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: **Eric Smith**, Partner, Conner & Winters

9:35 – 10:35 am
Session 2: The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities
Speaker: **Marina Edwards**, Founder, Marina Retirement LLC

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: **Judy Burdg**, Shareholder and Practice Group Leader, McAfee & Taft

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
Brandi Price, Auditor/Acting 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: **Mark Bodron**, Associate General Counsel-ERISA, Lumen Technologies
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

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

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

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 – OKC
- Program Activity ID: 647812
- 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 – OKC
- Program Activity ID: 24-SDKDN
- 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 into 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 – OKC

Date: March 15, 2023

Time: 8:30 AM – 4:20 PM

Location: 1 Park Ave, Oklahoma City, OK 73102

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-SDKDN	**HRCI Activity ID**: 647812
SHRM SHRM-CP | SHRM-SCP RECERTIFICATION PROVIDER	APPROVED PROVIDER 2024 HRCI.ORG
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BENEFITS ADMINISTRATION WORKSHOP

SWBA SouthWest BENEFITS Association

MARCH 15, 2024
OKLAHOMA CITY

Welcome

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- Founded in 1975
- Over **600 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
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Upcoming Events

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SWBA SouthWest BENEFITS Association 48TH ANNUAL CONFERENCE

MAY 15–17, 2024

Benefits Fiesta

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BENEFITS ADMINISTRATION WORKSHOP

SouthWest BENEFITS Association

MARCH 15, 2024
OKLAHOMA CITY

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

Speaker: **Eric Smith**, Partner, Conner & Winters

Speaker

Eric Smith, Partner, Conner & Winters

Eric Smith is an employee benefits attorney with Conner & Winters, LLP in Tulsa, Oklahoma. He has over 25 years of experience assisting with clients with retirement plan, health plan and deferred compensation plan issues. Eric has been included in the Best Lawyers in America among employee benefits practitioners each year since 2009. He has served as a director of the SouthWest Benefits Association, Tulsa Employee Benefits Group and Big Brothers and Sisters of Green Country.

What's Next with SECURE 2.0

Eric Smith
esmith@cwlaw.com
918-586-8505

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SECURE 2.0

- The SECURE 2.0 Act of 2022 became law on December 29, 2022, as Division T of the Consolidated Appropriations Act.
- SECURE 2.0 builds on the Setting Every Community Up for Retirement Enhancement Act of 2019.
- Plan amendments required – generally – by December 31, 2026 (same deadline for SECURE 1.0 and CARES Act).

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Practical Considerations

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Practical Considerations
Potential Plan Design Decisions

- Already available under SECURE 2.0, but dependent on vendor implementation:
  - Hardship self-certification.
  - Terminal illness distributions.
  - Qualified disaster distributions and loans.
  - Increases to QLAC premium limits.
  - Contribution incentives.
  - Roth treatment for matching and nonelective contributions.

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Practical Considerations
Potential Plan Design Decisions

- Available for plan years beginning after 12/31/2023, but dependent on vendor implementation:
  - Matching student loan payments.
  - Emergency personal expense distributions.
  - Domestic abuse withdrawals.
  - Pension-linked emergency savings accounts.
  - Increase in cash-out limit.
  - For 403(b)s, permit hardships from earnings on elective deferrals, QNECs and QMACs.
- Increased catch-up limits applicable for 2025.

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Practical Considerations
Documenting Plan Design Decisions

- The delayed amendment deadline can be a blessing and a curse.
  - Maintain clear records of your design elections, their effective dates and the details of the elections.
  - Keep in mind that you might have a different recordkeeper when an amendment is needed.
  - Keep elections and amendments in mind when doing plan mergers.
- Beware of automatic opt-ins.
- Keep amendment authority in mind.

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Practical Considerations
Distributions

- What is the employer's philosophy with respect to the many new distribution options (e.g., disasters, emergency expenses, domestic abuse, terminal illness, hardship self-certification, long-term care)?
- What will the vendor handle and what will be expected from the employer?
- How are these changes being communicated to participants?
- Don't forget the details, such as source and investment hierarchy for liquidation.

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Practical Considerations
Spousal RMD Elections

- Beginning in 2024, surviving spouses can elect to be treated as the employee participant for purposes of the timing and amount of RMDs.
    - Treasury to provide guidance on this election but that has not occurred yet.
- How is this being administered by your recordkeeper? What is being provided to a spouse beneficiary?

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Practical Considerations
Long-Term Part-Time Employee Rule

- LTPT employees may already need to be eligible to defer.
- Does the plan design avoid the need for LTPT analysis?
- If you have LTPTs, are they eligible only for deferrals or for all contributions?
- What communications are required?
- How is your recordkeeper helping to monitor?
- What is the approach for coverage/nondiscrimination testing?
- Prepare for 2025 change from 3 years to 2 years.

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RMD Relief
Notice 2023-54

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RMD Relief
Notice 2023-54

- Notice 2023-54 issued on July 14, 2023.
- Plan administrator does not fail to satisfy the 402(f) notice requirement, the rollover rules or the withholding rules merely because of a failure to treat the following as eligible rollover distributions:
  - A distribution made between 1/1/23 and 7/31/23;
  - To a participant born in 1951 (or that participant's surviving spouse); and
  - The distribution would have been an RMD but for the SECURE 2.0 change in the required beginning date.

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RMD Relief
Notice 2023-54

- 60-day rollover period for any such distribution extended to 9/30/23.
  - Example: A participant who was born in 1951 received a single-sum distribution in January 2023, part of which was treated as ineligible for rollover because it was mischaracterized as an RMD, that participant will have until September 30, 2023, to roll over that mischaracterized part of the distribution.
- Similar relief for IRA distributions (with special provisions related to one rollover per year rule).

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RMD Relief
Notice 2023-54

- Relief related to the “at least as rapidly” rule.
- Proposed regulations apply the “at least as rapidly” rule to designated beneficiaries who are not eligible designated beneficiaries (EDBs) – along with the new 10-year rule under SECURE 1.0. This was a surprise to the retirement plan community.
- Relief given in Notice 2022-53 for amounts not paid in 2021 or 2022 due to confusion.
- Similar relief given in Notice 2023-54.

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RMD Relief
Notice 2023-54

- Excise tax not applicable to distributions that would be required under the "at least as rapidly" rule for the year in which the employee (or designated beneficiary) died if the payment would be required to be made to:
  - a designated beneficiary of an employee if: (1) the employee died in 2020, 2021, or 2022, and on or after the employee's required beginning date, and (2) the designated beneficiary is not using the lifetime or life expectancy payments exception; or
  - a beneficiary of an EDB if: (1) the EDB died in 2020, 2021, or 2022, and (2) that EDB was using the lifetime or life expectancy payments exception.

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Roth Catch-up Contribution Relief

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Roth Catch-Up Contributions
Notice 2023-62

- Notice 2023-62 released on August 25, 2023.
- IRS announced 2-year administrative transition period for the requirement that catch-up contributions be made as Roth contributions.
- Requirement to apply for taxable years beginning after 12/31/25.

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Technical Corrections

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Technical Corrections

- Discussion draft of technical corrections bill jointly released by House and Senate on December 6, 2023.
- Key updates include:
  - Confirm that terminally ill distributions are permitted distribution events (contrary to Notice 2024-2).
  - Fix inadvertent elimination of all catch-up contributions beginning in 2024.
  - Clarify the RMD age change from 73 to 75 in 2033 for individuals who reach 73 after 2032.

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Technical Corrections

- Key updates include (continued):
  - Clarify that 2025 catch-up limit used for determining increased catch-up contributions for participants age 60-63.
  - Confirm that catch-up contribution increase applies for qualified student loan payments.
  - Revisions to mandatory automatic enrollment rules (1-year delay in statutory ceiling for enrollment percentage; application to multiemployer/multiple employer plans).
  - Clarify that lost and found database to include IRA and deferred annuity contract issuers.

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Long-Term Part-Time Employees

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Long-Term Part-Time Employees

- SECURE 1.0 rule:
  - 401(k) plans required to permit elective deferrals for employees who complete at least 500 hours of service in 3 consecutive 12-month periods.
  - Only years after 2020 must be counted for the 3-year requirement, so January 1, 2024 would be the first time that eligibility is required under this rule.
  - Matching and nonelective contributions not required.
  - Did not apply to 403(b) plans or collectively bargained plans.

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Long-Term Part-Time Employees

- SECURE 2.0 modifications:
  - For plan years beginning after December 31, 2024, employees who complete at least 500 hours of service in 2 consecutive 12-month periods must be eligible for deferrals.
  - The long-term part-time rules are added to ERISA, which means that 403(b) plans covered by ERISA are subject to the rule as described in SECURE 2.0. (Church 403(b) plans are still not covered.)
    - Under the ERISA rule, service before 2023 is disregarded.

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Long-Term Part-Time Employees

- SECURE 2.0 modifications (continued):
  - Only service on or after January 1, 2021 must be counted for purposes of counting vesting service under a 401(k) plan. (For these employees, vesting service must be counted for employees who work 500 hours in a 12-month period.)

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Long-Term Part-Time Employees Proposed Regulations

- IRS released proposed regulations on November 24, 2023.
- Apply to plan years beginning on or after 1/1/24, and permit reliance prior to publication of final rules.
- Good faith interpretation standard not provided.

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Long-Term Part-Time Employees
Proposed Regulations

- Plans can still exclude employees based on reasonable classifications that are not based on or a proxy for age or service (but will be subject to testing).
- Employees who become eligible under any other plan service requirement cease to be LTPT employees – and thus cease to be eligible for the testing exclusion for LTPT employees.
- LTPT employee rules generally don't apply to plans that use elapsed time, though testing relief for LTPT employees is not available for those plans.

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Long-Term Part-Time Employees
Proposed Regulations

- 12-month period for determining years with 500 hours begins on date first credited with hour of service, then can switch to plan year if elected by plan.
  - Note that switch to plan year can accelerate eligibility.
  - A plan can use the DOL hours equivalencies for LTPT equivalencies.
- Plan can apply same entry dates as for other employees.

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Long-Term Part-Time Employees
Proposed Regulations

- No break in service rule for LTPT employees, so immediate participation upon rehire and prior years with 500 hours of service will need to be considered upon rehire.
- Plans can use regular vesting computation period (anniversary year, plan year) for LTPT vesting years.
- Vesting rules applied to governmental and church plans that are not subject to these rules otherwise, thus requiring a year of service for each year in which an LTPT works at least 500 hours.

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Long-Term Part-Time Employees
Proposed Regulations

- Employer can exclude LTPT employees from coverage/nondiscrimination testing, but election must apply to all of the testing.
  - LTPT employees can be excluded from safe harbor contributions but exclusion must be set forth in plan document.
- Employer can exclude LTPT employees from top heavy contributions/vesting, but not for determining whether a plan is top-heavy

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IRS Notice 2024-2 (December 20, 2023)

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Mandatory Automatic Enrollment

- Effective for plan years beginning after December 31, 2024 (specific exception for church plans).
- 401(k) and 403(b) plans established after December 29, 2022 must provide for:
  - Automatic enrollment of at least 3% and no more than 10%.
  - Automatic escalation of one percentage point each year, up to at least 10%.
- Also exceptions for new businesses (less than 3 years) and small businesses (less than 10 employees).

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Mandatory Automatic Enrollment
Notice 2024-2

- Exception applies for CODAs established before 12/29/22.
  - New qualified CODA is established on the date adopted – not the date effective.
    - Example: Employer adopts a CODA on 10/3/22, with an effective date of 1/1/23. For this purpose, it was "established" on 10/3/22.
  - 403(b) treated as pre-enactment CODA if it was established before 12/29/22, without regard to the date of adoption of plan terms that provide for salary reduction.

CONNER WINTERS

Mandatory Automatic Enrollment
Notice 2024-2

- Detailed rules provided for plan mergers and plan spinoffs – including rules for multiple employer plans. Important to consider these rules closely any time a merger or spin-off occurs.
- Mandatory automatic enrollment rules do apply to starter 401(k) deferral-only arrangements and 403(b) safe harbor deferral-only plans, unless an exception applies.

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Financial Incentives for Plan Contributions
Notice 2024-2

- De minimis financial incentive for employees who elect to make contributions does not violate the contingent benefit rule applicable to 401(k) plans or the universal availability rule applicable to 403(b) plans
- $250 maximum incentive permitted
- Incentive can only be offered to employees for whom no election is already in place
- Incentive can be provided in installments that are contingent on continuing to defer, still subject to total $250 limit.
- A matching contribution cannot be an incentive for this purpose.

CONNER WINTERS

Financial Incentives for Plan Contributions
Notice 2024-2

- Incentive is taxable to the recipient and is subject to applicable employment tax withholding and reporting requirements – unless otherwise excluded under another Code provision.
  - Example: A $200 gift card is not excludable because it is a cash equivalent.
- The guidance also applies to 403(b) plans subject to the universal availability rule.

CONNER WINTERS

Terminally Ill Individuals
Notice 2024-2

- Distributions to "terminally ill individuals":
  - Not subject to 10% additional tax for early withdrawal
  - Eligible for repayment to plan
- Terminally ill: an individual who has been certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 84 months or less after the date of the certification.
- Physician: a doctor of medicine or osteopathy that is legally authorized to practice medicine and surgery by the State in which the doctor performs such function or action.

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Terminally Ill Individuals
Notice 2024-2

- Distribution must be made on or after the date on which the employee has been certified by a physician as having a terminal illness.
- Employee must furnish the physician's certification to the plan administrator.
  - Employee must retain certification and underlying documentation.
  - Certification must include specific information regarding participant and physician.
- Plan administrator cannot rely on employee self-certification.
- No dollar limit on amount.

CONNER WINTERS

Terminally Ill Individuals
Notice 2024-2

- Terminally ill distributions do not meet the distribution restrictions applicable to 401(k) and 403(b) plans.
  - Thus, elective deferrals cannot be distributed solely because of the terminal illness. These amounts must otherwise be eligible for in-service distribution.
  - Discussion draft of technical corrections bill would change this.
- Qualified plans are not required to permit terminally ill distributions.

