSION III (60 Minutes)
Mergers and Acquisition Issues for Retirement and Health & Welfare Plans

GENERAL SESSION IV (60 Minutes)
Mental Health Parity: How to Comply with DOL Regulations

GENERAL SESSION V (60 Minutes)
How Will that Impact my Plan?: Plan Document Compliance, Updating SBCs and other Participant Communications

GENERAL SESSION VI (60 Minutes)
COBRA Administration: Compliance Pitfalls and Successfully Partnering with your Vendor

TOTAL MINUTES ATTENDED: _____ (All Sessions=360)

Turn form in at registration desk.

SWBA Benefits Administration Workshop – Houston

Date: February 15, 2024

Time: 8:30 AM – 4:20 PM

Location: 2001 Post Oak Boulevard, Houston, TX 77056

Description: This Workshop will prove relevant to benefits administrators that handle the day-to-day details of the ever-changing world of employee benefits. Don't miss the most convenient, best valued one-day workshop of the year.

SHRM	HRCI
CE Hours: 6	**CE Hours: 6**
SHRM Activity ID: 24-QGSS4	**HRCI Activity ID**: 647805
SHRM SHRM-CP | SHRM-SCP RECERTIFICATION PROVIDER	APPROVED PROVIDER 2024 HRCI.ORG
Southwest Management LLC is recognized by SHRM to offer Professional Development Credits (PDCs) for the SHRM-CP® or SHRM-SCP®. This program is valid for 6 PDC for the SHRM-CP® or SHRM-SCP®. For more information about certification or recertification, please visit www.shrmcertification.org	This Program, ID No. 647805, has been approved for 6 HR (General) recertification credit hours toward aPHR™, aPHRi™, PHR®, PHRca®, SPHR®, GPHR®, PHRi™ and SPHRi™recertification through HR Certification Institute® (HRCI®). "The use of this official seal confirms that this Activity has met HR Certification Institute's® (HRCI®) criteria for recertification credit pre-approval

BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SWBA SouthWest BENEFITS Association

Welcome

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About SouthWest Benefits Association

- Founded in 1975
- Over **500 SWBA Members** representing a broad cross-section of benefits professionals (health & wellness, retirement, legal, compensation, etc.)
- **Annual Conferences, Workshops, Roundtables & Webinars** provide SWBA members opportunities to discuss key trends and critical issues confronting employee benefits professionals
- The **SWBA Job Bank** helps members advance their careers and develop professionally within the employee benefits industry

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Benefits of Membership

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- Member discounts to educational & networking events
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Did you pay the Non-Member fee to attend this workshop?

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MAY 15–17, 2024

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BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

Session 1 - What's Next with SECURE 2.0: Compliance Issues and Voluntary Provisions Update

Speaker: **Brian Giovannini**, Counsel, Haynes Boone

Speaker

Brian Giovannini, Counsel, Haynes Boone

Brian Giovannini serves as an advisor and benefits counsel to a diverse group of clients - from local governments to Fortune Global 500 corporations. Brian's clients value his in-depth technical knowledge and analytical skills, as well as his prompt assistance on numerous legal issues affecting the development and operation of their pension plans and executive compensation plans and agreements.

Brian leverages creativity in his day-to-day legal practice - whether he's uncovering a novel solution to a client's compliance problem, or designing a new integrated bonus-pool compensation structure that is unique to the client's business needs. Brian has restated and merged pension plans, provided counsel regarding liability, de-risking solutions for pension plans, and assisted in redesigning a comprehensive global benefits program.

HAYNES BOONE

SWBA BENEFITS ADMINISTRATION WORKSHOP

What's Next with SECURE 2.0:
Compliance Issues and Voluntary Provisions Update

Brian Giovannini

February 15, 2024

Overview of Selected Guidance

- SECURE 2.0 Act
- May 23, 2023, Letter from Congress (RMDs)
- IRS Notice 2023-43 (EPCRS)
- IRS Notice 2023-54 (RMDs)
- IRS Notice 2023-62 (Roth Catch-up Contributions)
- IRS Notice 2024-02 (Multiple FAQs)
- IRS Notice 2024-22 (PLESAs)
- Prop. Treas. Reg. § 1.401(k)-5 (LTPTs)
- January 17, 2024 DOL FAQs (PLESAs)

Nine SECURE 2.0 Act Compliance Updates

1. Amendment Deadline Extended
2. Small Financial Incentives
3. Roth Catch-up Contributions
4. Roth Employer Contributions
5. Required Minimum Distributions
6. Terminally Ill Individual Distributions
7. SIMPLE IRA Mid-year Change Exceptions
8. Pension-Linked Emergency Savings Accounts
9. Expansion of Automatic Enrollment

Amendment Deadline Extended

SECURE 2.0 Act Sec. 501 / Notice 2024-02

- Written amendment deadlines for SECURE Act, section 104 of the Miners Act, section 2202 or 2203 of the CARES Act, section 302 of the Relief Act, and the SECURE 2.0 Act are aligned
- Notice 2024-02 extended amendment deadlines:
  - December 31, 2026, for non-governmental/non-collectively bargained plan
  - December 31, 2028, for collectively bargained plans
  - December 31, 2029, for governmental plans
- Amendments after the deadline do not get cutback relief

Small Financial Incentives

SECURE 2.0 Act Sec. 113 / Code Sec. 401(k)(4)(A) / Notice 2024-02

- **Old Rule:**
  - No incentives to participate or not participate allowed other than matching contributions
- **New Rule:**
  - Small incentives up to $250 *to participate* are okay (e.g., small value gift cards)
  - Only to employees not already deferring
  - $250 can be spread across years
  - Incentive is taxable wages to employee unless a fringe benefit exception applies

Roth Catch-up Contributions

SECURE 2.0 Act Sec. 603 / Code Sec. 414(v)(1) / IRS Notice 2023-62

- Participant whose prior year compensation exceeds $145,000 may only make catch-up contributions as Roth contributions
- Participant whose prior year compensation does not exceed $145,000 must have option to make catch-up contributions as either pre-tax or Roth contributions
- $145,000 amount to be indexed in future years
- IRS issued guidance that it will *delay enforcement* for two years

Roth Employer Contributions

SECURE 2.0 Act Sec. 604 / Code Sec. 402A(a) / IRS Notice 2024-02

- Plan can permit employee to elect to have employer contributions be designated as Roth contributions
  - Contributions must be immediately 100% vested
  - Generally not treated as wages for FICA/FUTA
  - No withholding requirement
  - Includible in the employee's income
  - Report as in-plan Roth rollover on Form 1099-R
  - Not included in Section 415 safe harbor definition of compensation

Required Minimum Distributions

SECURE 2.0 Act Sec. 107 / Code Sec. 401(a)(9) /
IRS Notice 2023-54 / May 23, 2023, Letter from Congress

- **No RMDs for Roth Accounts**
- **Ambiguity in the Required Beginning Date Increase Fixed**
  - age 70 ½ if born before July 1, 1949
  - age 72 if born from July 1, 1949, through December 31, 1950
  - age 73 if born in 1951 through 1959
  - age 75 if born after 1959
- **Relief for RMDs in 2023 to persons age 72**

Terminally Ill Individual Distributions

SECURE 2.0 Act Sec. 326 / Code Sec. 72(t)(2)(L) / IRS Notice 2024-02

- Requirements
  - Participant is certified *before distribution* by a physician as having a terminal illness that is expected to result in death within 84 months
  - Physician cannot certify himself/herself
  - Participant must be otherwise eligible to receive an in-service distribution
- Participant can repay distribution within 3 years
- If plan does not add terminally ill individual distributions:
  - Participant can claim tax benefit on Form 5329 with tax return
  - Participant can repay amounts to an IRA

SIMPLE IRA Mid-year Change Exceptions

SECURE 2.0 Act Sec. 332 / Code Secs. 408(p)(11) and 72(t)(6)(B)
IRS Notice 2024-02

- **Old Rules:**
  - Employer that maintains a SIMPLE IRA plan for a calendar year may not maintain another plan in the same year
  - SIMPLE IRA plan distributions within participant's first two years can only be rolled over to another SIMPLE IRA plan
- **New Exceptions:**
  - Contributions to SIMPLE IRA plan may be replaced by replacement safe harbor 401(k) plan mid year
    - Subject to pro-rata contribution limits
    - SIMPLE IRA plan distributions can be rolled over to replacement plan if rollover subject to restrictions in 403(b)(11)

Pension-Linked Emergency Savings Account

SECURE 2.0 Act Sec. 127 / ERISA Sec. 3(45), 801 – 804
IRS Notice 2024-02 / January 17, 2024, DOL FAQs

- Eligibility limited to Non-HCEs
- Contributions
  - After-tax contributions up to $2,500 per participant
    - Overall cap not annual cap
    - Inclusive or exclusive cap
  - Excess contributions can be treated as retirement contributions
  - Automatic enrollment option up to 3%
  - Match required if plan matches elective deferrals
    - Match goes into retirement account
    - Annual PLESA match capped at PLESA cap
  - No annual limit for contributions

Pension-Linked Emergency Savings Account

SECURE 2.0 Act Sec. 127 / ERISA Sec. 3(45), 801 – 804
IRS Notice 2024-02 / January 17, 2024, DOL FAQs

- Investment
  - Either cash in an interest-bearing deposit account OR
  - Option designed to preserve participant contributions while providing liquidity and a reasonable rate of return
- Withdrawals
  - No fees on first four withdrawals
  - Fees thereafter must be reasonable
- All ERISA protections apply
- Annual PLESA Notice

Pension-Linked Emergency Savings Account

SECURE 2.0 Act Sec. 127 / ERISA Sec. 3(45), 801 – 804
IRS Notice 2024-02 / January 17, 2024, DOL FAQs

- May include **reasonable** anti-abuse provisions
  - *solely to the extent necessary to prevent manipulation of the rules of the plan to cause matching contributions to exceed the intended amounts or frequency*
- **Unreasonable:**
  - Forfeiture of matching contributions
  - Suspension of participant contributions to PLESA
  - Suspension of matching contributions on participant contributions to the underlying plan

Expansion of Automatic Enrollment

SECURE 2.0 Act Sec. 101 / IRS Notice 2024-02 /

- Cash or deferred arrangement (CODA) established after December 29, 2022 must be EACA
  - Establishment Date is when terms are adopted
  - Merger of two plans with Pre-Enactment CODAs: Pre-Enactment CODA
  - Merger of plan with Pre-Enactment CODA and plan with Post-Enactment CODA: Post-Enactment CODA unless merger during transition period in connection with a Code Section 410(b)(6)(C) transaction
  - Spin-off from plan with Pre-Enactment CODAs will be a Pre-Enactment CODA

Questions?

