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Managing the Risks and Costs of Autism Coverage

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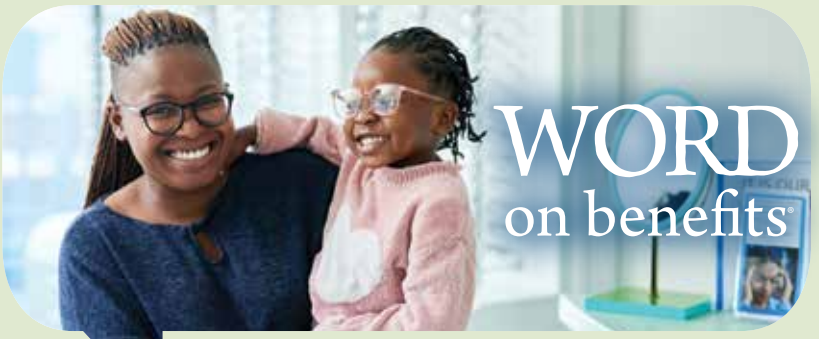

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in this issue

contributors

Employer-sponsored health plans are challenged to cover the cost of the behavioral interventions that treat autism spectrum disorder (ASD), a developmental disability that affects nearly one in 36 children in the United States. Attorneys **Nick Welle** and **Hannah Demsien** explain the legal requirements for covering ASD therapies and offer strategies to help plans remain in compliance with mental health parity and other laws while also managing costs. Welle is a partner at Foley & Lardner LLP in Milwaukee, Wisconsin, where Demsien is an associate.

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Other than a prohibition on appointing trustees who have been convicted of certain felonies, federal law does not specify who may serve as a trustee of an employee benefit plan or the exact method by which trustees are appointed or removed. Attorney **Sharon M. Goodman**, a principal at Slevin & Hart P.C. in Washington, D.C., and **Andrew T. Mills**, an associate at the firm, write that boards of trustees should still be mindful of ERISA's fiduciary duties and provisions of the Taft-Hartley Act when performing these functions.

p 20

Many governments around the world have enacted pay transparency and equity legislation to address pay disparities between men and women. **Edward Gow**, practice leader of global benefits for Vita Benefits, discusses the three key components of the equal pay movement and describes pay transparency legislation in the European Union, the United States and Canada.

p 28

Taking the time to understand the unique financial needs and goals of the workforce goes a long way toward supporting and improving employee financial well-being and creating an engaged workforce, contends **Jeanie Justice**. She identifies approaches for pinpointing workforce needs as well as options for financial wellness program content and delivery methods. Justice is vice president of total rewards at Tri Pointe Homes in Irvine, California.

p 34

Self-funded health plan sponsors have the power and legal obligation to look for new strategies to control prescription drug spending, write **Nina Lathia, Ph.D.**, chief executive officer of Healthcare Decision Making in Toronto, Ontario, and **Lauren Vela**, an independent consultant. They suggest five levers that plan sponsors can employ to reduce spending and improve plan member health.

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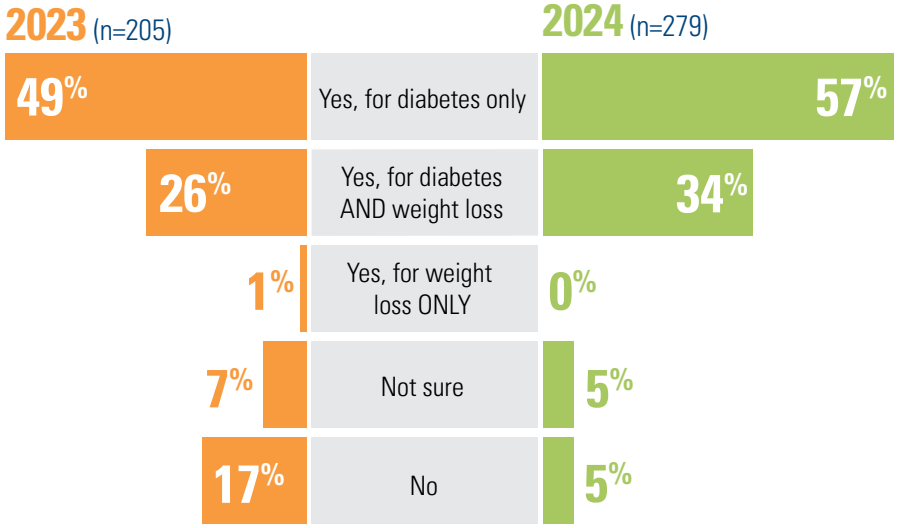
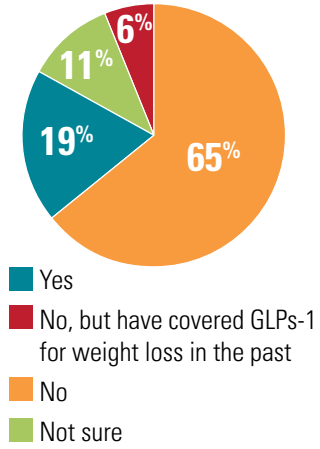
quick look | employer coverage of GLP-1 drugs