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Terminally Ill Individuals
Notice 2024-2

- Even if plan does not permit, individuals can treat and otherwise permissible in-service distribution as terminally ill individual distribution on individual's tax return.
- No guidance on Form 1099-R reporting.

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Correction of Elective Deferral Failures
Notice 2024-2

- SECURE 2.0 codified an alternative method of correcting an elective deferral failure in an automatic enrollment plan.
  - No correction for the missed deferral required if correct deferrals commence within certain period of time and timely notice provided to participant.
  - Corrective matching contributions always required.
- Matching contributions must be deposited within a reasonable period.
  - The last day of the sixth month following the month in which the correct elective deferrals begin is treated as reasonable.

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Correction of Elective Deferral Failures
Notice 2024-2

- Alternative method may be used for terminated employees as well.
  - Notice can be modified to remove information about current and future deferrals.

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Plan Amendment Deadlines
Notice 2024-2

- Amendment deadline for qualified plans generally extended to December 31, 2026.
  - Certain collectively bargained plans: December 31, 2028
  - Governmental plans: December 31, 2029
- Amendments made after the deadline are not eligible for anti-cutback relief.
- Deadlines apply to required and discretionary amendments.

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Plan Amendment Deadlines
Notice 2024-2

- Amendment deadline for 403(b) plans generally extended to December 31, 2026.
  - Certain collectively bargained plans: December 31, 2028.
  - Public school plans: December 31, 2029.

CONNER WINTERS

Roth Employer Contributions
Notice 2024-2

- Plans are not required to offer this option and may choose to offer for matching or nonelective.
- Designation as a Roth contribution must be made no later than the time the contribution is allocated to account and must be irrevocable. Separate accounting required.
- If election permitted, employee must have an effective opportunity to make or change designation at least once per plan year.
- Includible in income for the taxable year in which the contribution is allocated to the individual's account – even if the contribution is deemed to have been made on the last day of the prior taxable year.

CONNER WINTERS

Roth Employer Contributions
Notice 2024-2

- Participant must be fully vested in the type of contribution (matching or nonelective).
  - This restriction will not violate Code § 401(a)(4).
- For 401(k) and 403(b) plans, designated Roth matching and nonelective contributions:
  - Are not wages for income tax withholding purposes (excluded from wages under Code § 3401(a)
  - Are not wages for FICA or FUTA purposes (excluded form wages under Code §§ 3121(a) and 3306(b).
    - Separate rules for governmental 457(b) plans.

CONNER WINTERS

Roth Employer Contributions
Notice 2024-2

- Must be reported using Form 1099-R for the year in which the contributions are allocated to the individual's account.
  - The total amount of designated Roth matching and nonelective contributions that are allocated in that year are reported in boxes 1 and 2a of Form 1099-R, and code "G" is used in box 7.
- Not included in the wage withholding and Form W-2 safe harbor definitions of compensation.

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Roth Employer Contributions

- Administrative issues:
  - An election process will need to be established (it appears this can only be done at the employee's election).
  - Will this be an annual process or evergreen?
  - How often can an employee change an election?
  - Is this additional administrative burden needed if plan permits in-plan Roth conversions?

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Notice 2024-2
Other Items

- Amendment guidance re change to cash balance plan projection rules.
- Items generally applicable to employers with 100 or fewer employees.
  - Start-up Credit Enhancement.
  - Military Spouse Retirement Plan Eligibility Credit.
  - Increased contribution limits for SIMPLE IRAs and SIMPLE 401(k)s.
  - Mid-year termination and rollover changes for SIMPLE IRAs.
  - SIMPLE and SEP Roth IRAs.

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Pension-Linked Emergency Savings Accounts

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Pension-Linked Emergency Savings Accounts

- Optional SECURE 2.0 provision effective for plan years beginning after December 31, 2023.
  - Applicable only to defined contribution plans (appears to be limited to ERISA plans).
  - Different from emergency personal expense distributions.
- Optional savings account within plan available only to non-highly compensated employees - $2,500 limit.
- Automatic enrollment permitted up to 3% of compensation.
- Treated as Roth contributions.

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Pension-Linked Emergency Savings Accounts

- Must permit at least monthly withdrawals; first four must not be subject to administrative fee.
  - There does not appear to be any restrictions on the reason for the withdrawal.
- Must be separately record-kept.
- Treated as an elective deferral for matching contributions and contribution limits.
- Must be invested in an interest-bearing cash account or an investment product designed to preserve principal.

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Pension-Linked Emergency Savings Accounts
Notice 2024-22

- PLESA contributions must be treated as elective deferrals for matching contribution purposes.
  - Matching contributions are treated first as being made on non-PLESA contributions.
  - Matching contributions cannot exceed the maximum account balance ($2,500) for the plan year.
- Notice 2024-22, released on January 12, 2024, provides initial guidance on “anti-abuse” rules intended to prevent manipulation of the rules to cause matching contributions to exceed the intended amounts or frequency.

CONNER WINTERS

Pension-Linked Emergency Savings Accounts
Notice 2024-22

- Plan sponsors are not required to impose additional rules beyond what are in statute.
- Thus, not abusive for a participant to make a $2,500 contribution in one year, receive the matching contribution and then take $2,500 in distributions that year and repeat that pattern in subsequent years.

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Pension-Linked Emergency Savings Accounts
Notice 2024-22

- The following procedures are deemed to be unreasonable (and thus not permitted as part of PLESA design). A plan may not:
  - Provide that matching contributions already made on account of PLESA contributions will be forfeited by reason of a participant's withdrawal from a PLESA.
  - Suspend a participant's ability to contribute to the participant's PLESA on account of a withdrawal.
  - Suspend matching contributions made on account of participant elective deferrals to the underlying defined contribution plan.

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Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- FAQs released on 1/17/24 by Department of Labor in consultation with Internal Revenue Service.
- FAQs appear to contemplate that employer can have more generous eligibility requirements for PLESA than general plan participation.
- Automatic enrollment permitted but mandatory contributions not permitted.

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Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- A plan cannot:
  - Require a minimum amount for opening or keeping a PLESA.
  - Require a minimum balance.
  - Impose a penalty for falling below a specified amount.
  - Require a minimum contribution per pay period.
- A plan can require contributions in whole dollar amounts or whole percentages of no less than 1%.

CONNER WINTERS

Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- $2,500 account limit applicable to participant contributions limit is not required to include earnings – but plan can choose to include earnings.
- Plan cannot impose a limit on contributions in addition to the $2,500 limit.
- Same ERISA timing requirements apply for employer remittance of participant contributions as for deferrals and loan payments.
- PLESA amounts can be held in a segregated omnibus account provided the separate accounting and separate recordkeeping requirements are satisfied.

CONNER WINTERS

Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- A participant is not required to demonstrate the existence of an emergency or other need to obtain a PLESA distribution.
- Withdrawal fees (for withdrawals after the first four) must be reasonable and can be charged against the PLESA or against the participant's plan account.
- No restrictions on method of distribution at this time (e.g., check, debit card, electronic transfer).

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Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- Statute requires investment in cash, interest-bearing deposit account or other product designed to preserve principal and provide reasonable rate of return.
  - FAQ provides that objective is “capital preservation and liquidity consistent with immediate access to savings to respond to unexpected financial needs.”
  - Surrender changes are incompatible with that objective. (Potential issue for stable value funds.)
  - Generally cannot be the plan’s QDIA as that would not satisfy this objective.

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Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- No model notice available at this time, but under consideration by DOL and IRS.
- Pension benefit statements and fee disclosures not required to include PLESA information.
- DOL working on Form 5500 updates on how to reflect PLESAs.

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Pension-Linked Emergency Savings Accounts
Frequently Asked Questions

- No guidance on the following:
  - Form 1099-R or other reporting requirements.
  - Clarification of application to non-ERISA plans.
  - Interaction with mandatory cash-out rules.
  - Correction for inadvertent inclusion of HCE.

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Automatic Portability Transactions

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Automatic Portability Transactions

- Effective for transactions on or after December 29, 2023.
- Prohibited transaction exemption for "Automatic Portability Transactions."
  - Transfer of assets from a default IRA to an employer-sponsored defined contribution plan in which the individual is a participant.
  - Participant must be given notice of the transfer and not opted out.
- Multiple requirements for providers of these services.

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Automatic Portability Transactions
Proposed Regulations

- Issued by Department of Labor on January 18, 2024. Regulations focus on requirements for auto-portability providers.
- Plan sponsor/fiduciary considerations:
  - Whether to participate in programs when available.
  - How to evaluate vendors and compensation.
    - Vendor comp must be approved in writing.
    - Updates to service provider agreements.
  - How to disclose to participants.
  - Proper administration and investment of inbound transfers.

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Expanded Use of Self-Correction

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Expanded Use of Self-Correction Pre-SECURE 2.0

- Significant operational failures can be self-corrected by the last day of the third plan year following the plan year for which the failure occurred.
- Insignificant operational failures can be self-corrected at any time.
- To be eligible to self-correct, a plan sponsor must have established practices and procedures designed to promote and facilitate overall compliance with applicable Code requirements.
- To be eligible to self-correct significant plan failures, a plan must be the subject of a favorable letter and satisfy other requirements in IRS procedure document.

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Expanded Use of Self-Correction
SECURE 2.0

- An eligible inadvertent failure (EIF) may be self-corrected under EPCRS, except to the extent that:
  - The failure was identified by the Secretary prior to any actions that demonstrate a specific commitment to implement a self-correction with respect to such failure, or
  - The self-correction is not completed within a reasonable period after identification of the failure.

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Expanded Use of Self-Correction
SECURE 2.0

- Definition of eligible inadvertent failure:
  - A failure that occurs despite the existence of practices and procedures that satisfy: (i) the standards set forth in section 4.04 of IRS Revenue Procedure 2021-30 ("RP 2021-30"), or (ii) similar standards in the case of an IRA.
  - An EIF does not include any failure that is egregious, relates to the diversion or misuse of plan assets, or is directly or indirectly related to an abusive tax avoidance transaction.

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Expanded Use of Self-Correction
SECURE 2.0

- For self-correction of an EIF, the "correction period" is (generally) indefinite and has no last day, other than:
  - Failures identified by the Secretary prior to any actions that demonstrate a specific commitment to implement a self-correction with respect to the failure; or
  - A self-correction that is not completed within a reasonable period.
- EIFs relating to a loan may be self-corrected according to the rules of section 6.07 of RP 2021–30.
  - DOL to treat correction as meeting VFCP requirements.

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Expanded Use of Self-Correction
SECURE 2.0

- EPCRS to be expanded to allow IRA custodians to address EIFs with respect to IRAs, including but not limited to:
  - waivers of the excise tax under Code section 4974, and
  - rules permitting a non-spouse beneficiary to return distributions to an inherited IRA in a case where, due to an inadvertent error by a service provider, the beneficiary had reason to believe that the distribution could be rolled over without inclusion in income of any part of the distributed amount.

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Expanded Use of Self-Correction
SECURE 2.0

- IRS to issue guidance on correction methods that are required to be used to correct EIFs, including general principles of correction if a specific correction method is not specified by the IRS.
- Relief does not apply unless the correction of the EIF is made in conformity with the general principles that apply to corrections of such failures under the Code, regulations or other guidance and those principles and corrections set forth in RP 2021–30.
- IRS to revise RP 2021-30 within 2 years.
- Notice 2023-43 issued on May 25, 2023.

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Expanded Use of Self-Correction
Notice 2023-43

- A plan may self-correct an EIF before RP 2021-30 is updated, if:
  - The failure was not identified by the Secretary prior to any actions demonstrating a specific commitment to implement a self-correction with respect to the failure.
  - The self-correction is completed within a reasonable period after the failure was identified.
  - The failure is not egregious (per RP 2021-30, Section 4.10), does not directly or indirectly relate to an abusive tax avoidance transaction (per RP 2021-30, Section 4.12(2)), and does not relate to the diversion or misuse of plan assets.

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Expanded Use of Self-Correction
Notice 2023-43

- Self-correction of an EIF must also satisfy the provisions applicable to self-correction set forth in RP. 2021-30, including that:
  - Sponsor must have established practices and procedures reasonably designed to promote and facilitate overall compliance with applicable Code requirements, as described in RP 2021-30, § 4.04;
  - Sponsor must apply the correction principles and rules of general applicability set forth in RP 2021-30, § 6;
  - Sponsor may, but is not required to, self-correct using a correction method set forth in Appendix A or B of RP 2021-30; and
  - A plan sponsor may not use a correction method that is prohibited under RP 2021-30.

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Expanded Use of Self-Correction
Notice 2023-43

- A plan may not self-correct the following before RP 2021-30 is updated:
  - A failure to initially adopt a written plan
  - A failure in an orphan plan (as defined in § 5.03(1) of RP 2021-30).
  - A significant failure in a terminated plan.
  - Correction via amendment that is less favorable to participants.
  - Certain demographic failures.
  - Certain other failures related to SEPs / SIMPLEs / ESOPs.

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Expanded Use of Self-Correction
Notice 2023-43

- Provisions of RP 2021-30 that do not apply with respect to self-correction of an EIF:
  - Favorable letter requirement.
  - The prohibition of self-correction of all demographic failures and employer eligibility failures.
  - The prohibition of self-correction of significant SEP and SIMPLE failures.
  - The prohibition of self-correction of certain loan failures.

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Expanded Use of Self-Correction
Notice 2023-43

- Provisions of RP 2021-30 that do not apply with respect to self-correction of an EIF (continued):
  - Provisions relating to self-correction of significant failures that have been substantially completed before the plan or plan sponsor is under examination.
  - Requirement that a significant failure must be completed or substantially completed by the end of a specified correction period (in general, the last day of the third plan year following the plan year for which the failure occurred).