HAYNES BOONE

Brian K. Giovannini
Haynes and Boone, LLP
1221 McKinney Street, Suite 4000
Houston, Texas 77010
(713) 547-2025

BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SWBA SouthWest BENEFITS Association

Session 2 - The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities

Speakers: **Robert Massa,** Managing Director, Qualified Plan Advisors
Ed Razim, Partner, Locke Lord LLP

Speakers

Robert Massa, Managing Director, Qualified Plan Advisors

Robert Massa is the Managing Director of Retirement in Houston, TX for Qualified Plan Advisors (QPA). Rob is a retirement professional with more than 25 years of retirement industry experience. His primary responsibilities include practice management, strategic investment direction and advice, retirement plan design consulting and compliance, employee education and development, financial wellness strategies, client relationship management and SEC compliance.

Ed Razim, Partner, Locke Lord LLP

Ed Razim is Chair of the Firm's Tax Department and Chair of the Firm's Employee Benefits Practice Group. Ed's practice includes drafting and implementing employee benefit and executive compensation programs for large and small employers, addressing compliance issues regarding Section 409A of the Internal Revenue Code and various equity compensation plan design matters, addressing employee benefits matters in corporate mergers and acquisitions, and resolving unique plan design issues faced by controlled groups of corporations or businesses.

QUALIFIED PLAN ADVISORS

The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities

Your Comprehensive Fiduciary Partner

Moderator and Presenters

Ed Razim, III

Partner, Locke Lord

- Licensed Attorney for 30+ years
- Chairman, ERISA Industry Group
- Member, American Bar Association, Section of Taxation, Employee Benefits Committee
- Member, SouthWest Benefits Association (Past Chair, Education Committee)
- Named, The Best Lawyers in America®, Employee Benefits (2008-2010, 2013-2024), Tax Law (2024)
- Named, Houston Employee Benefits (ERISA) Law Lawyer of the Year, The Best Lawyers in America® (2020)

Robert Massa, ChFC®, CEBS®, CPFA®, AIF®, CHSA®

Managing Director, Houston Market Retirement Practice Leader

- 30+ year professional
- Adviser of the Year, 2016 & 2023
- National Speaker on plans
- PS Magazine Adviser of the Year Finalist 2014, 2018, and 2022
- Top NAPA DC Advisor Team

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ROADMAP

1. What is an RFP?
2. Fiduciary 101
3. Why do you need a RFP?
4. When should they be done?
5. Who are the players?
6. Getting Started
7. What type of RFP is needed?
8. What resources are needed?
9. RFP content categories
10. RFP stages
    - Stage 1
    - Stage 2
    - Stage 3
    - Common mistakes
11. RFP Process
12. Post RFP implementation
13. Conversion Considerations
14. Post Conversion issues
15. Some final tips
16. Remember…

WHAT IS AN RFP?

1.
2.
3.
4.

WHAT IS AN RFP?

1. Search for vendor
2. Asks pointed service questions
3. Helps with due diligence
4. Addresses fiduciary prudence

FIDUCIARY 101

- A person is a fiduciary with respect to a plan if that person exercises any discretionary authority or control over the management of a plan or its assets (including selection and oversight of plan vendors)
  - Select plan vendors prudently
  - Regularly monitor quality of vendors' performance
  - Review vendors' compensation

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FIDUCIARY 101

"Many of the problems with respect to service providers arise because the responsible fiduciary either does not understand his role and responsibility in the selection and monitoring of service providers or exercises poor judgment because he does not have experience or an appropriate source of information concerning legal requirements and industry practices."

[DOL's ERISA Advisory Council]

FIDUCIARY 101

- Focus on (and Document) the Process
  - Interview a number of potential vendors
  - Investigate the background of selected vendor
  - Enter into a reasonable agreement
  - Monitor performance

WHY DO YOU NEED AND RFP?

1.
2.
3.
4.
5.
6.

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WHY DO YOU NEED AND RFP?

1. It’s time
2. Fiduciary
3. Fees
4. Service
5. Capabilities
6. Security

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WHY DO YOU NEED AND RFP?

RFP Tasks to Fulfil Your Fiduciary Responsibilities

1. Establish the Process
2. Interview a number of potential vendors
3. Investigate the background of selected vendor
4. Document the Process
5. Enter into a reasonable agreement
6. Monitor performance

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WHY DO YOU NEED AND RFP?

Fiduciary Responsibility

1. Any person that exercises any discretionary authority or control over the management of a plan or its assets (including selection and oversight of plan vendors)
    1. Select plan vendors prudently
    2. Regularly monitor quality of vendors' performance
    3. Review vendors' compensation

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WHY DO YOU NEED AND RFP?

DoL's Advisory Council

> "Many of the problems with respect to service providers arise because the responsible fiduciary either does not understand his role and responsibility in the selection and monitoring of service providers or exercises poor judgment because he does not have experience or an appropriate source of information concerning legal requirements and industry practices."

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WHEN SHOULD THEY BE DONE?

1.
2.
3.
4.
5.

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WHEN SHOULD THEY BE DONE?

1. Every 3 – 5 years
2. There are administrative problems
3. Fees may be high
4. Participant experience is lagging
5. Cybersecurity deficiencies
6. Your needs have changed

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WHO ARE THE PLAYERS?

- Recordkeepers
- Third Party Administrators
- Fiduciary Plan Administrator
- Fiduciary Advisor
- Consultant
- Broker
- Auditor
- Trustee
- Actuary

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GETTING STARTED

- Consider the 5 Ws
  - WHO
    - Who will be responsible for the RFP?
    - Who will be responsible for the conversion?
  - WHAT
    - What needs to be done before you proceed?
  - WHERE
    - Where do you want to end up?
      - What's good about your current recordkeeper?
      - What needs improvement?
  - WHEN
    - When is the targeted date for the conversion?
  - WHY
    - Why are you doing a vendor search?

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WHAT TYPE OF RFP IS NEEDED?

Collect Bids
To get a Baseline

Inquire About
Similar Size Plans for Benchmarking

Full Proposal
to Consider Switching Providers

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WHAT RESOURCES ARE NEEDED?

- Committee
- HR
- Benefits
- Payroll
- IT
- Consultant
- Legal
- Procurement

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RESOURCES: A WORD ABOUT USING *"PROCUREMENT"*

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RFP CONTENT CATEGORIES

- Blind or Announced
- General plan information
- RFP contacts
- Timeline
- Vendor experience
- Administrative capabilities
- Investment flexibility
- Education and communication
- Fees and fee transparency
- Transition process
- Participant satisfaction
- Employer satisfaction and support
- Systems technology
- Cyber Security
- Support with other plans
- Miscellaneous

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RFP STAGES

Stage 1: Data Gathering, Analysis and RFP Release

- Data gathering
- Analysis
- RFP construction
- Review and approve RFP
- Identify vendors & and release RFP
- *Time: 2-4 weeks*

Stage 2: Service Provider Analysis

- Collect and review responses
- Send clarifying questions
- Analyze and compile results
- Present findings
- Select Finalists
- *Time: 3 – 6 weeks*

Stage 3: Service Provider Selection

- Schedule presentations
- Conduct presentations
- Evaluate results and select winner
- Negotiate contract details
- Inform all vendors of RFP results with feedback
- *Time 2 – 4 weeks*

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THE RFP PROCESS – STAGE 1

- Prepare a request for proposal
  - Plan information
  - Goals and search objectives
  - Focused questionnaire
- RFP should address the issues most important to the company
  - Services needed
  - Menu of options/quality of choices
  - Costs/fees/revenue sharing
  - Cyber security
- Identify potential vendors for distribution

THE RFP PROCESS – STAGE 2

- Collect and review responses in a matrix
  - Send clarifying questions as needed
- Analyze and compile results
- Present findings
- Select Finalists
- Begin assembling internal documents for possible vendor conversion

THE RFP PROCESS – STAGE 3

- Schedule presentations
  - Try to schedule on same day or close together
  - Demand proof or performance
- Conduct presentations
- Consider site visits
  - Review the work environment
  - Meet the service team in person and examine personalities
- Test drive the service platform
  - Visit the websites (participant and sponsor)
  - Call the service center
- Check references
- Evaluate results and select winner
- Negotiate contract details
  - Discuss service guarantees
- Inform all vendors of RFP results with feedback

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THE RFP PROCESS – COMMON MISTAKES

- Common Mistakes
  - Failure to identify your operational needs and communicate them to vendors
  - Failing to ensure decision-makers have no conflicts to predispositions
  - Failure to distinguish sales claims from service capability
  - Not procedurally diligent
  - Fast tracking the process
  - Deciding on a vendor too early in the process
  - Lack of independence
  - Not asking enough hard questions
  - Basing the decision solely on cost
  - Basing decision solely on prior vendor familiarity
- Remember: This is your plan – As the fiduciary, you will be responsible for your vendor's mistakes in most cases

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POST-RFP IMPLEMENTATION

- Project plan
- Communication plan
- Payroll
- Plan document review
- Conversion method
- Employee education
- Records retention
- Deconversion
- Post-conversion mop up