A growing percentage of corporate employers are covering glucagon-like peptide-1 (GLP-1) drugs, a recent International Foundation pulse survey shows. More than half (57%) of the 279 employers in the May survey said they provide coverage of the drugs for diabetes only, up from 49% from a similar survey conducted in October 2023. More than one-third (34%) of respondents cover GLP-1s for both diabetes and weight loss, up from 26% in 2023. Visit www.ifebp.org/GLP1drug2024 for more information and to view the full survey report. Highlights include the following.

Coverage of GLP-1 Drugs

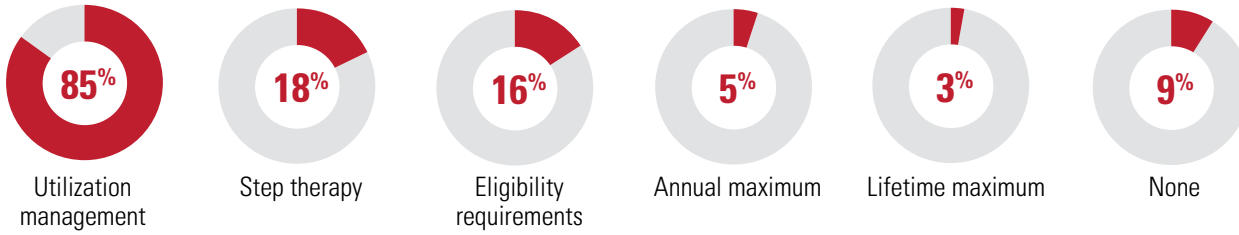


Considering Offering Coverage for GLP-1 Drugs for Weight Loss* (n=158)



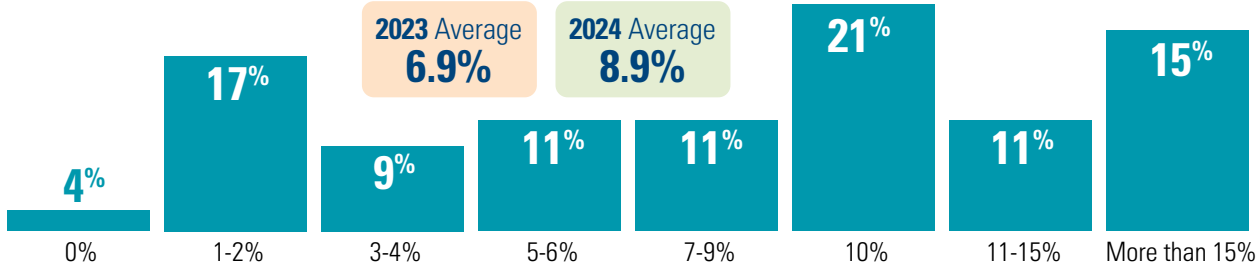
Respondents who only offer GLP-1 drugs for diabetes answered this question.

Cost-Control Mechanisms in Place for GLP-1 Drugs for Weight Loss* (n=94)



Among organizations that offer GLP-1 drugs for weight loss. Respondents were asked to select all that apply.

Representation of GLP-1 Drugs for Weight Loss in Total Annual Claims for 2023* (n=53)



Among organizations that offer GLP-1 drugs for weight loss.

what's working | giving members somebody to LEAN on

Diana Marburger, GBA
Welfare Director,
Greater St. Louis Construction Laborers' Welfare Fund,
St. Louis, Missouri

by | **Kathy Bergstrom, CEBS**

Diana Marburger, GBA, was hesitant when a trustee approached her with the idea of starting a peer mental health and addiction support program under the umbrella of the welfare fund she directs.

"My initial thought was that's not something we really need to do out of the welfare fund," said Marburger, who is the welfare director of the Greater St. Louis Construction Laborers' Welfare Fund in St. Louis, Missouri. Since the peer supporters would visit jobsites to interact with workers, she thought it would be a better fit for the Laborers Union locals to run. She recalled saying: "If you guys want to do it out of the unions, go for it."