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Expanded Use of Self-Correction
Notice 2023-43

- An EIF is treated as having been identified by the Secretary when the plan or plan sponsor comes under examination, as defined in Section 5.08 of RP 2021-30.
- Accordingly, before RP 2021-30 is updated, once the plan or plan sponsor comes under examination, the EIF is no longer eligible for self-correction unless the plan sponsor has, before the plan or plan sponsor comes under examination, demonstrated a specific commitment to implement a self-correction with respect to the EIF.
    - Insignificant failures can still be corrected even if the sponsor is under exam or if the failure is discovered on exam.

CONNER WINTERS

Expanded Use of Self-Correction
Notice 2023-43

- A reasonable period is determined by considering all relevant facts and circumstances.
- Except with respect to certain employer eligibility failures, a failure that has been corrected by the last day of the 18th month following the date the failure is identified by the plan sponsor will be treated as having been completed within a reasonable period after it is identified.
- For employer eligibility failure, sponsor must cease all contributions to the plan as soon as practicable but no later than last day of 6th month after failure is identified.

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Expanded Use of Self-Correction
Notice 2023-43

"Q-8. Before Rev. Proc. 2021-30 is updated pursuant to section 305(g) of the SECURE 2.0 Act, is a plan sponsor prevented from self-correcting an Eligible Inadvertent Failure on or after December 29, 2022, merely because the Eligible Inadvertent Failure occurred prior to December 29, 2022?

A-8. No."

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Expanded Use of Self-Correction
Notice 2023-43

- Self-correction of an EIF with respect to which an excise tax or additional tax applies does not automatically result in the waiver of the tax.
    - A plan sponsor may still request that the IRS not pursue certain excise taxes or additional taxes that apply with respect to the EIF through a VCP.
- VCP can still be used to correct an EIF.

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Expanded Use of Self-Correction
Notice 2023-43

- Section 305 of SECURE 2.0 does not impose new recordkeeping requirements, but current requirements continue to apply.
- If requested upon an exam, a plan sponsor must be able to provide documentation substantiating the self-correction, such as documentation that:
  - identifies the failure, including the years of occurrence, the number of employees affected, and the date the failure was identified;
  - explains how the failure occurred and demonstrates there were established practices and procedures (formal or informal) reasonably designed to promote and facilitate overall compliance that were in effect when the failure occurred;

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Expanded Use of Self-Correction
Notice 2023-43

- If requested upon an examination, a plan sponsor must be able to provide documentation substantiating the self-correction, such as documentation that (continued):
  - identifies and substantiates the correction method and the date of the completion of the correction; and
  - identifies any changes made to those established practices and procedures to ensure that the same failure would not recur.

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Expanded Use of Self-Correction
Notice 2023-43

- If requested upon an examination, a plan sponsor must be able to provide documentation substantiating the self-correction, such as documentation that (continued):
  - identifies and substantiates the correction method and the date of the completion of the correction; and
  - identifies any changes made to those established practices and procedures to ensure that the same failure would not recur.

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The foregoing presentation is a summary of certain legislation and guidance. As with any summary, some details are omitted.

This summary should not be relied upon for legal or tax advice for particular situations.

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BENEFITS ADMINISTRATION WORKSHOP

SouthWest BENEFITS Association

MARCH 15, 2024
OKLAHOMA CITY

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

Speaker: **Marina Edwards**, Founder, Marina Retirement LLC

Speaker

Marina Edwards, Founder, Marina Retirement LLC

Marina Edwards is the founder of Marina Retirement, LLC, a boutique ERISA retirement consulting business. Marina applies her 30+ years of defined contribution plan expertise to conduct fiduciary training, vendor searches, fee benchmarking, compliance reviews, and other strategic projects (i.e., merger and acquisition due diligence and strategy) to plan sponsors and advisors. She primarily serves Fortune 500 companies and large not-for-profit entities and specializes in complex retirement plan designs and operations.

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

Presented by:

Marina Edwards, Founder
Marina Retirement, LLC

ERISA is a highly complex area of law. The information contained in this material is strictly educational in nature and is not intended as legal advice. Plan sponsors are strongly encouraged to consult with legal counsel on all ERISA matters.

Introduction

Marina Edwards, Founder

email: marina@marinaretirement.com
website: www.marinaretirement.com

- 30 Year career focused on ERISA compliance and fiduciary risk mitigation
- 20+ Years with Willis Towers Watson as Senior Consultant focused on DC plans with +$1B AUM
- Areas of specialization:
  - Fiduciary training
  - Vendor search
  - Plan governance
  - Compliance
  - Plan benchmarking

Agenda

1	Review of ERISA Fiduciary Basics
2	The RFP Process
3	Managing the Aftermath
4	RFP Toolkit ✓ Copy of Presentation with Checklists ✓ 35-Point Fiduciary Checklist ✓ Sample Starter-RFP ✓ Sample Performance Standards

Introduction to ERISA

Employee Retirement Income Security Act of 1974 (ERISA)

A federal law to …

- Protect the interests of employee benefit plan participants and beneficiaries
- Impose strict standards on those who have discretionary authority over employee benefit plans and assets (fiduciaries)
- Prohibit conflicts of interest and self-dealing
- Allow DOL and IRS to conduct random and targeted plan audits
- Allow plan participants and the DOL to sue if things go wrong
- Charge civil enforcement provisions and penalties for noncompliance

ERISA prudence

Overarching duty of loyalty

> **…a fiduciary shall discharge his duties…solely in the interest of plan participants and beneficiaries…”**

Source: ERISA § 404(a)(1)

MARINA RETIREMENT LLC
Your Fiduciary Anchor

ERISA Fiduciary Duties

Exclusive purpose

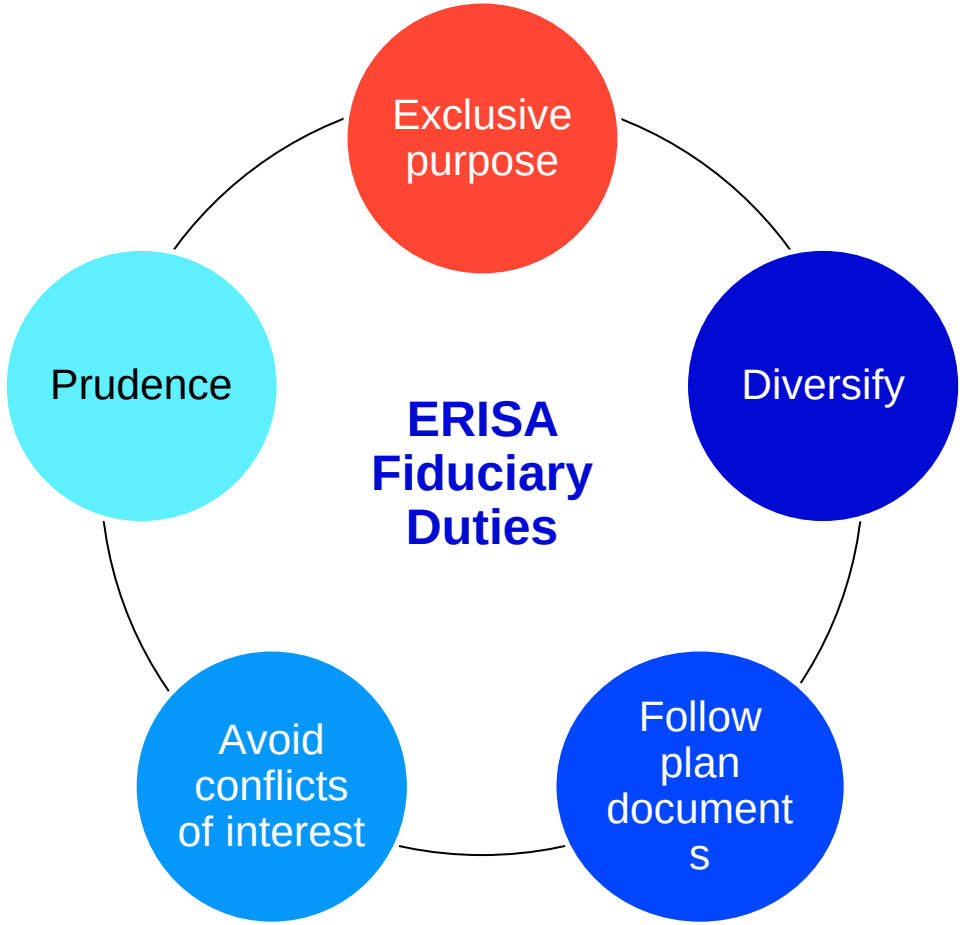
Act for the exclusive benefit of plan participants and providing plan benefits and defraying reasonable expenses of plan administration.

Prudence

Act with the care, skill, prudence and diligence under the current circumstances that a prudent man acting in a like capacity and familiar with such matters would use (hire the expertise if you don't have it). Prudence includes the responsibility to monitor fiduciary actions, decisions, appointments and delegations ***on an ongoing basis.***

Avoid conflicts of interest

Refrain from causing or permitting a plan to engage in "prohibited transactions" with any "party in interest."



Diversify

Diversify plan investments to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

Follow plan documents

Act in accordance with the "documents and instruments" governing the plan to be consistent with ERISA, which can mean more than just the official plan document – e.g., some courts include investment policy statements under the phrase "documents and instruments."

Who is a fiduciary

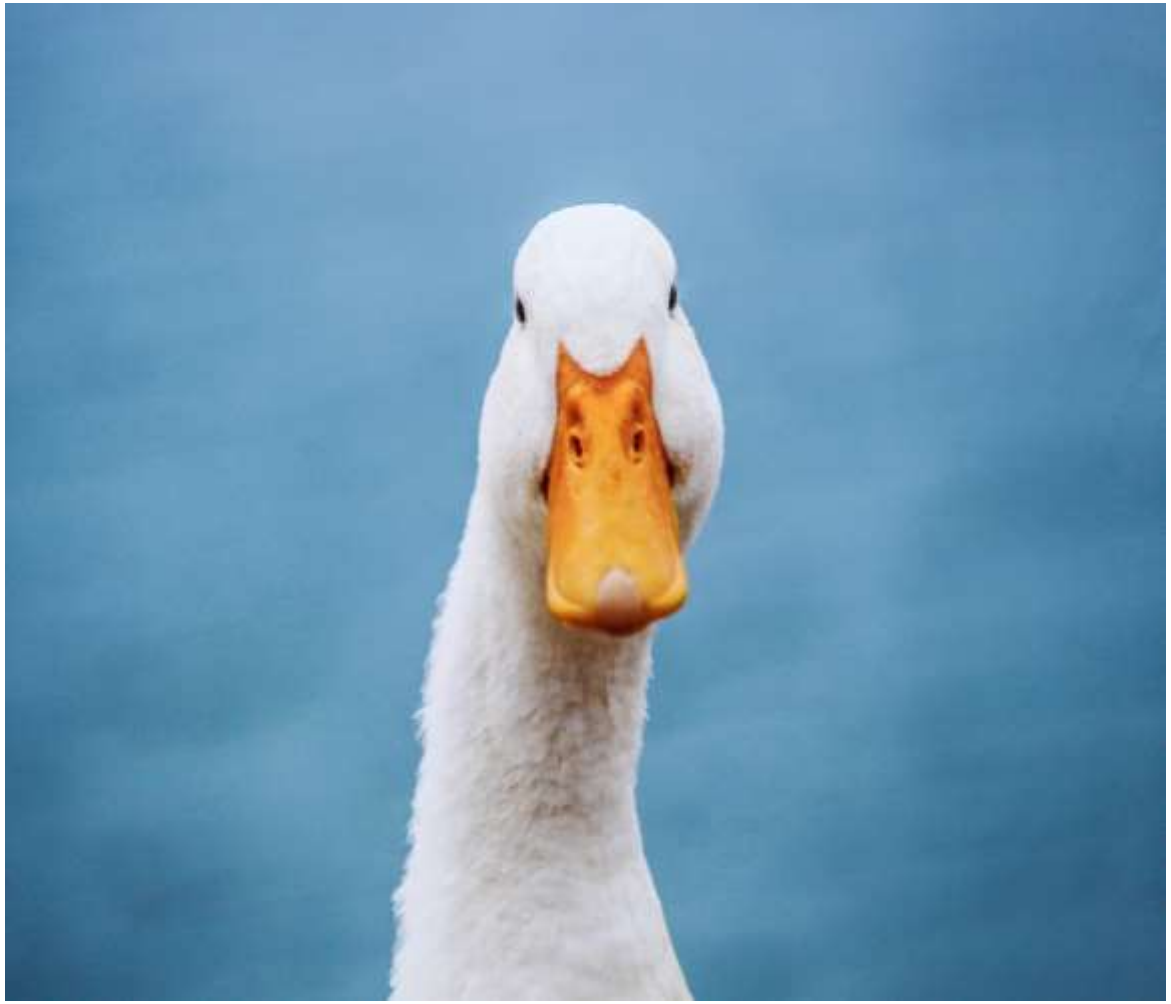
You are a fiduciary under ERISA if you:

1. Are named as a fiduciary in plan documentation, or
2. Function or act as a fiduciary
   - Has discretion over the plan administration
   - Has discretion over the plan investments and assets
   - Provide investment advice for a fee

⚠ **Limit the number of functional fiduciaries as they are often accidental fiduciaries, and not intentional**