CONVERSION CONSIDERATIONS

- The SIX P's - Prior Proper Planning Prevents Poor Performance
- Identify
  - Key events
  - Target date for when the events should occur
  - Responsible party
- How will assets be transferred?
- Consider conversion logistics

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CONVERSION CONSIDERATIONS

- Conversion logistics – Existing vendor
  - Determine the last day for processing various plan related transactions
  - Timing issues
    - Test data set
    - Live data set
  - Post-transfer run out period for uncashed distributions made prior to conversion
  - Outstanding check report/stopped payment check report
  - Payment of final fees
  - Data availability as needed for research or correction of any pre-conversion operational failures
  - Transfer of loan documents to new vendor

CONVERSION CONSIDERATIONS

- Conversion logistics - New vendor
  - Communicate fund sources to new vendor
  - Communicate data needs/format to existing vendor
  - Use the test data file/live data file to establish participant database for conversion data
  - Determine if the data is sufficient to
    - Establish participant accounts
    - Reconcile asset transfer
    - Communication regarding the change in the vendor and trustee will begin
      - By the time you decide to communicate it is too late
    - New vendor kits will be mailed
    - Participant education meetings will begin
    - Last day for participants to complete new vendor enrollment form
      - Elective deferrals
      - Investment of future contributions

CONVERSION CONSIDERATIONS

- Conversion logistics - New vendor
  - Determine when
    - Participants can begin to change the investment mix with respect to transferred assets
    - The website will be available
    - The phone service will be available
    - All new services will be available
    - First statement will be sent to participants
  - Investments
    - Will fund menu be the same or is it changing
    - Will you map current investments to new investment options that are in the same fund family
    - Will you map to a cash investment and require new participant elections
    - What will be the default fund
      - Mixed portfolio that is rebalanced periodically
      - Target Date fund
      - Actively managed

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CONVERSION CONSIDERATIONS

- Other considerations –
  - Data from payroll vendor must be in format acceptable to new vendor
    - Complete a test run
  - New contributions (deferrals, match, etc.)
    - Where will they go during the conversion?
  - Loan payments
    - Where will they go during the conversion?
    - Loan reconciliation issues
- New vendor may not accept loan payments or new contributions until the post conversion reconciliation is complete

BLACKOUT PERIOD

- What is a Blackout Period?
- Why does it exist?
- What is affected?
- How long does it last?
- Things that can affect how long it lasts
- Considerations

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POST CONVERSION ISSUES

- Access to historical data/records
  - Historical service data for rehires (USERRA)
  - Refunding of forfeitures (with respect to participants who repay prior distributions)
  - Nondiscrimination testing (ADP/ACP testing) issues if converting mid-year
  - Cost basis of employer stock
  - QDROs
- Residual dividends

POST CONVERSION ISSUES

- Plan data
  - Retention
  - Ownership
  - Privacy
  - Access
- Annual reporting considerations
  - Form 5500 and related schedules
  - Summary Annual Report
  - Forms 1099-R

POST CONVERSION ISSUES

- But, for all of the SIX P's
- If anything can go wrong
  - It will
  - On the last possible day to get it done
  - At 5:00 p.m.
  - On Friday
  - Before a 3-day weekend
  - It will involve the CEO's account

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SOME FINAL TIPS

- Confirm payroll integration with your PAYROLL vendor and the recordkeeper
- Have both the vendor sales and service people at finals
- Never assume:
  - Their bid is their best offer
  - That a promised capability or service is included in the bid
  - That a verbally promised capability can be fulfilled; get it in writing by someone senior
- Spend time on data security
- Consider an administration pre-finals presentation
- Look for CITs
- Use demographics to select qualified default fund
- Beware special fee offers for using proprietary funds
- Ask for performance guarantees

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QUALIFIED
PLAN ADVISORS

BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

Session 3 - Mergers and Acquisition Issues for Retirement and Health & Welfare Plans

Speaker: **Barbara Klepper**, Shareholder, Winstead PC

Speaker

Barbara Klepper, Shareholder, Winstead PC

Barbara Klepper is a shareholder in Winstead's Tax Practice Group whose practice encompasses all aspects of executive compensation, nonqualified and qualified employee benefits planning, and related tax matters. She regularly helps clients navigate complex executive compensation, benefits, and tax issues in mergers and acquisitions and other business transactions, and frequently advises on post-closing benefits structuring, Section 409A and 280G issues, negotiating severance and executive employment contracts, change of control agreements, and drafting and structuring equity incentive plans and arrangements. She also counsels governing boards of directors, compensation committees, and benefits and investment committees and is known for her ability to provide practical, effective advice while meeting the business objectives and fiduciary obligations of her clients. Barbara also has significant experience working with the Department of Labor and the IRS in connection with benefits and tax matters.

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Mergers and Acquisitions: Issues for Retirement/Health & Welfare Plans

Barbara Klepper
Shareholder, Winstead PC

SWBA Benefits Administration Workshop
February 15, 2024

Types of Transactions

Stock Purchase Transaction
(including merger)

- Buyer generally “steps into shoes” of Seller
- Seller’s identity as employer does not change

Asset purchase transaction

- Seller ceases to be employer of transferred employees
- Buyer does not typically assume plans

General Considerations

In addition to type of transaction, parties must consider:

- Post-transaction benefits structure (Buyer)
- Affected employees/retention/morale
- Sponsoring entity of plan
- Compliance issues
- Potential liabilities

Due Diligence Process

- Understand goals of Buyer and Seller – the LOI
- Seller preparation and information gathering
- Determine existing, future and contingent liabilities
  - *Draft/review representations and warranties of Seller*
  - *Draft/review disclosure schedules of Seller*
- Design and prepare for post-transaction benefit structure
  - *Draft/review covenants of Buyer and Seller*
  - *TIMING is important consideration*
- Findings can result in additional negotiations
  - *Indemnification*
  - *Purchase price adjustment*

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Employer-sponsored Benefit Programs Covered Today

- Qualified retirement plans
- Health and Welfare plans
- Nonqualified deferred compensation plans, equity incentive plans, & transaction-based payments

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Qualified Retirement Plans: Significant Issues and Potential Liabilities

Significant Issues

- Controlled group liability
- ERISA reportable events
- Partial termination
- Breach of fiduciary duty/ERISA compliance matters
- Prohibited transactions
- Qualification failures
- Participant loans
- Employer stock
- PEOs

Potential Liabilities

- Accrued but unpaid obligations
- PBGC premiums
- Ongoing funding obligations
- Restoration of plan losses
- Excise taxes and penalties
- Costs of correction
- PEO and vendor contracts

Decision Points for Retirement Plans

- Terminate plan pre-closing
- Assume plan/spin-off
- Maintain separate plan for Seller employees
- Merge into Buyer plan
- Freeze plan
- Trustee-to-Trustee Transfer
- Consider: Nondiscrimination testing/transition period

Additional action items required depending on decision

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Health and Welfare Plans: Significant Issues and Potential Liabilities

Significant Issues

- COBRA liability
- Retiree health plans
- MEWAs
- ACA compliance
- HIPAA privacy/security
- Breach of fiduciary duty/ ERISA compliance matters
- Flexible spending accounts
- Severance Plans
- PEOs

Potential Liabilities

- Accrued, unpaid premiums
- Participant claims for benefits
- Excise taxes and penalties
- State insurance laws
- PEO and vendor contracts
- Severance liability
- Executive agreements

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Decision Points for Health and Welfare Plans

- Terminate plan pre-closing
- Assume plan
- Maintain separate plan for Seller employees
- Testing
- Establish new plan (either mirror or non-mirror)
- Amend existing plan to cover Seller employees/exclude from seller severance benefits

Additional action items required depending on decision

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NQDC Arrangements, Equity Incentive Plans, & Transaction-based payments: Significant Issues and Potential Liabilities

Significant Issues

- Plan/award documentation
- Tax compliance – Section 409A, Section 280G
- Breach of fiduciary duty/ ERISA compliance matters
- Specified employees
- Change in Control: Single or Double Trigger

Potential Liabilities

- Allocation of benefit costs
- Ongoing 409A compliance
- 280G liabilities
- Costs of corrections
- Ongoing funding obligations
- Gross-up obligations

Decision Points for NQDC Plans, Equity Incentive Plans, and Transaction-Based Payments

- Terminate plan pre-closing
- Plan aggregation requirements
- Assume plan
- Transaction Payments
- Reduction to purchase price
- Indemnification
- Release Agreements
- Stock Option and other Equity Award Alternatives

Additional action items required depending on decision

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Additional Action Items

- Board and committee resolutions
- Plan administrative consents
- Transition services, third-party service provider, and funding agreements
- Notices to participants/agencies
- Plan amendments
  - *Change identity of plan sponsor, named fiduciaries*
  - *Prevent dual eligibility*
  - *Provide service credit*
- ***Be careful to preserve transition period where applicable***

Additional Action Items

- Protection of PHI during transaction process
- Final Form 5500s
- Timing of employee communications
- 401(k) plan investments
- Coordination of seller and buyer parties
- Coordination with plan vendors

WINSTEAD
ATTORNEYS

Any Questions?

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BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

Session 4 - Mental Health Parity: How to Comply with DOL Regulations

Speaker: **Beth Allen**, Attorney, Allen Benefits Law
Tina Godfrey, Sr. Advisor for Health Investigations, U.S. Department of Labor, EBSA

Speakers

Beth Allen, Attorney, Allen Benefits Law

Beth Allen has made a career of advising employers and benefits professionals on the legal obligations imposed by federal and state benefits-related laws. She has a knack for taking complicated compliance concepts and effectively explaining them to plan sponsors, HR leaders, and company executives, alike. Her career involved providing benefits compliance guidance to employer plan sponsors nationwide as benefits compliance counsel at an international brokerage. In this role, she researched and summarized state and federal regulatory issues, answered thousands of benefits compliance questions, developed and updated compliance tools, contributed to compliance-centered publications, and trained benefits firm personnel and clients on benefits laws.

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

Ms. 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.

MENTAL HEALTH PARITY

HOW TO COMPLY WITH DOL REGULATIONS

Beth Allen
Attorney
Allen Benefits Law

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

SWBA Benefits Administration Workshop | 2024

AGENDA

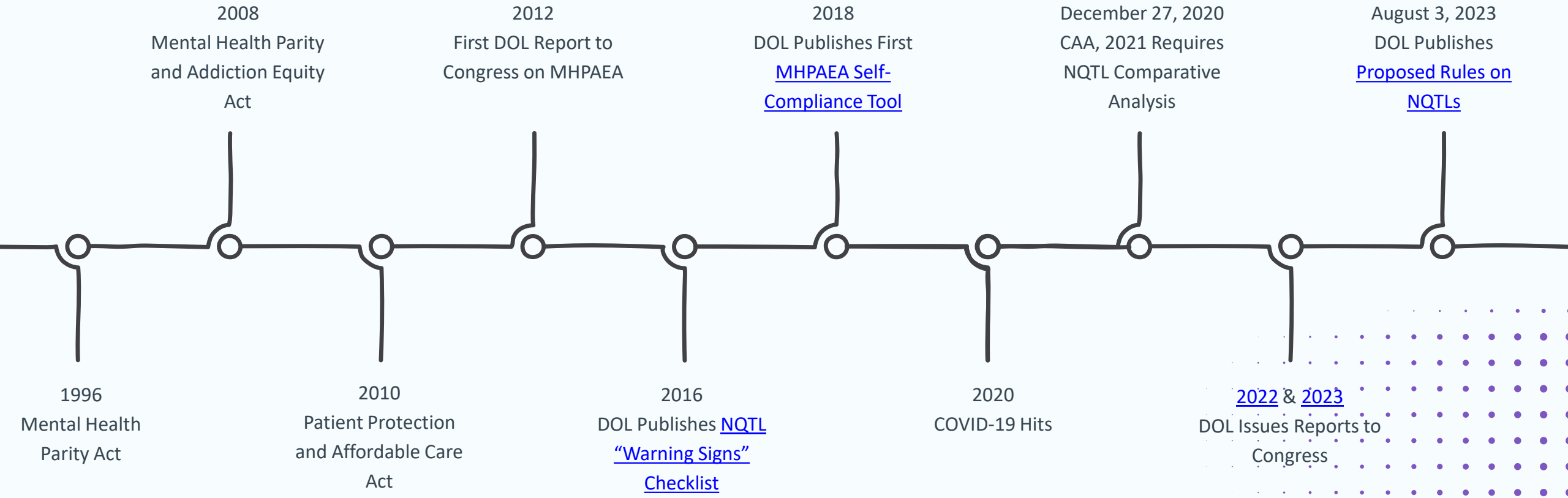
- Mental Health Parity Background
- NQTL Comparative Analysis Requirement & DOL Enforcement
- Employer Best Practices
- How Practitioners Can Bring Value

MENTAL HEALTH PARITY OVERVIEW

Group health plans or health insurance issuers offering health insurance coverage must ensure that parity requirements are met in the coverage of MH/SUD and Med/Surg benefits with respect to:

- Annual and Lifetime Dollar Limits
- Financial Requirements
- Treatment Limitations, including:
  - Quantitative Treatment Limitations (QTLs); and
  - Non-Quantitative Treatment Limitations (NQTLs)

MENTAL HEALTH PARITY – THE 30-YEAR SAGA



NQTL COMPARATIVE ANALYSIS

The Consolidated Appropriations Act, 2021

- Amended MHPAEA to require group health plans and insurers to document compliance with MHPAEA by providing an NQTL comparative analysis.
- Analyses were required to be completed by February 10, 2021, at which point plans were required to provide it to the Departments, state agencies, or participants upon request.
- NQTL Comparative Analyses are required to explain the factors used to apply NQTLs to benefits, the evidentiary standards upon which those factors are based, and the process used in the comparative analysis.
- The DOL was directed to request no fewer than 20 comparative analysis.

DOL ENFORCEMENT OF NQTL COMPARATIVE ANALYSIS REQUIREMENT

2022 Report to Congress

- The DOL reviewed 156 comparative analyses, and each one was insufficient in the information provided.
- Common Deficiencies:
  - Failure to identify the benefits, classifications or plan terms to which the NQTL applies.
  - Failure to describe in sufficient detail how the NQTL was designed or how it is applied in practice to MH/SUD benefits and medical/surgical benefits.
  - Failure to identify or define in sufficient detail the factors, sources and evidentiary standards used in designing and applying the NQTL to MH/SUD and medical/surgical benefits.
  - Failure to analyze in sufficient detail the stringency with which factors, sources and evidentiary standards are applied; and/or
  - Failure to demonstrate parity compliance of NQTLs as written and in operation.
- DOL immediately found that 30 plans had non-compliant NQTLs.
- Types of Issues Found: ABA therapy exclusions; nutritional counseling exclusions; medication-assisted treatment for opioid use disorder exclusions; blanket pre-certification for MH/SUD benefits.

DOL ENFORCEMENT OF NQTL COMPARATIVE ANALYSIS REQUIREMENT

2023 Report to Congress

- Between February 2021 and July 2022, the EBSA requested 182 comparative analyses, for which 138 insuffiency letters covered over 290 NQTLs were issued.
- Many of the common deficiencies identified in the 2022 report remained in 2023.
- DOL identified six priority areas:
  - Prior authorization requirements for in- and out-of-network inpatient services.
  - Concurrent care review for in- and out-of-network inpatient and outpatient services.
  - Standards for provider admission to participate in a network, including reimbursement rates.
  - Out-of-network reimbursement rates (methods for determining usual, customary, and reasonable charges).
  - New — impermissible exclusions of key treatments for mental health conditions and substance use disorders (e.g., ABA therapy to treat autism spectrum disorder and nutritional counseling for eating disorders).
  - New — adequacy standards for MH/SUD provider networks (e.g., adequacy of provider networks and provider reimbursement rates).

DOL ENFORCEMENT OF NQTL COMPARATIVE ANALYSIS REQUIREMENT

Proposed Rules

- On August 3, 2023, the DOL, HHS, and IRS announced proposed rules on MHPAEA. If finalized, the proposed rules would be effective beginning with 2025 plan years.
- Provisions of the proposed rules:
  - Delineated a three-part test for imposing NQTLs on MH/SUD benefits;
  - Added a “meaningful benefits” obligation;
  - Specified six elements required for a sufficient NQTL comparative analysis;
  - Required certification of the comparative analysis by a named ERISA plan fiduciary;
  - Illustrated how the proposed rules apply to NQTLs
- The DOL simultaneously released a technical release on network composition

NQTL COMPARATIVE ANALYSIS INDUSTRY RESPONSE: WHAT WE KNOW SO FAR

MHPAEA is Complex

Most employers (and many benefits professionals) couldn't explain what MHPAEA requires to save their lives.

Fiduciary Uninvolvement

While employers are fiduciaries of their plans and ultimately on the hook for any violations of applicable law, they generally do not control how mental health is offered.*

Insurer Uncooperation

Health insurers/TPAs know employers are caught in the middle and have somewhat exploited it to drag their feet.

DOL Has to Enforce the Law

The DOL knows very well that employer plan sponsors are in this position, but they can't turn a blind eye to employers who do nothing.

NQTL COMPARATIVE ANALYSIS INDUSTRY RESPONSE: WHAT WE KNOW SO FAR

Insurance Carriers/TPA Responses

- Carriers have them and will provide them* for fully-insured plans.
- TPAs will provide NQTL Comparative Analysis they give to fully-insured plans* to self-funded plan sponsors who ask, with major caveats.
- Vendors and some law firms jumped in to assist with providing NQTL comparative analyses. Many of them have not actually been able to provide one.

EMPLOYER BEST PRACTICES

- Obtain an NQTL Comparative Analysis
  - Fully-Insured Plan Sponsors -
    - Get the insurer's report and keep it in your files.
    - Consider whether you need to report an insurer that won't provide it.
  - Self-Funded Plan Sponsors -
    - Get the TPA's report, review it, and keep it in your files.
    - Consider a vendor if you can't obtain one or what's provided is woefully deficient.

EMPLOYER BEST PRACTICES

- Look out for Problematic QTLs and Financial Requirements.
- Take ALL participant complaints seriously.
- Complete the DOL Self-Compliance Tool.
- Review Plan for NQTL “Warning Signs”.

HOW PRACTITIONERS CAN BRING VALUE

1. Set the tone on the issue of MHPAEA compliance. Ensure that the client understands the gravity of the requirements and enforcement.

2. If the client wants to engage a vendor in preparing or reviewing the NQTL anlysis, assist them in vetting said vendor. Ensure that any vendor that is engaged is clear about the service they are offering.

3. If an insurer/TPA sends a communication signaling that one of the plan's terms violates MHPAEA and asking the self-funded plan sponsor what they want to do…ENCOURAGE THE CLIENT TO REMOVE THE PROVISION OR RETAIN COUNSEL.