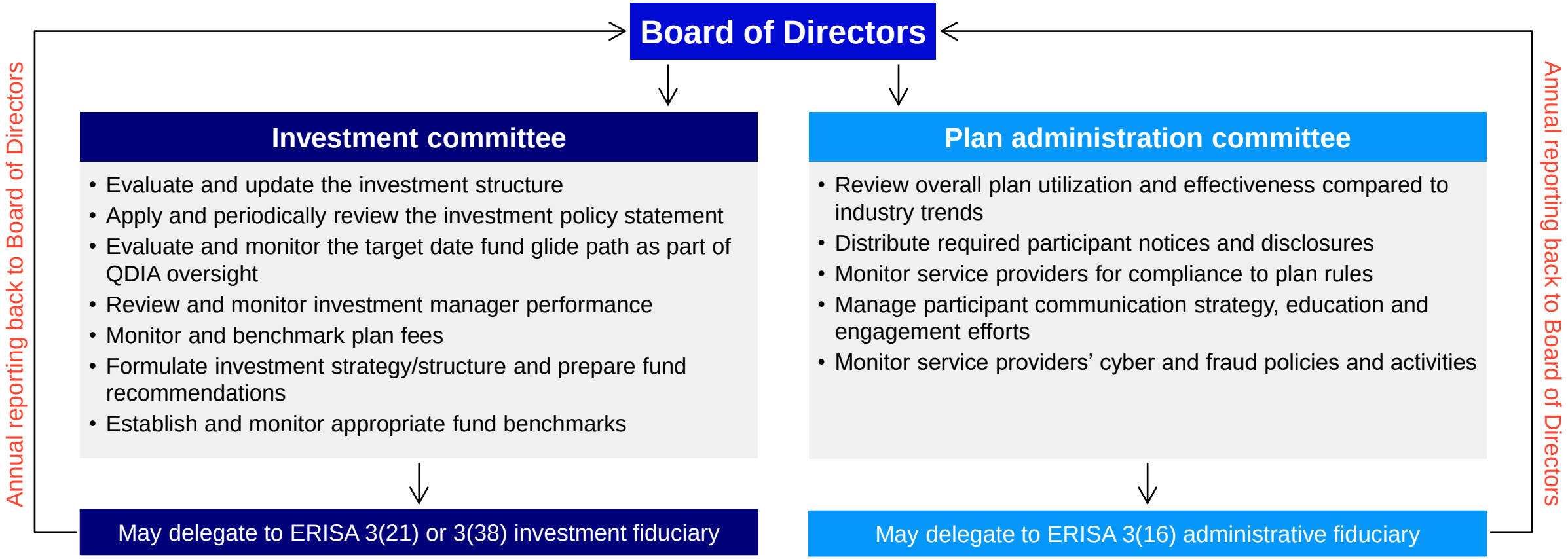
Who is typically <u>not</u> a fiduciary:

- Recordkeepers and third-party administrators
- Attorneys, auditors and consultants
- Certain financial advisors who may provide guidance *(but not advice)*



Sample fiduciary delegation and monitoring

- ERISA §402 requires any ERISA benefit plan to have a process for naming at least one overall fiduciary for that plan
- The board of directors generally delegates fiduciary duty to the committee(s) and members are generally appointed by the board, senior management or by terms of the plan document



Outsourcing investment and fiduciary services

ERISA § 3(21) Investment recommendations

- Makes recommendations
- Discusses fund manager changes
- Guides fund decisions with plan sponsor
- Makes recommendations
- No authority to make decisions alone

ERISA § 3(38) Investment decisions

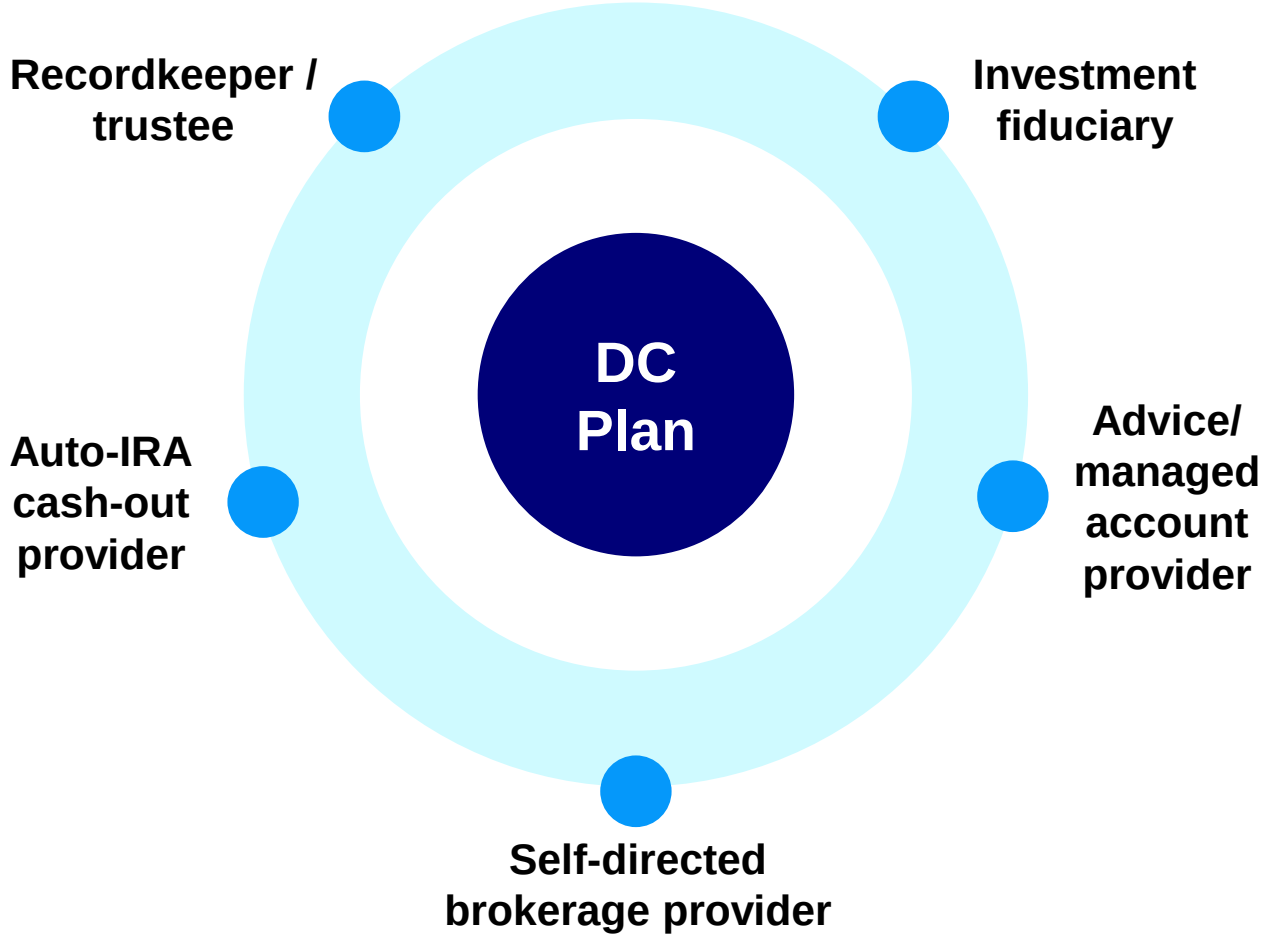
- Makes decisions
- Has full discretion
- Hire/fire all fund managers
- Solely responsible to monitor investments

ERISA § 3(16) Administrative outsourcing

- Day-to-day admin
- Required notices
- Review plan reports
- Governmental filings
- Approve plan distributions

Often overlooked: Fiduciary duty to select and monitor all plan providers

Each “bolt-on” service to the plan is a fiduciary decision that should be evaluated with an RFP.



When service providers change, new fiduciary due diligence should be conducted

More about process and documentation, and less about outcome

Process, process, process

To evaluate performance a court will normally examine the process the fiduciary followed regarding the decision or activity being examined:

- Information the fiduciary solicited
- Questions asked
- Evaluation of advice or recommendations
- Reasonableness of the decision or action

Documentation

Fiduciary decision-making and oversight process should be structured, documented and follow delegation.

- Document themes of the discussions
- Minutes should include detail, but individuals' names may be omitted

Outcome

It is more about process, as opposed to the court applying hindsight based on the outcome of the fiduciary's decisions or actions.

However, outcome is not completely irrelevant. Occasionally, there are outcomes that are egregious enough to question the prudence of the process that led to the outcome.

"A pure heart and an empty head are not enough."[1]

[1]Source: Donovan v. Cunningham, 5th Cir. 1983

Civil and criminal liability

Civil liability

- Personal exposure for plan losses and/or profits made as a result of a breach of the ERISA prudent man standard of care
- In a breach of fiduciary duty suit in which the department of labor (DOL) is a party, the agency may assess an additional penalty equal to 20% of the award or settlement amount
- Fiduciaries can be liable for breaches of other fiduciaries under a “co-fiduciary” liability standard, which generally requires knowingly facilitating/covering up the other fiduciary’s breach
- ERISA contains a 3 to 6-year statute of limitations for breach of fiduciary duty actions

Criminal liability (partial list)

- Up to $100,000 fine and/or 10 years imprisonment for “willful violation” of ERISA title I -- if convicted fine can be up to $500,000
- Penalties and/or imprisonment for theft, embezzlement, mail fraud, wire fraud, etc.
- Persons convicted of certain crimes are prohibited from serving as fiduciaries

Employee Retirement Income Security Act (ERISA), (29 USC §1001 et seq., 29 CFR Part 2509 et seq.)

The RFP Process

2

ERISA prudence

Overarching duty of loyalty

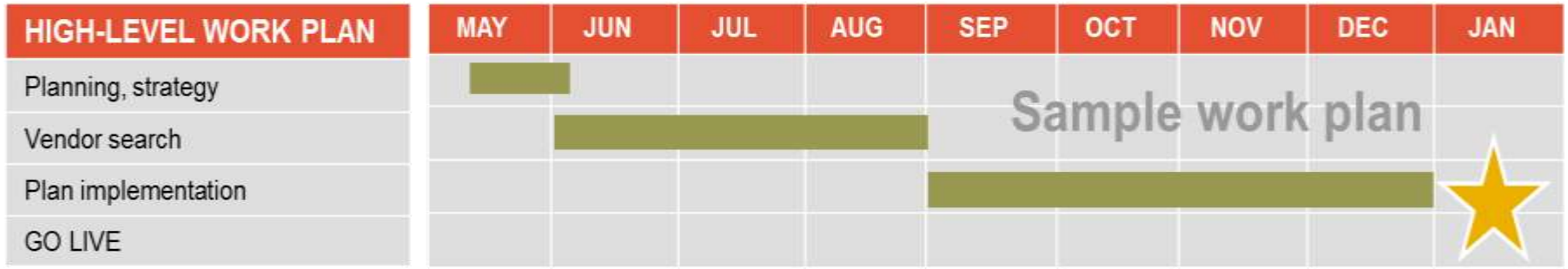
“…a fiduciary shall discharge his duties with the care, skill, prudence, and diligence … that a prudent person … would use…”

Source: ERISA § 404(a)(1)

Vendor Search Process

Plan	Search	Analysis	Selection
Weeks 1 - 2	Weeks 3 - 8	Weeks 8 - 11	Weeks 11 - 14

▪ Gather data needed for vendor search
▪ Kick-off project
  ▪ Outline deliverables, timeline, and milestones
  ▪ Set objectives
  ▪ Determine search criteria
  ▪ Discuss potential vendors
	▪ Draft and distribute RFP
	▪ Host bidder teleconference
	▪ Receive RFP responses
		▪ Score responses
		▪ Review and summarize responses
		▪ Catalog and analyze fees
		▪ Prepare Analysis Report for Committee
		▪ Review Analysis Report and select finalist candidates
			▪ Check references
			▪ Hold finalist meetings
			▪ Site visits
			▪ Fee and service negotiations
			▪ Vendor award decision
			▪ Review contracts
			▪ Establish service level agreements
			▪ Begin implementation



Sample Project Timeline

Project Milestones	Date
Kickoff meeting to set objectives	April 18
Issue RFP	May 1
Q&A: Questions from bidders due	May 8
Q&A: Answers due to bidders	May 11
RFP Responses due from bidders	May 25
RFP Analysis meeting with Committee	Week of June 12
Finalist meetings	Week of June 26
Notice of award	Week of July 3
Conversion begin date (if applicable)	Before September 1
Contract begins	January 1, 2024

Fiduciary Decision Process & Stakeholders

Discussion:

- Do you have a separate Investment and Administrative Committee?
  - How often do they meet?
  - Are there pre-meetings prior to the Committee meetings?
  - When do materials need to be distributed?
- Are there any key stakeholders outside the Committees?
- Do you have an Investment Policy Statement(s)?
- What was the most recent change in investment lineup or structure?
- Are there any changes being planned on the investments or plan design?
- Have there been any changes to the fee structure within the last few years?
- Are there any issues/concerns/strengths with current service providers?
- When was the last time that you benchmarked the plan administration fees?
- Which fees are passed through to participants, including revenue sharing?

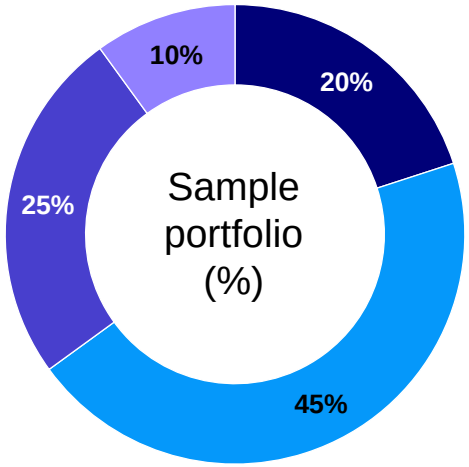
Vendor Search Goals & Objectives

Discussion:

- How will you know whether your provider search has been successful?
- What will be improved?
- What do you hope remains the same?
- What will the ideal provider look like?
- What is unusual for you that “works” and must be kept?
- What is unusual for your Plan where improvement should be sought?
- Do you seek participant advice on investment fund selection?

Guidance vs. Advice: Know the difference

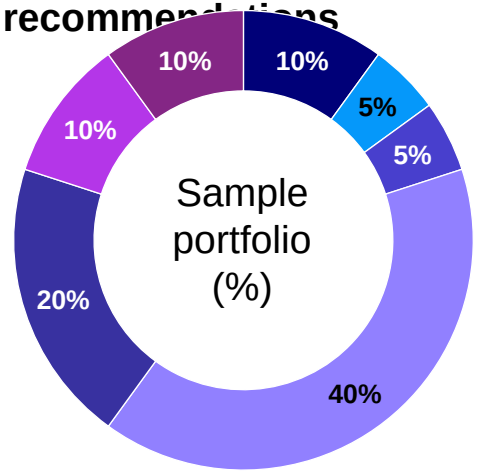
Guidance — participant receives general asset allocation



Conservative/fixed income	20%
Large cap	45%
Small/mid cap	25%
International	10%

- General financial/investment information
- Asset allocation models and education
- Interactive investment guides and tools

Advice — participant receives actual fund recommendations



Fund A	10%
Fund B	5%
Fund C	5%
Fund D	40%
Fund E	20%
Fund F	10%
Fund G	10%

- Advice on specific funds and asset allocations
- Compensated on a fee for service basis
- ⚠ **Fiduciary to the plan under ERISA §3(21)**

Key Service Criteria

Discussion:

Approach to educating participants

- Education versus guidance versus advice versus managed accounts
- Electronic versus print versus onsite meetings for content
- Provider branded materials vs. your company logo/branding

Other key aspects

- ERISA 3(16)
- Fee structure
- Data handling and quality
- Acquisition / spinoff handling
- Small cash-out IRA provider
- Service level agreement with fees at risk
- Post conversion compliance review
- Future changes under consideration
  - Plan design changes
  - Investment changes
  - Investment advice provider

Services Search Criteria and Ranking

Criteria	Considerations for New Provider	Importance (1=low…5=high)
Organization & Management	• Long term business focus with strong business leaders, stable and thriving • Services plans comparable in size to the Plan • Track record of satisfying and retaining clients	
Implementation	• Quality processes and project management • Dedicated staff • Experienced team with detailed written implementation plan	
Plan Sponsor Services	• Attentive, qualified staff • Immediate access to data at participant and plan level • Annual business planning philosophy • Consultation related to plan activity, compliance, cyber/fraud policies, etc.	
Plan Administration	• Handles unique plan features • Integrated workflow and imaging • Written plan administration manual and call center script • Payroll editing and verification processes	
Compliance	• Consultation related to recent legislation • Comprehensive testing services & support • Audit and compliance support	
Investment Capabilities	• Types of investment vehicles • Willingness to maintain current lineup, if desired • Self-directed brokerage option, advice/managed accounts, annuity solutions	
Participant Services	• Call centers, website content and functionality • Commitment to technology • Balance onsite representatives with other service channels	
Communication & Education	• Customized program designed for retail clients • Demonstrated, measurable results • Retirement planning tools and onsite counselors	

Sample vendor pool: Invite 4-5 providers to RFP process

1	Fidelity Investments	2,394
2	Empower	1,043
3	Vanguard	645
4	Principal Financial Group	555
5	Schwab Retirement Plan Services, Inc.	403
6	T. Rowe Price	315
7	Voya Financial	217
8	Transamerica Retirement Solutions LLC (Transamerica)	188
9	Bank of America Corporation	149
10	John Hancock	128

Source: Plansponsor.com 2022 Recordkeeping Survey. Top 10 Providers, by 401(k)s with >$100MM in assets

Managing the Aftermath

Prohibited transaction examples

Poor disclosure

Contracts with service providers who provide noncompliant required fee disclosures under §408(b)(2)

Late deposits

Delinquent contributions of employee salary deferrals and loan repayments to the DC plan trust. Deposit by earlier of:

- As soon as possible, or
- By the 15th business day of the month following the deferral

Plan loans

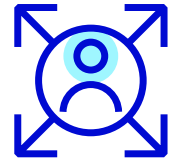
Noncompliant DC plan participant loans that do not follow the terms of the loan policy including timely repayment

Excessive fees

Payment out of trust assets of excessive fees or expenses

Pay from plan

Improper payment of plan expenses from the plan assets



Self selection

Fiduciary using their fiduciary authority to select themselves to provide services to the plan, and/or to set their own compensation

Plan documentation and required notices

- **Written plan document formalizes the plan design provisions and is the controlling document to qualified plan operation**
  - Amending a prototype plan may jeopardize reliance on the prototype's IRS opinion letter
  - Participants must receive a summary plan description (SPD) within 120 days after enrolling in the plan

- **Any plan amendments must be in writing**
  - Participants must receive a summary of material modification (SMM) within 210 days after the close of the plan year in which the modification was made

- **Carefully review service agreements for proper naming of fiduciaries, handling of Plan data, and reciprocal indemnifications**

Cybersecurity: Review service provider practices and contracts

DOL Issues guidance on managing cybersecurity risk

Establish a formal, well documented cybersecurity program

- ***DOL provides a list of 12 best practices for ERISA-covered plans***
- Identify personally identifiable information (PII) data to be protected
- Issue a Cyber/Fraud RFI with current and competing leading service providers
  - Determine how data is accessed, shared, stored, controlled, transmitted, secured and maintained
- Establish protocols and policies covering assessment of cybersecurity procedures
  - Updating, reporting, training, data retention, controlling access and third-party risks

Review service provider contracts and practices

- ***DOL provides a service provider review checklist for plan sponsors***
- Define security obligations, indemnifications, reporting and monitoring responsibilities

Communicate to participants

- ***DOL provides a retirement account tip sheet for participants***
- Educate participants on protecting their assets, what to do and who to contact if their accounts or identity has been compromised

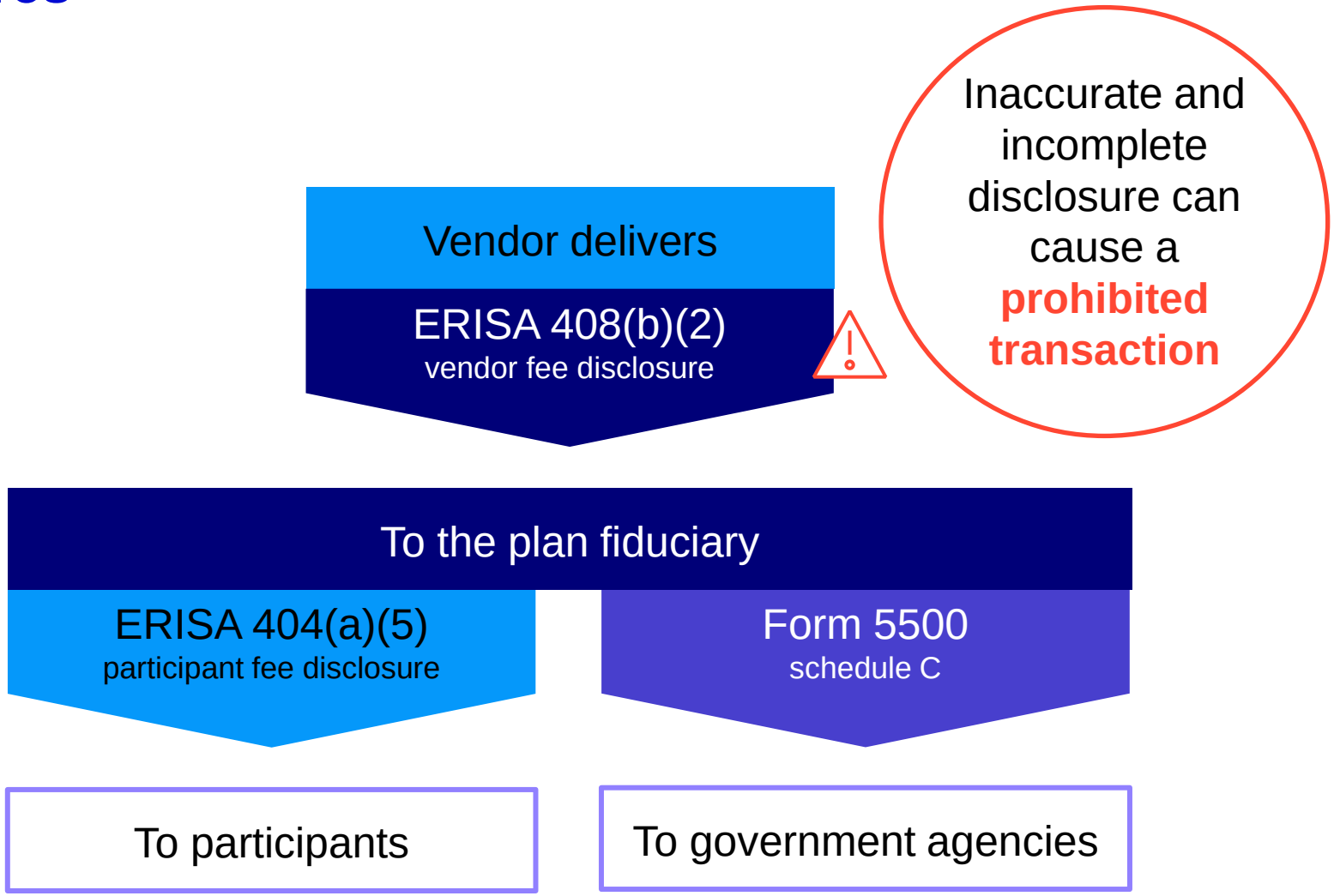
Review insurance coverages

- Understand overall insurance programs covering plans and service providers
- Evaluate whether cyber insurance has a role in a cyber risk management strategy and consider the need for a separate policy covering the DC plan

Required participant notices

Annual Notice	Yes	No
Periodic benefit statements (at least annually)	☐	☐
401(k) automatic contribution notice (for auto-enroll)	☐	☐
401(k) safe harbor notice	☐	☐
Qualified default investment alternative (QDIA) notice	☐	☐
Summary annual report (SAR) (for 5500 highlights)	☐	☐
Notice of rights of divestiture of employer securities	☐	☐
Notice of trading blackout periods	☐	☐
Participant fee disclosure (initial and annual), §404(a)(5)	☐	☐

Plan fee disclosures



Service provider fee disclosure – ERISA §408(b)(2)

Failure of the covered service provider to provide ERISA 408(b)(2) disclosure can cause the plan fiduciaries to incur a prohibited transaction.

	Covered service providers required disclosure	Yes	No
01	**Description of services to be provided**	☐	☐
02	**Status of covered service provider (CSP)** (or affiliate or subcontractor), if applicable • As fiduciary to plan or to investment product holding plan assets • As registered investment adviser (under state law or investment advisers act of 1940) to plan	☐	☐
03	**All direct compensation to be received** (either in aggregate or by service)	☐	☐
04	**All indirect compensation to be received** (describing services and payer)	☐	☐
05	**Any related party compensation** (paid among CSP, affiliate, or subcontractor) **if set on a transaction basis, or charged directly against plan's investment and reflected in net value of investment** (including identification of services, payers and recipients, and status of payer and recipient as affiliate or subcontractor)	☐	☐
06	**Any termination compensation, including how any prepaid amounts will be calculated and refunded**	☐	☐
07	**Description of manner of receipt** (e.g., Billed or deducted)	☐	☐

Service provider fee disclosure – ERISA §408(b)(2) additional disclosures

Recordkeeping:

Covered Service Providers Required Disclosure		Yes	No
01	**Description of all compensation** (direct and indirect) **for recordkeeping services** (to be received by CSP, affiliate or subcontractor)	☐	☐
02	**If no explicit compensation for recordkeeping services is disclosed** (or if offset by other compensation received)**, a reasonable, good faith estimate of recordkeeping service cost** (including estimate assumptions, methodology, and explanation of recordkeeping services)	☐	☐
03	**Description of manner of receipt** (e.g., billed or deducted)	☐	☐

Investments:

Covered Service Providers Required Disclosure		Yes	No
01	**Description of any compensation** (charges/fees/loads) that will be charged directly against amount invested (i.e., "transactional", such as acquisition, sale, transfer of, withdrawal from investment product)	☐	☐
02	**Description of annual operating expenses** (e.g., expense ratio) **if return not fixed**	☐	☐
03	**Description of any other ongoing expenses** (e.g., wrap fees, mortality & expense fees)	☐	☐

Participant fee disclosure – ERISA §404(a)(5)

Plan administrators are required to provide certain disclosures to all eligible participants in a plan annually. Such information includes, but is not limited to:

Investment-related information

- ❑ Name of investment option
- ❑ Name of investment managers
- ❑ Fees, including expense ratios associated with the investment
- ❑ 1, 5 and 10-year returns for the investment and corresponding benchmark return
- ❑ A website address to be able to obtain additional information about each of the investments
- ❑ Certain types of investments such as annuity contracts and fixed return investments, have their own disclosure requirements

Plan-related information

- ❑ An explanation of how participants may direct their accounts and any limitations to directing their accounts
- ❑ A description of the brokerage window (if one is offered)
- ❑ An explanation of all fees and expenses associated with participating in the plan and investing in certain funds

Conversion considerations: Investments

1. Mapping assets to same/like funds vs. re-enrolling all participants to age-appropriate target date funds
2. Evaluate QDIA into managed accounts vs TDF
3. Careful consideration of any proprietary fund utilization and fee credits
4. Short term redemption fees on any plan investment option (including SDBA funds)
5. Self-directed Brokerage Account (SDBA) share class availability
6. Comparison of SDBA trading fees/commissions to “current fees”
7. Comparison of SDBA cash sweep vehicle and expense ratio to “current”
8. Carefully ensure proper source taxation if Roth is allowed in SDBA
9. Ensure proper handling of Stable Value equity wash rules
10. Loss of historical performance of account balance (can this be captured and loaded to new platform?)
11. Manager notification of fund liquidation and ensure same day buy/sell
12. Blackout period communication and coordination
13. Establish 404(c) compliance process
14. Review new fee disclosures for completeness and accuracy under 408(b)(2) and 404(a)(5)
15. Fee structure changes (participant asset based fees, flat dollar fee, paid by whom)