THANK YOU

BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

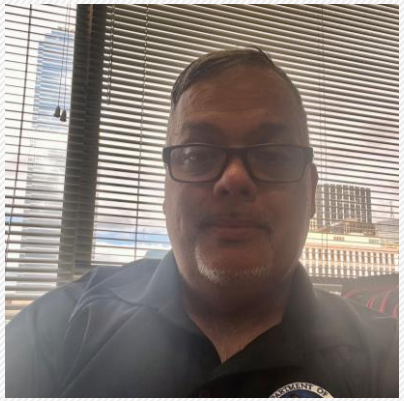
Session 5 - How Will that Impact my Plan?: Plan Document Compliance, Updating SBCs and other Participant Communications

Speakers: **Felicia Finston**, Partner, Finston Friedman Fisher Law Group
Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

Speakers

Felicia Finston, Partner, Finston Friedman Fisher Law Group

Felicia A. Finston has over 30 years of experience handling benefit and compensation issues for Fortune 500 and other public and private companies and tax-exempt entities (including church-related organizations and government employers). Felicia prides herself on developing and maintaining long-term relationships with her clients, such that she in essence serves in the capacity of an in-house benefits counsel for many of her clients. Felicia regularly provides legal counsel on qualified plan and health plan regulatory concerns, including ACA and HIPAA compliance issues, Form 1094 and 1095 filings and penalty assessments and Medicare coordination of benefit matters. She also advises clients regarding executive compensation and governance matters, such as SEC disclosure and filing issues, shareholder approval issues and proxy disclosure requirements involving compensatory arrangements. An important part of her practice also involves representing clients before the IRS, the DOL and the PBGC in connection with employee benefit plan audits and under voluntary submission programs such as EPCRS and DFVC.



Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

Cesar currently works as a Senior Benefits Advisor for the Employee Benefits Security Administration at the United States Department of Labor. He assists close to 1,500 participants a year in understanding their rights under ERISA and finding lost retirement benefits. Mr. Santiago has recovered
over $25,000,000 in benefits for participants since he started working for the agency in 2011. Mr. Santiago previously worked for the Internal Revenue Service and the Social Security Administration. He is a graduate of Haverford College with a Bachelor degree in Economics and has a Juris Doctorate degree from Temple University's Beasley School of Law.

HOW WILL THAT IMPACT MY PLAN

Southwest Benefits Association – 2024 Plan Administrator Workshop

Houston (February 15), Oklahoma City (March 15) and Dallas (March 28)

Felicia A. Finston and Mark A. Bodron and Cesar Santiago

OVERVIEW

- Plan Document Compliance
- Plan Document Related Compliance Issues
- Summary Plan Description Problems
- Summaries of Benefits and Coverage
- Other Participant Communications

PLAN DOCUMENT COMPLIANCE

- Must be in writing
- Multiple documents allowed
  - Wrap plan with component program documents provides most flexibility
    - SPDs describe benefits and can be updated annually
    - One 5500
  - Plan document can also serve as SPD, but more cumbersome
- Potential Gotchas
  - Cafeteria plan
  - Ambiguous or missing terms
  - Conflict with service provider documents
  - Inability to respond to document requests

FIXING PLAN DOCUMENT FAILURES

- No formal IRS correction program
- Correction depends on status of plan document
  - No plan document
  - Plan document has not been formally adopted
  - Plan document is incomplete, ambiguous or inaccurate
- Considerations
  - Timing
  - Impact on existing claims
  - Who has authority to adopt
  - Do plan administrative appointments need to be approved

FIXING PLAN DOCUMENT FAILURES CONT'D

- No plan document
  - Steps should be taken to complete and formally adopt the plan
  - Will plan document be in the form of a wrap document with cafeteria plan provisions or are multiple plan documents required
  - Documents regarding plan's operation should be relied on to complete terms and document prior operations
  - If plan terms have changed, both should be documented in formal plan document
  - Document should be adopted currently – no back dating
  - Participants should be advised of material changes

FIXING PLAN DOCUMENT FAILURES CONT'D

- Plan document is incomplete, ambiguous or inaccurate
  - Steps should be taken to complete and formally adopt the plan
  - Incomplete, ambiguous or inaccurate terms should be spelled out
  - Documents regarding plan's operation should be relied on to complete terms and document prior operations
  - If plan terms have changed, both should be documented in formal plan document
  - Document should be adopted currently – no back dating
  - Updated terms should be communicated to participants through SPD or plan document if it also serves as SPD

FIXING PLAN DOCUMENT FAILURES CONT'D

- Potential gotchas
  - Historical pre-tax elections may not be honored
  - For self-funded plan, failure to have plan document may result in historical violation of trust requirement which could raise prohibited transaction and fiduciary breach issues
  - If plan terms do not support participant desired outcomes or prior communications, participant lawsuits based on informal plan terms could ensue
- Considerations
  - Adoption of plan document evidences good faith compliance in the event of a DOL or IRS audit
  - Correcting documentation ensures compliance with ERISA document requests

ERISA DOCUMENT REQUESTS

- Section 104(b)(4) of ERISA requires the plan administrator to provide specific documents to a participant upon written request (i.e., the plan document, SPD, latest annual report, any terminal report, the bargaining agreement, trust agreement, contract or any other instrument under which a plan is established or operated).
- Failure to provide the requested documents within 30 days can subject administrator to a $110 penalty per day.
- Sometimes these requests are broad leading to the question of what documents must be provided.
- The key is not to ignore the request.

ERISA DOCUMENT REQUESTS CONT'D

- Question with self-funded welfare plans as to whether the administrative services agreement ("ASA") is an instrument under which the plan is established or operated.
- Courts are split on whether disclosure of the ASA is required
- Determination boils down to whether the ASA governs the relationship of the administrator with respect to the plan
- Key is to read the ASA to make the determination
- If disclosure is necessary, will likely need to redact financial terms

ERISA DOCUMENT REQUESTS CONT'D

- Train plan staff to forward to the plan's administrator or legal all participant/beneficiary requests for plan related documents immediately upon receipt. Do not allow document requests to fall into the "put them aside and deal with them later" category.
- Determine whether the requested documents exist and where they are located. For some plans, receiving a request for plan documents is when an administrator first realizes it may not have all the plan related documents required by law (and now has only 30 days to prepare them).
- Consult with experienced employee benefits legal counsel to confirm what documents the law requires be provided upon request. Not all documents that exist in connection with a plan are "instruments under which the plan is established or operated."
- Prepare and maintain a file of plan related documents so that the administrator can quickly respond to document requests. Doing so will also make for more effective plan administration and assist the administrator in the event of an IRS or DOL audit.

CLAIMS PROCEDURE

- Every ERISA covered plan must have an internal claims procedure
- The plan/claims administrator acts as fiduciary in resolving benefit claims and has a duty to act in the sole interest of participants in deciding such claims.
- Most plans provide the plan/claims administrator with discretionary authority in resolving benefit claims in hopes that this delegation will result in a deferential standard of review of the claim decision on judicial review.
- However, if the plan/claims administrator is the payor of the claim, a less deferential standard of review may apply due to the administrator's inherent conflict of interest.
- Exhaustion of the claims procedure is a mandatory precondition to filing an equitable or legal action against the plan or its fiduciaries
- DOL regulations provide that a failure to comply with the claims procedure eliminates the requirement to exhaust
- Failure to comply with the claims procedure may also result in a less deferential standard of judicial review

CLAIMS PROCEDURE CONT'D

- Typically, welfare claims determinations are delegated to the third-party administrator ("**TPA**") or insurer whose procedures may not comply with ERISA's claims rules (e.g., explanation of benefits ("**EOB**") often not sufficient to constitute proper denial of claim)
- Plan sponsor should ensure administrative service agreement or insurance contract obligates the TPA or insurer to comply with the claims rules and monitor TPA and insurer for compliance.
  - Concern is heightened in self-funded plan because plan sponsor bears cost of claims
- ERISA claims procedures are designed to provide claimant a full and fair review of claim which requires TPA or insurer
  - Investigate the claim and consider evidence relevant to that claim.
  - Consult with experts when required and follow that advise
  - Make sure response deadlines are met
  - Determine claim based on administrative record
  - Provide claimant access to relevant documentation and data
- Substantial compliance with the claims rules may be sufficient to avoid a de novo standard of review

BENEFIT CLAIM STATUTE OF LIMITATIONS ISSUES

- ERISA does not provide a statute of limitations ("**SOL**") for benefits claims and most courts rely on the most analogous state SOL which in most cases is the state SOL for bringing a contract claim
- To provide administrative certainty and consistency, plans may specify SOL for bringing suit following exhaustion of the internal claims procedure
- A plan's limitations period must be given effect unless it is unreasonably short or a controlling statute prevents it from taking effect.
- Plan should disclose SOL to participants in summary plan description and claim denial letters.

ANTI-ASSIGNMENT PROVISIONS

- Employer group health plans often include anti-assignment language to prevent providers from filing suits for plan benefits.
- This is to be contrasted to actions by providers where the provider is the authorized representative of the participant for filing a benefit claim.
- The courts have generally held that anti-assignment clauses are enforceable
- Payment by plan to provider will not waive right to enforce anti-assignment clause.
- State law cannot invalidate anti-assignment clauses and require that benefits be assigned to a health care provider.