Conversion considerations: Administrative

16. Establish new record layout requirements with payroll early
17. Timing of zero balance on participant quarterly statements
18. Zero balance of trust reports for audit issues
19. Establish timing of enrollment window for new hires
20. Service level agreements / performance standards / conversion guarantee
21. Plan Requirements documents
22. Plan Source consolidation / reconciliation
23. Communications: Summary plan guides, announcement letter, FAQ's
24. Update SPDS, enrollment kits, mail new PIN letters
25. Communicate to new hires of upcoming transition (courtesy)
26. Small balance cash-outs
27. Stale-dated check report
28. Pre-conversion participant loan compliance review
29. Post-conversion compliance review
30. Expect issues to arise during conversion and navigate them with persistence

RFP Toolkit:

Copy of Presentation and Checklists
Sample Starter-RFP for Plan sponsors
Sample Vendor Performance Standards

4

Request by email:
marina@marinaretirement.com

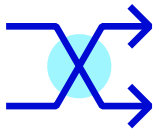
www.linkedin.com/in/marinaretirement

ERISA fiduciary checklist

Governance

1. Create a governance charter document that outlines the fiduciary delegation, formal acceptance, and monitoring process.
2. Carefully use “Plan Sponsor” and “Plan Administrator” in documents.
3. Carefully select committee members for expertise and conflicts (CEO/CFO/Legal).
4. Conduct annual fiduciary training and document the attendees and materials covered.
5. Carefully craft fiduciary committee minutes to capture enough detail on process, but not too much detail where it could be questioned in court.
6. Review insurance for cyber/plan coverage (Fidelity bond, fiduciary policy, cyber, errors & omissions).
7. Hire expertise where needed [(3(21) vs. 3(38) investment consultant, independent fiduciary, consultant].
8. Conduct vendor search of all service providers every 5-6 years (recordkeeper, trustee, managed accounts, brokerage, auto-IRA, investment consultant).
9. Benchmark service providers fees and service every 1-2 years; document any “Indirect Compensation” from rollover IRAs, managed accounts, brokerage accounts, float income, revenue sharing.
10. Consider use of Attorney-Client Privilege if timing on vendor search and/or fee benchmarking are stale.
11. Add fiduciary detail to annual audit report (last date of fee benchmarking, share class review, use of revenue sharing, etc.).

ERISA fiduciary checklist



Investments

12 Document fund structure rationale as a clear deliberate fiduciary decision (active vs. passive) and watch for overlapping funds.

13 Ensure each fund has meaningful benchmarks.

14 Continually monitor each fund for lowest share class including CITs and separate accounts.

15 Carefully evaluate any proprietary fund use: revenue sharing, performance, share class.

16 Credit revenue sharing back to participants (vs. paying plan fees); evaluate funds' "net expense" after revenue credits are applied.

17 Continually monitor fund performance to meaningful benchmarks and peer groups, including any funds frozen to new contributions.

18 Annually review QDIA selection using DOL guidelines and monitor participant utilization.

19 Monitor self-directed brokerage provider fees/service and participant utilization.

20 Monitor custom TDF fiduciary for reasonable glidepath; use plan data to help determine a "to or through" glidepath.

21 Consider hiring an independent fiduciary for company stock; document decision to unitize with cash position or not (share accounting); document cash "drag" on fund performance.

ERISA fiduciary checklist

Plan fees

22 Evaluate fee structure (asset based, flat dollar, or hybrid) and document rationale; ensure asset-based fees are capped.

23 Employer to pay participant fees (reduces potential harm to participants).

24 Review both plan sponsor and participant fee disclosure for accuracy (hidden revenue in float, SDBA sweep vehicles, managed accounts).

Plan documentation

25 Consider adding mandatory arbitration clause to plan document to deter class-actions.

26 Consider adopting fiduciary policies to document process: Investment, fee, cyber/fraud, education – if adopted, it must be followed.

27 Review service contracts for cyber/fraud language including make-whole protection.

28 Review service contract for cross-sell language and who owns the data (require no cross-selling without participant consent).

ERISA fiduciary checklist

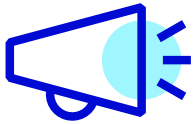
Plan administration

29 Create fiduciary file on cyber/fraud evaluation (issue RFI, review insurance, communicate with participants, review DOL audit questions).

30 Review service provider SOC 1 and 2 reports annually and address any deficiencies.

31 Conduct periodic compliance reviews of plan operation especially missing participants, plan loans and definition/use of plan compensation.

32 Review loan program for use of collateralized “Plan Loans” (vs. normal participant loans) in 403(b) plans.



Plan communications

33 Carefully draft employee communication to not overly promote “improved”, “lower cost.”

34 Communicate cyber/fraud risk to participants with annual reminder to check account activity.

35 Monitor participant fund selection (heavy allocation to multiple TDFs, stable value, company stock, etc.).

Thank you!

BENEFITS ADMINISTRATION WORKSHOP

SouthWest BENEFITS Association

MARCH 15, 2024
OKLAHOMA CITY

Session 3 - The RFP Process and Managing the Aftermath: Best Practices & Fiduciary Responsibilities

Speaker: **Judy Burdg**, Shareholder and Practice Group Leader, McAfee & Taft

Speaker

Judy Burdg, Shareholder and Practice Group Leader, McAfee & Taft

Judy is an ERISA attorney and her practice encompasses a broad range of employee benefits matters involving retirement plans, health and welfare plans, and executive compensation. Judy's employee benefits practice is focused on the design, implementation and administration of various forms of retirement and health plans, including 401(k) plans, 403(b) plans, defined benefit plans, collectively-bargained pension plans, employee stock ownership plans (ESOPs), employer-sponsored health plans, wellness programs, and medical plans to cover on-the-job injuries compensable under the Oklahoma Employee Injury Benefit Act.

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

SWBA Benefits Administration Workshop

March 15, 2023

McAfee & Taft

TYPES OF TRANSACTIONS

- The structure of the transaction (asset vs equity) typically determines what approach the parties take with respect to employee benefit plans
  - Asset transaction – buyer can generally choose whether to assume seller's plans
  - Equity transaction - buyer "steps into the shoes" and generally assumes the plans and associated liabilities as a matter of law; diligence will be more extensive

DUE DILIGENCE PROCESS

- Due diligence is the process by which the parties exchange information so that each side can assess risk
- Buyer needs to understand the seller's benefit plans and asses potential risks
- Seller must identify all benefit plans and be prepared to make representations about their operation and administration

DUE DILIGENCE PROCESS (CONT.)

- How to prepare
  - identify what employee benefit plans you have and ensure you have the appropriate documentation for each
  - keep records of vendor contracts
  - keep records of governmental filings and correspondence
  - keep records of compliance and corrections issues
  - have a clear understanding of controlled group and affiliated service group issues

DUE DILIGENCE PROCESS (CONT.)

- Retirement plans
  - IRS determination letter and timely amendment for changes in the law
  - Operational compliance and correction issues
  - Nondiscrimination testing
  - Ability to amend and terminate
  - Accrued but unpaid obligations
  - Funding issues
  - Past, pending or threatened litigation

DUE DILIGENCE PROCESS (CONT.)

- Health and welfare plans
  - Fully insured vs self-insured
  - Operational compliance
  - Ability to amend and terminate
  - COBRA compliance
  - ACA compliance and reporting
  - MEWAs
  - Accrued but unpaid premiums
  - Past, pending or threatened litigation

DUE DILIGENCE PROCESS (CONT.)

- Executive compensation plans
  - NQDC plans, equity or equity-like compensation, etc.
  - Copies of plans, employment agreements, grants/awards, etc.
  - 409A compliance (if applicable)
  - 280G compliance (if applicable)
  - Operational compliance
  - Past, pending or threatened litigation

THE PURCHASE AGREEMENT

- Representations and Warranties
- Covenants
- Responsibilities of the Parties Before Closing
- Price Adjustments, Indemnification, and Escrows
- Disclosure Schedules
- Transitions Services Agreements
- Responsibilities of the Parties After Closing

REPRESENTATIONS & WARRANTIES

- Enforceable promises that consist of statements concerning a past or existing fact.
- Heavily negotiated and vary depending on the business being acquired
- Typically focus on the issues that have arisen during due diligence that present the greatest potential cost or exposure after closing

REPRESENTATIONS & WARRANTIES (CONT.)

- General Purposes
  - obtain factual disclosures;
  - provide a basis for a party's right to terminate the transaction before or at the closing; and
  - provide a basis for indemnification and other contractual remedies if it turns out after the closing that one or more of the seller’s representations were not accurate and resulted in liability to the buyer.

REPRESENTATIONS & WARRANTIES (CONT.)

- Employee benefit plans representations
  - Plan documentation
  - Plan administration and compliance
  - Plan qualification
  - Withdrawal liability
  - COBRA
  - Retiree health and welfare
  - Claims/litigation (other than routine claims for benefits)
  - Executive compensation (409A and 280G)

AFFIRMATIVE AND RESTRICTIVE COVENANTS

- Employee Benefit Covenants
  - What employee benefits will be provided to employees after the transaction closes
    - Seller may require buyer to make covenants with respect to the offers of employment and compensation and benefits post-closing
    - May require maintenance of a certain level of benefits

AFFIRMATIVE AND RESTRICTIVE COVENANTS (CONT.)

- Retirement Plan Choices
  - terminate the seller's plan before the closing
  - freeze the seller's plan as of the closing
  - continue the seller's plan after the closing
  - transfer assets from the seller's plan after the closing
  - merge or spin off the seller's plan to the buyer’s plan after the closing
  - accept participant elective transfers into the buyer’s plan from the seller's plan

AFFIRMATIVE AND RESTRICTIVE COVENANTS (CONT.)

- Heath and Welfare Choices
  - continue seller's plans—assuming that this is possible (or practical) given the type of transaction involved
  - establish "mirror" plans for the transaction-related employees
  - amend existing plans to cover transaction-related employees
  - establish new plans that do not mirror prior benefits

AFFIRMATIVE AND RESTRICTIVE COVENANTS (CONT.)

- Executive Compensation Choices
  - Terminate plan(s) pre-closing
  - Assume plan(s)
  - Plan aggregation requirements
  - Transactions payouts
  - Release agreements

AFFIRMATIVE AND RESTRICTIVE COVENANTS (CONT.)

- Covenants that may aid in a smooth transition
  - Qualified retirement plans
    - Termination of the plan; crediting eligibility and vesting, addressing 401(k) plan loans, etc.
  - Health and welfare plans
    - Eligibility; crediting deductibles, co-pays, and out-of-pocket maximums; COBRA M&A qualified beneficiaries; FSA contributions; PTO

AFFIRMATIVE AND RESTRICTIVE COVENANTS (CONT.)

- Transition Services Agreement
  - agreement requiring a seller to continue to provide certain services to the buyer in connection with the sale of the business
  - common because certain services that are essential to the business sold are intertwined with the seller's own operations and not included in the sale
  - allows parties to enter into transactions without the delay that would otherwise be necessary for a buyer set up or secure all the core operations and support services necessary to run the purchased business

DISCLOSURE SCHEDULES

- Critical to the Buyer so it is aware of issues related to the target company and critical to the Seller so it can make appropriate disclosures and avoid potential liability in the future
- If the business has substantial operations this part of the transaction is often more time intensive than the actual negotiation and preparation of the Purchase Agreement

EMPLOYEE COMMUNICATIONS

- The M&A transaction process can be lengthy and cause uncertainty among employees
- Regardless of the type of transaction, great care should be taken in communicating with employees of the affected entities during the M&A negotiation period and immediately following the closing of the M&A transaction, particularly with respect to benefits and employment issues

EMPLOYEE COMMUNICATIONS (CONT.)

- Confidentiality provisions may complicate the situation
- The parties should discuss how communications to the seller's employees will be handled (e.g., who will speak on behalf of each party, who will answer questions, and how employee communications will be made)
- Unless precluded by confidentiality provisions pre-closing, any communications to employees should be made jointly by the buyer and seller

EMPLOYEE COMMUNICATIONS (CONT.)

- If joint communications are not possible, then the buyer and seller should agree that a party wishing to make an employee communication will provide notice to the other party before doing so
- Not uncommon for the buyer and seller to review and agree beforehand on any written communications made during the M&A negotiation period

LESSONS LEARNED

- Transition rules
- Leave issues
- SIMPLE IRAs
- Participant loan issues
- Employee communication issues
- Union negotiations
- Executive compensation issues

Questions?

BENEFITS ADMINISTRATION WORKSHOP

FEBRUARY 15, 2024 HOUSTON

SouthWest BENEFITS Association

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

Speakers: **Beth Allen**, Attorney, Allen Benefits Law
Brandi Price, Auditor/Acting 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.

Brandi Price, Auditor/Acting Sr. Advisor for Health Investigations, U.S. Department of Labor
Brandi Price joined the U.S. Department of Labor Employee Benefits Security Administration (EBSA) as an Auditor in December 2019. She has worked as an Acting Sr. Advisor-Health Investigations (SAHI) since January 2024, while also continuing to investigate various health and retirement plans to ensure they comply with the Employee Retirement Income Security Act (ERISA). As Acting SAHI, she assists fellow investigators/auditors with their health investigations.

MENTAL HEALTH PARITY

HOW TO COMPLY WITH DOL REGULATIONS

Beth Allen
Attorney
Allen Benefits Law

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

1996
Mental Health Parity Act

2008
Mental Health Parity and Addiction Equity Act

2010
Patient Protection and Affordable Care Act

2012
First DOL Report to Congress on MHPAEA

2016
DOL Publishes NQTL "Warning Signs" Checklist

2018
DOL Publishes First MHPAEA Self-Compliance Tool

2020
COVID-19 Hits

December 27, 2020
CAA, 2021 Requires NQTL Comparative Analysis

2022 & 2023
DOL Issues Reports to Congress

August 3, 2023
DOL Publishes Proposed Rules on NQTLs

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.

Compliance Assistance on Mental Health Parity

U.S. DEPARTMENT OF LABOR
EMPLOYEE BENEFITS SECURITY ADMINISTRATION

Who is Subject to Mental Health Parity?

- Employer-sponsored health plans and health insurance issuers offering health insurance coverage for medical/ surgical benefits **AND** mental health/substance use disorder benefits
- Private employer plans with 51+ workers
- Most smaller employer plans
- Health insurance coverage sold to individuals (i.e. Marketplace plans)

Must A Business Offer These Benefits?

Federal mental health parity does **not require** group health plans or issuers to provide **mental health/substance use disorder benefits,** but does require that **when such benefits are offered**, they be offered **in parity.**

What Protections Does Mental Health Parity Provide?

- All **financial restrictions** and **treatment limitations** applicable to MH/SUD benefits must be **comparable to** the requirements or limitations applied to medical/surgical benefits

Financial requirements	**and**	**Treatment limitations**
- copays, deductibles, coinsurance, out-of-pocket max		- visit/day limits, duration of treatment, preauthorization reqs

General Mental Health Parity Requirements

- Prohibited:
  - **Lifetime and annual dollar limits** on MH/SUD benefits that are **lower than** those limits imposed on medical/surgical benefits*
  - **Cumulative financial requirements** or **cumulative quantitative treatment limitations** for MH/SUD benefits **that accumulate separately** from medical/surgical benefits in the same classification
- Required
  - Disclosures on **criteria for medical necessity** and **reasons for denial**

Classification of Benefits

- Plans must classify mental health and substance use disorder benefits within **six classifications**:
  - Inpatient, in-network
  - Inpatient, out-of-network
  - Outpatient, in-network
  - Outpatient, out-of-network
  - Emergency care
  - Prescription drugs

Financial Requirements and Quantitative Treatment Limitations

- If a plan provides MH/SUD benefits in **any** classification, MH/SUD must be provided in **every** classification in which medical/surgical benefits are provided

- A plan **may not** impose a requirement or limitation to MH/SUD benefits that is **more restrictive** than the **predominant** financial requirement or treatment limitation of that type that is applied to **substantially all** medical/surgical benefits in the same classification.

Financial Requirements and Quantitative Treatment Limitations - Example

- Example: Josh is insured by X Health Plan:
  - **Psychiatrist** (Outpatient, in-network Mental Health) Copay: **$75**
  - **Primary Care** (Outpatient, in-network Physical Health) Copay: **$20**

- **Impermissible** – the financial requirement applicable to MH/SUD benefits are **not comparable** to the financial requirement applied to medical/surgical benefits in the outpatient, in-network classification.

Financial Requirements and Quantitative Treatment Limitations - Summary

General Rule Analysis – Need to identify the…

1. **Classification** (outpatient, in-network, etc)
2. **Type** of financial requirement or quantitative treatment limitation
3. **Predominant** level of copay applied to **substantially all** medical/surgical benefits within the classification
4. **RESULT** – This is the **most restrictive copay** that can be applied to MH/SUD benefits

Financial Requirements and Quantitative Treatment Limitations

Special Rules

- Multi-Tiered Prescription Drug Benefits
- Multiple Network Tiers
- Sub-classification for office visits, separate from other outpatient services

Nonquantitative Treatment Limitations (NQTLs)

- **Non-quantitative** treatment limitations **also require parity**
- General rule:
  - A plan **may not impose** NQTLs on MH/SUD benefits in any classification **unless** any processes, strategies, evidentiary standards, or other factors used in applying that NQTL are **comparable to** and **apply no more stringently** than other factors that are used in applying that NQTL to Med/Surg benefits in the classification.

Nonquantitative Treatment Limitations (NQTLs)

- An NQTL is a limitation on the **scope or duration** of benefits for treatment
  - Such as medical necessity determinations, or fail-first policies
- Generally not expressed numerically
- A plan **may not** impose an NQTL that is a separate treatment limitation **applicable only to MH/SUD** benefits

Nonquantitative Treatment Limitations (NQTLs) - Examples

EXAMPLE - Medical management standards that limit benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative

EXAMPLE - **Preauthorization** or concurrent review standards

EXAMPLE - Standards for provider admission to participate in a **network**, including reimbursement rates

Nonquantitative Treatment Limitations (NQTLs)

- Compliance is required as written **and** in operation
- Plans are allowed to consider **clinically appropriate standards of care**
- **Do not focus on the results** – outcomes are not necessarily the same.
  - However, a plan cannot have an NQTL that is applicable **only** to mental health or substance use disorder benefits.

Nonquantitative Treatment Limitations (NQTLs) – Examples continued

EXAMPLE - Plan methods for determining usual, customary and **reasonable charges**

EXAMPLE - Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (i.e. **step-therapy** or **fail-first policies**)

EXAMPLE - Restrictions based on **geographic location**, facility type and **provider specialty**, etc that limit the scope or duration of benefits for services

NQTL Warning Signs

Blanket preauthorization requirements

- ✓ Preauthorization required for all MH/SUD services

Treatment facility admission preauthorization

- ✓ If admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, the insured will be responsible for 100% of the cost of services received

Prescription Drug Preauthorization

- ✓ Preauthorization is required every three months for pain medications prescribed in connection with MH/SUD conditions

NQTL Warning Signs

Treatment Attempt Requirements –

- ✓ For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program

Likelihood of Improvement –

- ✓ For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement

Treatment Plan Submission on a Regular Basis –

- ✓ Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months

NQTLs – Questions to Ask

Questions you might ask while conducting an NQTL analysis:

- Does the application of the NQTL include similar requirements for medical/surgical and MH/SUD in writing and in operation?
- Is the reasoning for applying the NQTL to MH/SUD benefits supported by evidence, and is the evidence being used in a comparable way?
- Is the process used in applying the NQTL similar or comparable?

NQTLs – Questions to Ask

- Are differences arbitrary?
- Are differences in the application of the NQTL to MH/SUD benefits consistent with practice guidelines?
- Is it harder to "pass" the NQTL for MH/SUD than it is for medical/surgical?
- Are the consequences more severe for failing to meet the NQTL requirements as they apply to MH/SUD benefits?

Guidance on the Appropriations Act – Mental Health Parity Requirements

- The plan or issuer should have available documentation included in the comparative analysis:
  - NQTL **processes and application** to ensure it can demonstrate compliance with the law
  - Anything it has relied on to determine that the NQTLs apply **no more stringently** to MH/SUD benefits
  - Samples of **covered and denied** MH/SUD and medical/surgical benefit claims
  - Documents related to parity compliance with respect to **service providers**
- Participants and beneficiaries can request the comparative analyses and other applicable information from their plan

Increased Enforcement under the Consolidated Appropriations Act

- **<u>Initial</u> finding of noncompliance**
  - Plan or issuer takes corrective actions and provides the Departments additional comparative analyses **within 45 days**.

- **<u>Final</u> determination of noncompliance**
  - Plan or issuer notifies all covered individuals **within 7 days**,
  - Departments **share findings** with the State and **notify Congress** in a publicly-available annual report.

Guidance on the Appropriations Act – Mental Health Parity Requirements

Comparative Analysis - NQTL Element	Example of Insufficient NQTL Comparative Analysis
Clear description of specific NQTL, plan terms, and policies at issue	Conclusory or **generalized statements**, including mere recitations of the legal standard, **without specific supporting evidence** and detailed explanations

Guidance on the Appropriations Act – Mental Health Parity Requirements

Comparative Analysis - NQTL Element	Example of Insufficient NQTL Comparative Analysis
Identify factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL, and in **determining which MH/SUD benefits** and medical/surgical benefits are subject to the NQTL	Production of large volume of documents **without a clear explanation** of their relevance to the comparative analysis

Guidance on the Appropriations Act – Mental Health Parity Requirements

Comparative Analysis - NQTL Element	Example of Insufficient NQTL Comparative Analysis
Analyses should explain if there is **any variation** in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits	Identification of processes, strategies, sources, and factors **without clear and detailed analysis** or explanation of how they were defined and applied

Guidance on the Appropriations Act – Mental Health Parity Requirements

Comparative Analysis - NQTL Element	Example of Insufficient NQTL Comparative Analysis
Discussion of the findings/conclusions as to the **comparability** of the processes, strategies, evidentiary standards, factors, and sources within each affected classification, and their relative stringency, **both as written and as applied**	Reference to factors and evidentiary standards that were defined or applied in a **quantitative** manner, **without the precise definitions**, data, and information necessary to assess their development or application

Mental Health Self-Compliance Tool

- **Who is it for?**
  - Group health plan sponsors and administrators, health insurance issuers, State regulators, and other stakeholders
- **What does it do?**
  - Helps determine whether a group health plan or health insurance issuer complies with the mental health parity laws
- Updated every **two years** (most recently 2020)

Best Practices for Establishing an Internal Compliance Plan Continued

- **Conducting internal monitoring and regular compliance reviews**
  - Auditing samples of adverse benefit determinations
  - Clear protocols in delegating management of benefits to another entity

- **Responding promptly to detected offenses and developing corrective action plans**
  - Includes retroactive relief and notice to potentially affected participants

Mental Health Self-Compliance Tool

- The Tool contains:
  - **Updated examples** that demonstrate how plans and issuers can correct certain parity violations
  - Practices that may be **warning signs** of potential parity violations
  - **Best practices** for establishing an internal mental health compliance plan
  - Appendix I – **additional examples** and illustrations of compliance
  - Appendix II – Provider Reimbursement Rate Warning Signs

Other Mental Health Parity Guidance and Publications

- **FAQs**
  - Guidance is released on an ongoing basis to help stakeholders understand the law, including 66 frequently asked questions (as of August 2021).
- Biennial DOL **reports to Congress** on mental health parity implementation and enforcement
- Mental health parity enforcement **fact sheets** (fiscal years 2015-2020)
- Other **publications** on mental health benefits

U.S. Department of Labor Mental Health Parity Resources

- For more information about the federal mental health and substance use disorder law:
  - EBSA's dedicated Mental Health Parity page - https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
  - Your state's department of insurance website and contact information, which can be found on the National Association of Insurance Commissioners website – https://content.naic.org/cmte_b_mhpaea_wg.htm
  - The Substance Abuse and Mental Health Services Administration (SAMHSA) Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) website: www.samhsa.gov
  - For more specific questions you can also contact a benefits advisor by visiting askebsa.dol.gov or calling 1-866-444-3272

Questions?

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: **Mark Bodron**, Associate General Counsel-ERISA, Lumen Technologies
Cesar Santiago, Sr. Benefits Advisor, U.S. Department of Labor, EBSA

Speakers

Mark Bodron, Associate General Counsel-ERISA, Lumen Technologies
Mark is Associate General Counsel at Lumen Technologies, Inc. in Monroe, Louisiana. He advises the company on compliance, design and ERISA fiduciary matters for Lumen's retirement and welfare plans and executive compensation arrangements. He also supports the Human Resources and Compensation Committee of the Lumen Board of Directors.

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.

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

SWBA 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).

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.

COBRA Administration

Compliance Pitfalls and Successfully Partnering with your Vendor

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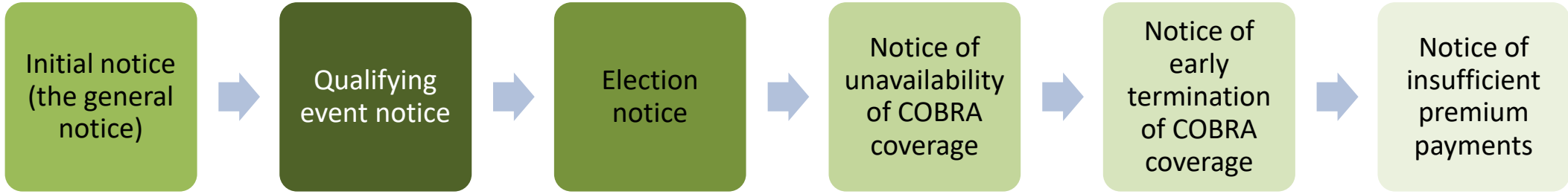
COBRA

- 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.