ANTI-ASSIGNMENT PROVISIONS CONT'D

- Plan sponsors can take actions to improve the enforceability of an anti-assignment provision:
- Include the language in both the plan document and the summary plan description (if they are not one and the same)
- Explicitly indicate that the language applies to healthcare providers
- Specify that any attempted assignment is void or invalid if performed without the plan's consent and that the plan will not recognize any such assignment
- Specify the procedure a participant must follow to designate a provider (or other person) as an authorized representative for benefit claims

CROSS PLAN OFFSETTING

- Potential for conflict with plan document
- Involves recouping alleged overpayments to a provider for services provided to patients in employer-sponsored health plans by withholding payments due to the same provider for services provided to patients in different employer-sponsored health plans.
- Raises ERISA fiduciary and prohibited transaction concerns
- Review plan documents to see if cross-plan offsetting is permitted — implicitly or explicitly.
- Analyze administrative-service agreements and determine whether — and if so, how — the TPA recoups overpayments through cross-plan offsetting or other means. Follow up with TPAs if additional information is necessary.
- Ask service providers to report whether they made any offsets against payments from the self-funded plan, whether the plan specifically made any overpayments, and whether/how those amounts were recouped.
- Consider limiting to in-network providers and obtaining agreement by those providers

SUMMARY PLAN DESCRIPTIONS Common Problems

- All health and welfare and pension benefit plans must have and SPD unless top hat or other exemption applies
- Must distribute to participants within 90 days of enrollment and on request
  - $110 per day penalty if not produced within 30 days of request
- Common Issues
  - No SPD
  - Incomplete or misleading content – may result in plan having to cover otherwise noncovered services or provide additional benefits

    Example: Plan excludes dependent pregnancy, but SPD provided to participants says dependent pregnancy is covered, plan may not be able to avoid payment to pregnant dependent covered under plan
  - Improper distribution – must be in paper or electronically using DOL safe harbor

SUMMARY OF BENEFITS AND COVERAGE Which Plans and When

- What plans are required to provide the SBC
  - Group health plans, grandfathered and non-grandfathered
  - Insured or self-funded
  - Not excepted benefits (e.g., HSA, Health FSA, HRA)
- Who must provide
  - Plan Administrator of self-funded plan
  - Insurer of insured plan
  - Contractual obligation to provide SBC
- Up to $1,000 (as adjusted for inflation currently $1,406) per day penalty for each failure to provide
  - Self reporting of failures is required under IRS Form 8928

SUMMARY OF BENEFITS AND COVERAGE

- Paper
- Electronic by the plan sponsor to participants and beneficiaries covered by the plan if:
  - In accordance with DOL disclosure requirements
  - In connection with online enrollment or renewal of coverage
  - Upon request
  - Paper copy is available on request
- Electronic by the plan sponsor to eligible employees and beneficiaries if:
  - the format is readily accessible,
  - a paper copy is provided free of charge and on request
  - If the electronic form is an internet posting, the plan notifies the individual in paper form (such as a postcard) that the documents are available on the internet and provides the internet address

SUMMARY OF BENEFITS AND COVERAGE CONT'D

- Electronic by an Insurer if:
  - the format is readily accessible by the plan,
  - a paper copy is provided free of charge and on request
  - If the electronic form is an internet posting, the insurer advised the plan or its sponsor in paper form or email that the documents are available on the internet and provides the internet address

SUMMARY OF BENEFITS AND COVERAGE Timing

- Before enrollment or reenrollment
  - As part of any written application materials distributed by plan sponsor or insurer for enrollment
  - If no written application materials are distributed, no later than the first date the participant is eligible to enroll for coverage
  - Before enrollment, if no change to content occurs before enrollment
  - If renewal is automatic (e.g., passive enrollment) at least 30 days before first day of renewed coverage
  - If insured coverage has not been renewed before the 30-day period, as soon as practicable, but no later than 7 days after issuance of new policy
- Within 90 days of HIPAA special enrollment
- Upon request, within 7 days
- For COBRA beneficiaries, at enrollment or reenrollment or upon qualifying event if coverage offered differs from coverage being lost

SUMMARY OF BENEFITS AND COVERAGE CONTENT

- Uniform definitions of standard insurance and medical terms
- Description of coverage, including cost sharing, for each category of benefits identified in separate guidance
- Exceptions, reductions or limitation of coverage
- Cost sharing provisions, including deductibles, coinsurance and copayments
- Renewability and continuation of coverage
- Coverage examples
- If coverage satisfies minimum essential coverage and minimum value requirements
- Statement SBC is a summary and plan document or insurance contract should be consulted to determining governing contractual provisions of the coverage

SUMMARY OF BENEFITS AND COVERAGE CONTENT CONT'D

- Contact information for questions
- For insurers, an internet address where the group certificate of coverage can be reviewed and obtained
- If applicable, an internet address of similar contact information for obtaining a list of network providers, including a list of the lactation counseling providers within the network
- For plans that use a formulary in providing prescription drug coverage, an internet address or similar contact information for obtaining information on prescription drug coverage
- An internet address for obtaining the uniform glossary and a contact phone number to obtain a paper copy.

SUMMARY OF BENEFITS AND COVERAGE Updates

- Plans and insurers must provide notice of material modification of any update to plan terms not reflected in the most recent SBC that occurs other than in connection with renewal (i.e., mid-year)
- A material modification is any change in plan coverage that would be considered by an average plan participant to be an important change in covered benefits or terms of coverage
  - May include changes or modifications that reduce or eliminate benefits, increase premiums and cost sharing or impose a new referral requirement
- Must be provided no later than 60 days before the date on which the coverage change will be effective
- May be provided in paper or electronic form
- Can be satisfied by providing a separate notice of change or updated SBC

OTHER PARTICIPANT COMMUNICATIONS List

- Summary of Material Modifications (SMM) - 210 days after end of the plan year in which modification is adopted unless updated SPD is provided. Same penalty as SPD.
- Summary Annual Report (SAR) - 9 months after closed of the plan year or 2 months after due date for filing Form 5500 plus extensions. Technically, no penalty.
- Denial of Benefits – Differs for health, disability and other welfare benefit claims. Failure impacts ability to require exhaustion.
- Various Notices – Initial notice of COBRA rights, HIPAA privacy notice, Newborns, Women's Cancer Rights Act, HIPAA special enrollment, CMS notice of creditable coverage, CHIP notice ($141 per day penalty), wellness notice

COBRA

- The Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**") allows employees and their dependents the opportunity to continue to participate in their employer's group health plan when coverage would otherwise be lost due to a termination of employment or other qualifying events.
- Plan administrators are required to provide an initial notice advising employees of their COBRA rights and a COBRA election notice informing them of their right to elect COBRA coverage.
- COBRA mandates that the notices include specific information and be "written in a manner calculated to be understood by the average plan participant.
- A statutory penalty up to $110 per day may apply for each participant that received inadequate notice
- IRS self-reporting required on Form 8928
- Potential participant lawsuits for failure

COBRA NOTICE ISSUES

- Failure to identify name, address and telephone number of plan administrator
- Failure to specify qualifying event
- Failure to describe how to enroll in COBRA coverage
- Failure to include required explanatory language regarding the coverage
- Failure to write notice in a manner that could be understood by the average participant
- Failure to comply with the DOL model COBRA notice

COBRA TAKE AWAYS

- Employers should review their COBRA notices to ensure they comply with the statutory requirements
- Model notices issued by the DOL may be helpful
- Make sure that the initial COBRA notice is not forgotten
- Review COBRA qualifying event notification and election processes with COBRA vendor to make sure they are up to date and comply with current guidance
- Make sure COBRA vendor agreements specify who is responsible for specific COBRA notice and election procedures
- Periodically audit COBRA operations

QUESTIONS????

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BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

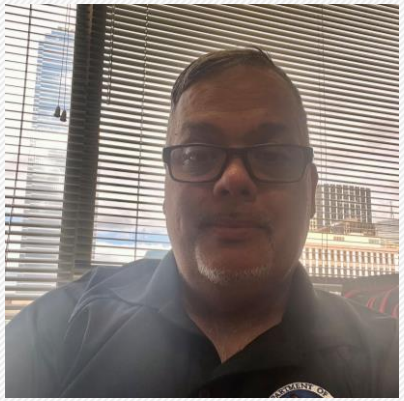
Session 6 - COBRA Administration: Compliance Pitfalls and Successfully Partnering with your Vendor

Speakers: **Angela Stockbridge**, Of Counsel, Steptoe and Johnson, PLLC
Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

Speakers

Angela Stockbridge, Of Counsel, Steptoe and Johnson, PLLC

Angela is an experienced attorney whose practice focuses on advising employers and insurers on employee benefits, executive compensation, and equity plans, with an emphasis on navigating employee benefits issues during mergers and acquisitions. She offers comprehensive guidance and support to facilitate compliance with regulations from the Internal Revenue Service and the Department of Labor, including preparation of 280G analyses and voluntary correction program documentation. Angela is skilled in designing customized equity incentive plans for both private and public companies. She has a proven track record in negotiating with the Internal Revenue Service and Department of Labor on behalf of employers to mitigate penalties and taxes related to the requirements of the Affordable Care Act (ACA). Additionally, Angela has a passion for advising employers, insurers, and health management organizations on the impact of state legislation on health services that may be mandated or restricted by conflicting state and federal laws.



Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

Cesar currently works as a Senior Benefits Advisor for the Employee Benefits Security Administration at the United States Department of Labor. He assists close to 1,500 participants a year in understanding their rights under ERISA and finding lost retirement benefits. Mr. Santiago has recovered over $25,000,000 in benefits for participants since he started working for the agency in 2011. Mr. Santiago previously worked for the Internal Revenue Service and the Social Security Administration. He is a graduate of Haverford College with a Bachelor degree in Economics and has a Juris Doctorate degree from Temple University's Beasley School of Law.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COBRA Administration

Compliance Pitfalls and Successfully Partnering with your Vendor

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COBRA

- The **employer's group health plan** is subject to COBRA
- The individual experiences a **qualifying event** which, but for COBRA coverage, would result in the loss of health insurance coverage
- The individual is a **qualified beneficiary** who loses coverage because of a **qualifying event**

Implementation and Enforcement

- The Department of Labor (DOL) issues regulations addressing COBRA's notice provisions. The DOL's interpretive and regulatory responsibility is limited to COBRA's disclosure and notice requirements. The DOL also may bring actions to enforce COBRA.
- The Department of the Treasury, through the Internal Revenue Service (IRS), issues regulations under the Internal Revenue Code on COBRA's rules regarding eligibility, coverage, and premiums.
  - The IRS may assess penalties for COBRA violations.
- The Department of Health and Human Services (HHS) administers the COBRA provisions of the Public Health Service Act (PHSA) in the context of public sector health plans.
- The courts enforces COBRA through litigated disputes between plan participants and beneficiaries.