COBRA: Notice Requirements



COBRA Delivery of Notice

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

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

Relationships

Communication

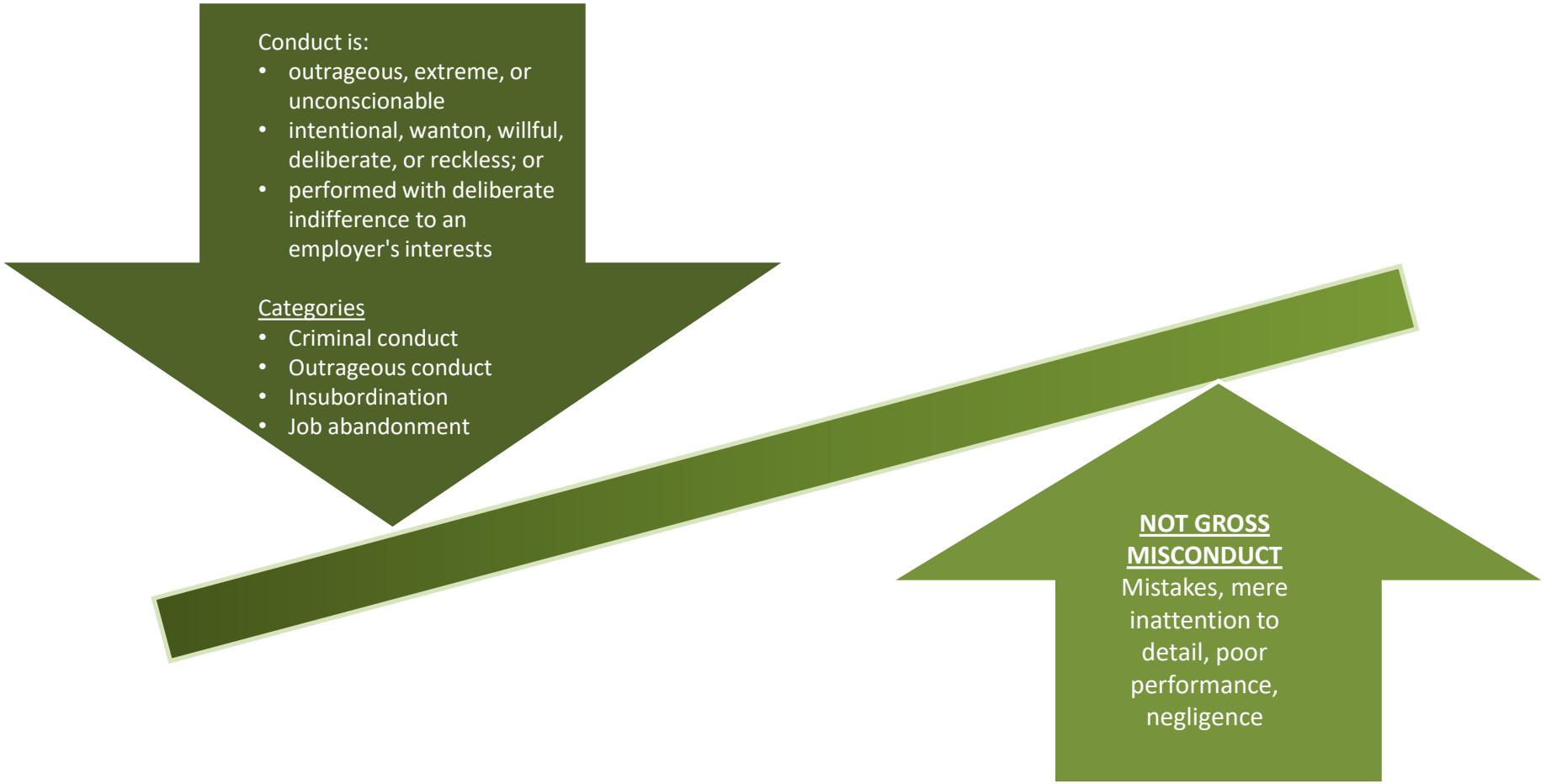
Budgeting and Staffing

Know-How

Results

COBRA: Qualifying Events

COBRA: Gross Misconduct Exception



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**

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

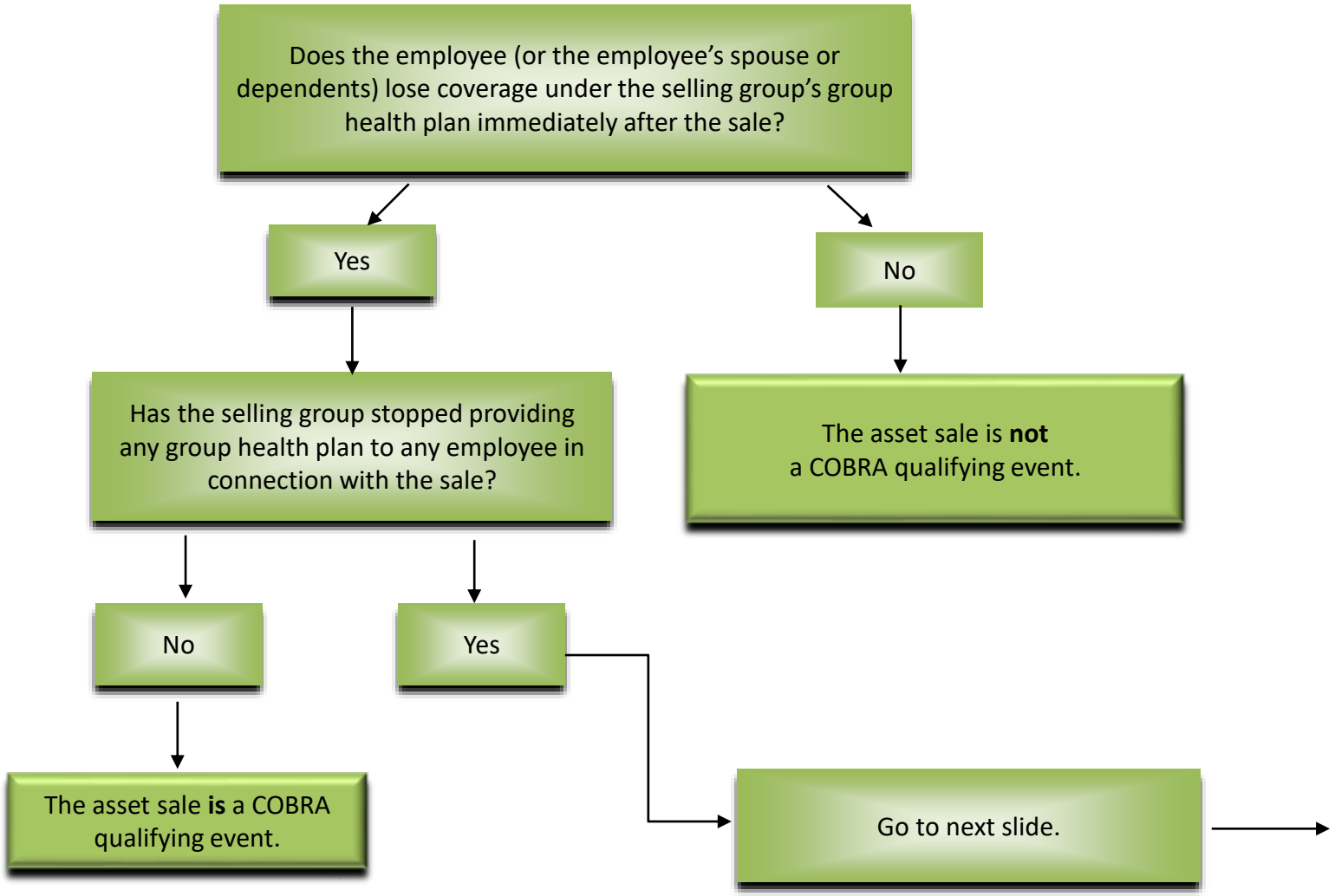
HSAs

- Not subject to COBRA

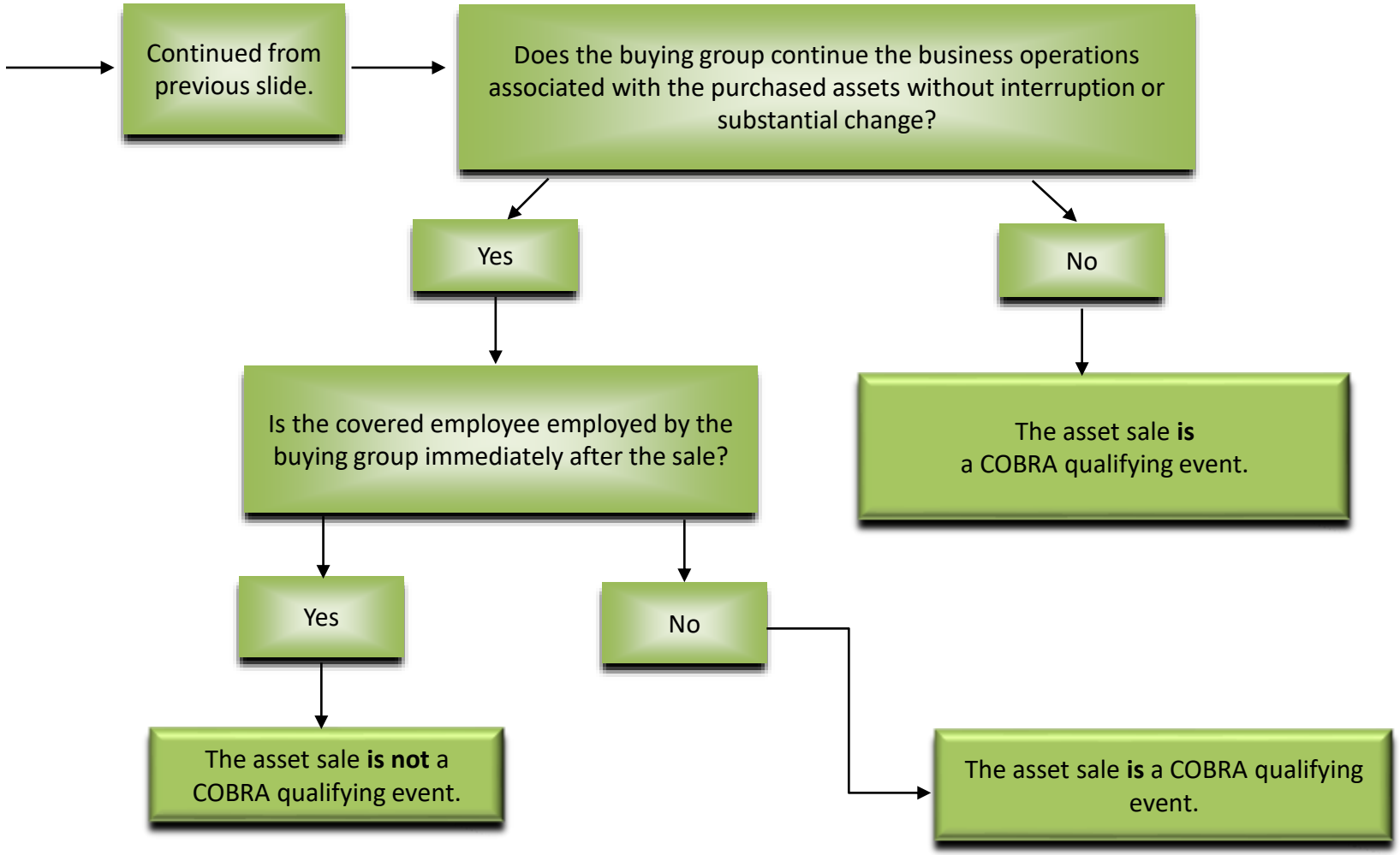
Cafeteria Plans COORDINATE WITH VENDOR

- 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.

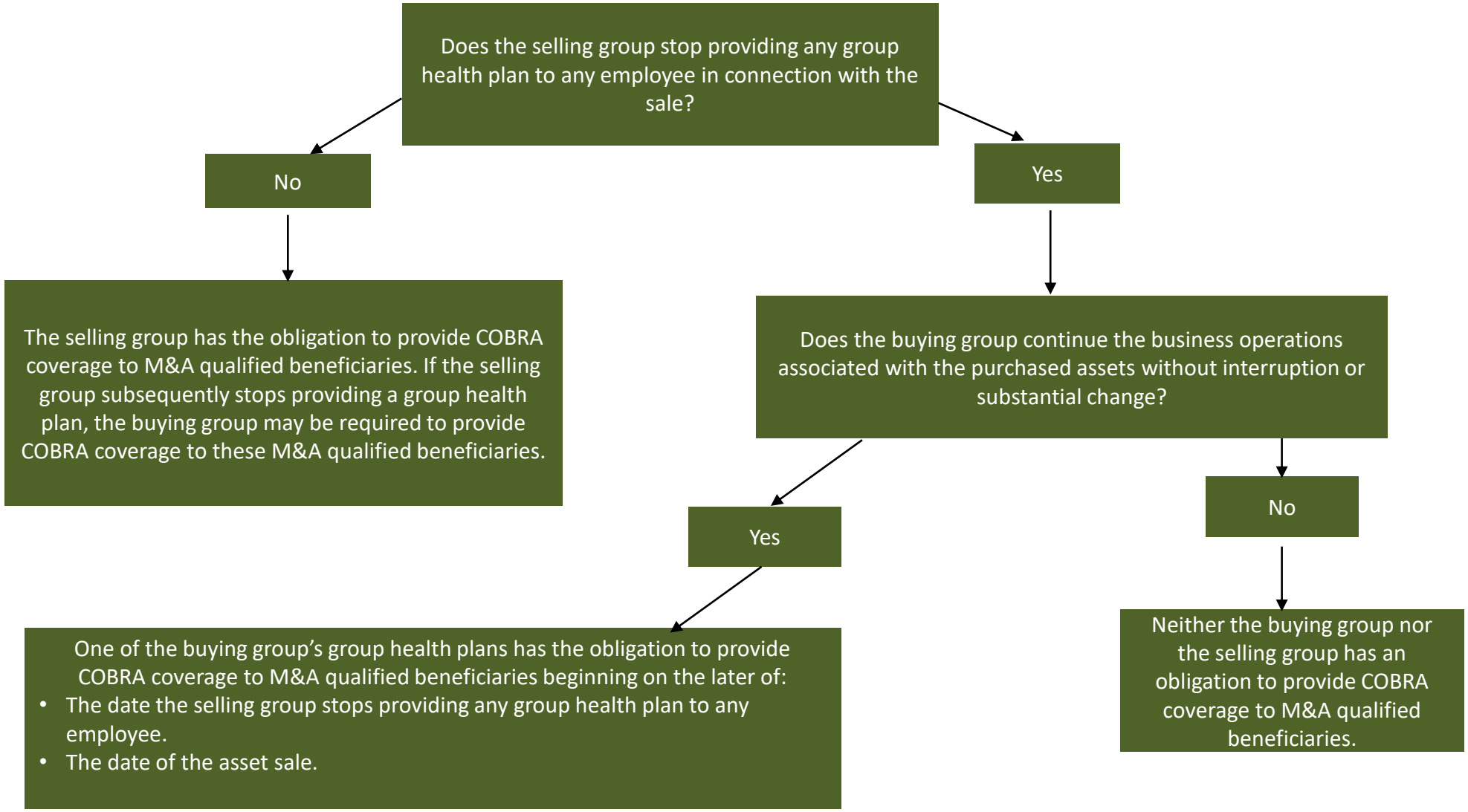
Mergers & Acquisitions



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.


Relationships


Communication


Budgeting
and Staffing


Know-How


Results

QUESTIONS?