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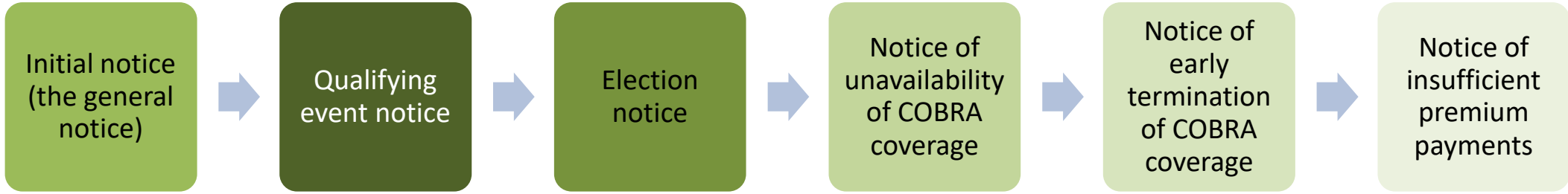
COBRA: Notice Requirements



COBRA Delivery of Notice

- Hand delivery
- First-class or certified mail
- Electronic disclosure

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COBRA & ERISA

COORDINATE WITH VENDORS

- COBRA rights must be described in the plan's Summary Plan Description (SPD).
- ERISA requires group health plans to give each participant an SPD within **90 days** after becoming a plan participant (or within **120 days** after the plan is first subject to ERISA's reporting and disclosure provisions).
- If there are material changes to the plan, the plan must give participants a Summary of Material Modifications (SMM) not later than **210 days** after the end of the plan year in which the changes become effective.
- If the change is a material reduction in covered services or benefits, the plan administrator must furnish the SMM within **60 days** after the reduction is adopted.
- If a covered participant or beneficiary requests in writing a copy of these or any other plan documents, the plan administrator must provide them within **30 days**.

Initial Notice

Content

- Contact info
- A general description of the continuation coverage provided under the plan
- An explanation of what qualified beneficiaries must do to notify the plan of qualifying events or disabilities
- An explanation of the importance of keeping the plan administrator informed of addresses of the participants and beneficiaries
- A statement that the general notice does not fully describe COBRA or the plan and that more complete information is available from the plan administrator and in the SPD
- **DOL model general notice**

Qualifying Events

Employer must notify the plan WITHIN 30 DAYS OF

- Termination or reduction in hours of employment
- Death of the covered employee
- Covered employee becoming entitled to Medicare, or
- Employer bankruptcy

Employee or QB must notify the plan in the event of

- Divorce
- Legal separation, or
- A child's loss of dependent status under the plan

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COBRA: Qualifying Events

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COBRA: Gross Misconduct Exception

Conduct is:

- outrageous, extreme, or unconscionable
- intentional, wanton, willful, deliberate, or reckless; or
- performed with deliberate indifference to an employer's interests

Categories

- Criminal conduct
- Outrageous conduct
- Insubordination
- Job abandonment

NOT GROSS MISCONDUCT

Mistakes, mere inattention to detail, poor performance, negligence

Qualifying Event Notice Procedures

Time limit cannot be shorter than 60 days, starting from the latest of:

- The date the qualifying event occurs,
- The date the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event, or
- The date the qualified beneficiary is informed

Election Notice

Timing

- Within 14 days of receipt of qualifying event notice

Content

- Contact info;
- Identification of the qualifying event;
- Identification of the qualified beneficiaries (by name or by status);
- An explanation of the qualified beneficiaries' right to elect continuation coverage;
- The date coverage will terminate (or has terminated) if continuation coverage is not elected;
- How to elect continuation coverage;
- What will happen if continuation coverage isn't elected or is waived;
- What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
- How continuation coverage might terminate early;
- Premium payment requirements, including due dates and grace periods;
- A statement of the importance of keeping the plan administrator informed of the addresses of qualified beneficiaries; and
- A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the plan administrator and in the SPD
- **DOL Model Notice**

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What Coverage Must Be Offered?

Coverage available to similarly situated active employees and their families

Rules for filing benefit claims and appealing claims denials.

Copayment and deductible requirements.

Coverage limits.

Other Notices

Notice of Unavailability of Continuation Coverage

- Within 14 days after the request is received
- Must explain the reason for denying the request

COBRA Notice of Early Termination of Continuation Coverage

- Notice of early termination must be given as soon as practicable after the decision is made

Special Rules for Multiemployer Plans

- May adopt its own uniform time limits for the qualifying event notice or the election notice.
- May choose not to require employers to provide qualifying event notices, and instead to have the plan administrator determine when a qualifying event has occurred.
- *Any special multiemployer plan rules must be set out in the plan's documents (and SPD)*

Duration of COBRA Coverage

COBRA coverage generally extends for up to 18 or 36 months from the date of the qualifying event.

COORDINATE WITH VENDORS:

- At the employer's option, a plan may provide longer periods of coverage than those required by law.
- A plan sponsor may choose to start the COBRA coverage after a loss of coverage instead of the date of the qualifying event, which can extend the period of coverage.
- However, an employer that wants to extend COBRA beyond the period of time required by law should seek written approval from either:
  - The insurer for an insured health plan.
  - The stop-loss carrier for a self-insured health plan.

Early Termination of Coverage

A group health plan may terminate COBRA before the end of the maximum coverage period if:

- The employer ceases to maintain any group health plan.
- A qualified beneficiary does not **timely pay premiums**. – **COORDINATE WITH VENDORS**
- A qualified beneficiary enrolls in coverage under another group health plan after electing COBRA coverage if that plan does not impose an exclusion or limit affecting a preexisting condition of the qualified beneficiary
- A qualified beneficiary becomes entitled to benefits under Medicare after electing COBRA.
- A qualified beneficiary's COBRA is terminated for cause. - **COORDINATE WITH VENDORS**
- A qualified beneficiary whose disability extends the coverage period to 29 months is determined not to be disabled before the end of the extended coverage period.- **COORDINATE WITH VENDORS**

If COBRA coverage is terminated early, the plan must provide the qualified beneficiary an early termination notice.

Payment of Premiums

A group health plan can terminate a qualified beneficiary's coverage as of the first day of any period for which timely payment is not made (26 C.F.R. § 54.4980B-8, Q&A-1(a)).

“Timely” if made within 30 days after the due date (or a longer period permitted by the plan).

The initial premium payment is considered timely if made within 45 days after the day on which the qualified beneficiary made the initial coverage election (26 C.F.R. § 54.4980B-8, Q&A-5).

Amount paid may be less than what is owed if the plan permits it and:

- Notifies the qualified beneficiary of the amount of the deficiency.
- Permits a reasonable period of time for the qualified beneficiary to remedy the deficiency. In general, 30 days is considered a safe harbor for this purpose. (26 C.F.R. § 54.4980B-8, Q&A-5.)

EAPs, FSAs, HRAs, HSAs, Cafeteria Plans

EAPs COORDINATE WITH VENDOR

- Referral only is not subject to COBRA.
- HOWEVER, EAPs that offer counseling typically provide employees with a limited number of counseling sessions. If the counseling involves any form of medical care the EAP is a group health plan and therefore is subject to COBRA. The EAP also is considered a group health plan if it provides counseling services for other non-medical issues.

FSAs COORDINATE WITH VENDOR

- subject to COBRA UNLESS:
  - Benefits provided under the health FSA are excepted benefits
  - The maximum amount that the health FSA could require to be paid for COBRA coverage equals or exceeds the benefit available under the health FSA for the year.

HRAs

- Subject to COBRA

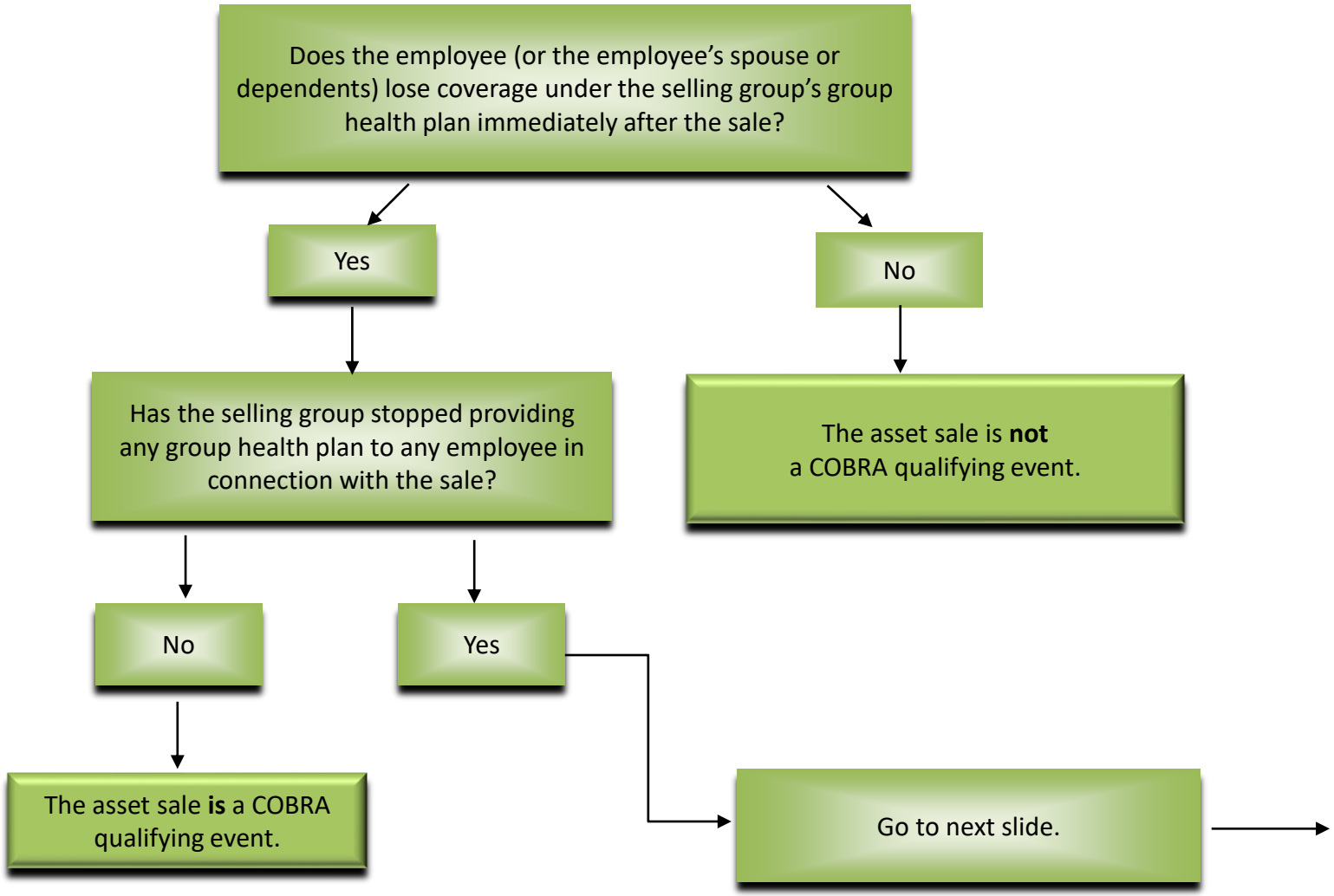
HSAs

- Not subject to COBRA

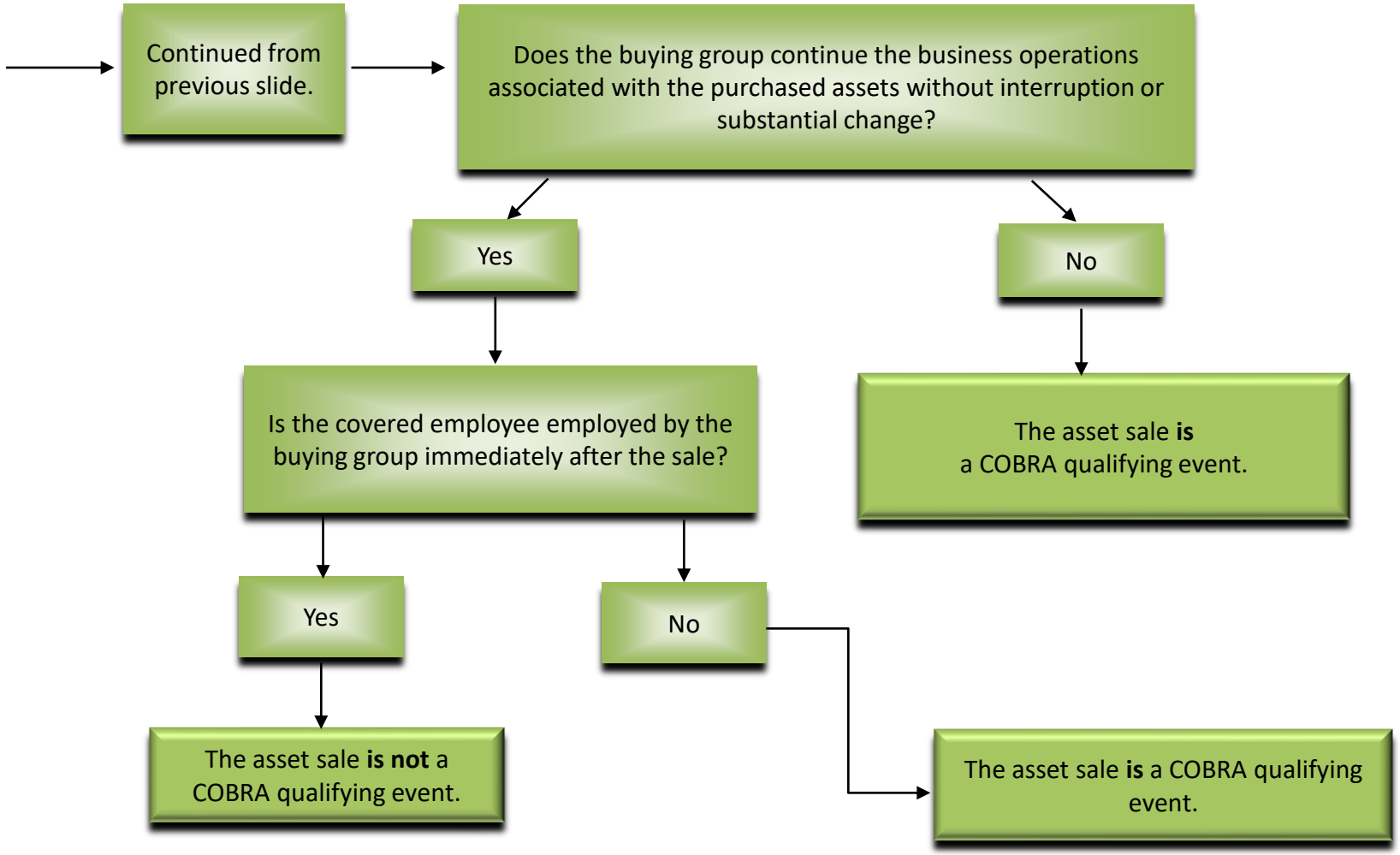
Cafeteria Plans COORDINATE WITH VENDOR

- COBRA premiums may be paid through a cafeteria plan if certain conditions are met (Prop. 26 C.F.R. § 1.125-1(a)(3)(C)).
- Plan amendment may be needed—for instance, to provide for pre-tax payment of COBRA premiums or midyear election changes on account of a COBRA qualifying event.
- COBRA coverage for a former spouse cannot be paid for on a pre-tax basis under a cafeteria plan because a former spouse will not qualify as the employee's spouse or tax dependent for health coverage purposes.

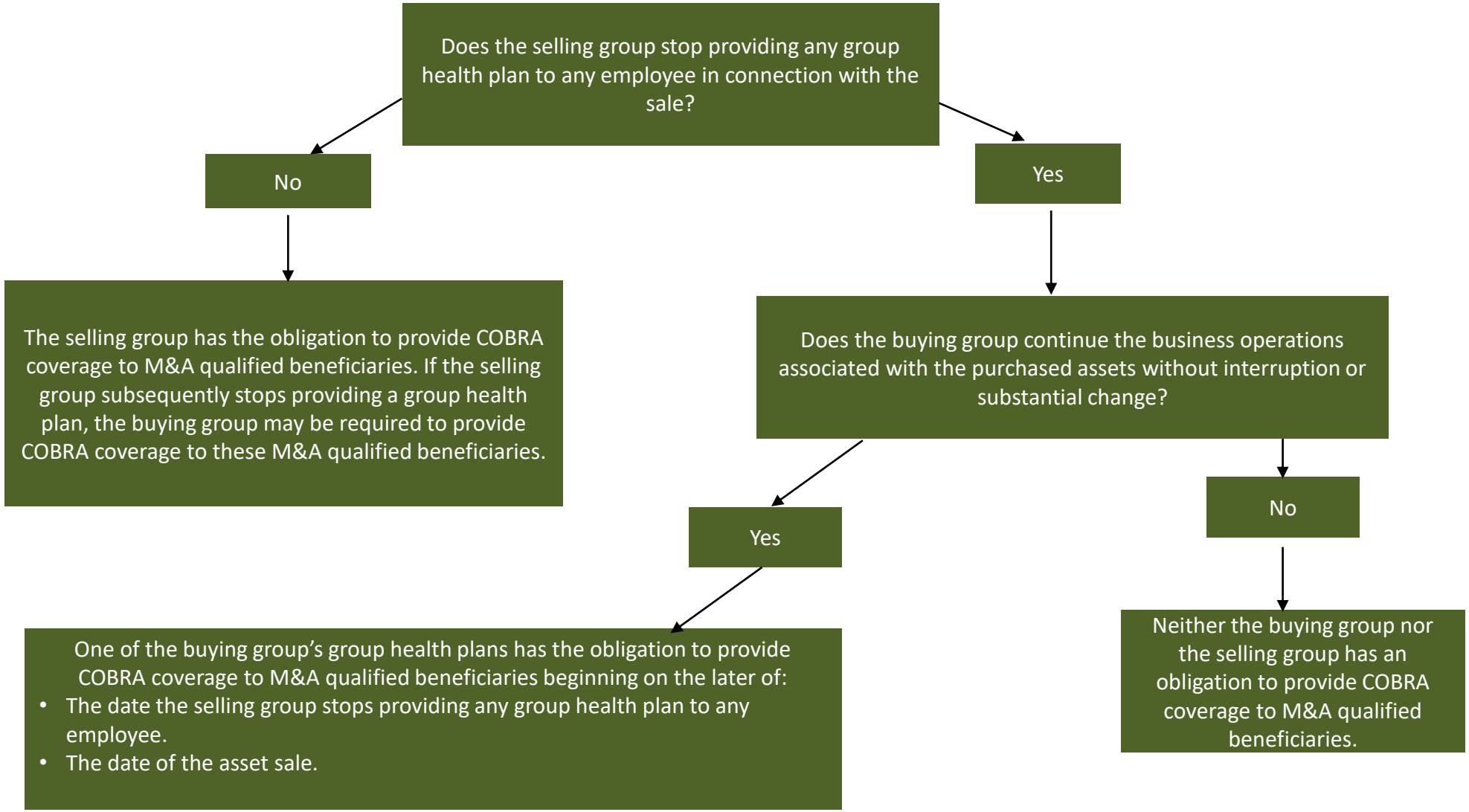
Mergers & Acquisitions



Mergers & Acquisitions (cont'd)



Asset Sale


Does the selling group stop providing any group health plan to any employee in connection with the sale?
No
Yes
The selling group has the obligation to provide COBRA coverage to M&A qualified beneficiaries. If the selling group subsequently stops providing a group health plan, the buying group may be required to provide COBRA coverage to these M&A qualified beneficiaries.
Does the buying group continue the business operations associated with the purchased assets without interruption or substantial change?
Yes
No
One of the buying group's group health plans has the obligation to provide COBRA coverage to M&A qualified beneficiaries beginning on the later of:
• The date the selling group stops providing any group health plan to any employee.
• The date of the asset sale.
Neither the buying group nor the selling group has an obligation to provide COBRA coverage to M&A qualified beneficiaries.

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