The welfare fund serves the 4,200 members of the Laborers Union Local 42 and 110. It has a total of 11,000 covered lives.

The idea of a peer support program was first suggested back in 2021 by Don Willey, a fund trustee and at that time the business manager of Local 110. Willey is a vocal mental health and substance use recovery advocate and was impressed with a peer support program started by the Massachusetts Laborers' Benefit Funds.

Willey was persistent in pushing the idea. As Marburger learned more about the program, talked to plan members and looked at national mental health trends, "my tune completely changed. This is a benefit to our members, so absolutely it should go into our welfare fund," she realized. "We know this is a problem nationwide—worldwide—and we definitely weren't exempt from it. Once I had my eyes and ears open, we decided it was time to do something."

The fund launched Laborers Escaping Addiction Now (LEAN) STL in March 2023. In slightly more than a year of operation, the program has fielded hundreds of calls and text messages from participants seeking help for mental health and substance use issues.

LEAN STL
LABORERS ESCAPING ADDICTION NOW

Designing the Program

After about eight months of research, including discussions with the Massachusetts Laborers, Marburger developed an action plan for the program and sought approval from the fund's board of trustees. LEAN STL is modeled closely after the Massachusetts program, which means the fund pays salaries to two peer support specialists rather than relying on volunteers.

In Massachusetts, "it definitely seemed like they were helping members. Their phones were ringing, they were being well-received," Marburger said. "We knew that we could launch this program the way we wanted it and build it the way we wanted it if we had paid peer support specialists."

The fund decided to hire one person from each local to fill the peer supporter role. "Each local was aware of individuals who were either in recovery themselves or had the lived experience that we felt was needed for this position," she added.

James Pursell and Aaron Walsh, union members who were both in recovery, came on board as full-time recovery specialists in March 2023. Pursell had been studying social work at a community college, and Walsh knew firsthand the benefits of informal peer support from his own journey to recovery.

Salaries for the two specialists make up 58% of the program's total budget. Twenty-three percent is devoted to training, and marketing and communication expenses make up the other 19% of program costs.

The program has an oversight committee that reviews ideas before they go to the fund's board of directors. In the future, leaders hope to develop a group of volunteer peer supporters to help further break down the stigma of mental health and substance use issues.

Mentoring, Advocating and More

Walsh and Pursell are available 24/7 via text or phone through a toll-free hotline. They do not diagnose members or provide treatment but offer the following services.

- **Recovery planning:** The peer support specialists work with members to develop treatment plans and help them identify the internal and external factors that will help them sustain their recovery.
- **Connection to resources:** They provide care coordination and connect members to resources, support groups and treatments for both mental health and substance use disorder (SUD) issues.
- **Mentorship:** Peer specialists regularly meet one-on-one with individuals or in group settings. They model mental health and SUD recovery and act as personal and professional mentors.
- **Advocacy:** They attend appointments with plan members and ensure that they have access to the care and support necessary for mental health and SUD recovery. The fund's board also consults with them on budget and policy decisions.

Communication Is Key

"Anybody in the multiemployer world knows that communication is one of our most challenging tasks with our benefits. We've tried to amp it up a little bit," Marburger commented. The communication plan includes the following key elements.

- A website accessible from the benefit fund's home page

- Printed materials, including jobsite fliers and mailings to members' homes, such as a postcard with a refrigerator magnet advertising the hotline
- Outreach to contractor associations. The fund asked the associations to promote the program to member contractors. "That's worked. They've gotten calls from foremen or from members who said their foreperson came to them and told them about the program," Marburger said.
- In-person presentations. Pursell and Walsh visit jobsites to talk about LEAN STL and mental health. They also promote the program in presentations to each new class of apprentices at the Laborers training center and at union and retiree meetings, health fairs and wellness program events.

"We're hoping that the word spreads that yes, you can call these guys, and you can trust these guys," Pursell said. They also believe that the program has helped to remove some of the stigma and encouraged more open discussion of mental health and substance use issues.

Building Relationships With Members and the Community

When a member calls, the peer support specialists' first goal is to make sure the member is safe. Then they use a conversational approach to determine the member's needs. "We find an informal process to be more effective, because if we fire off this assessment type of interview, it tends to negate this peer relationship," Pursell said. "The reason the peer model works is because we're having a conversation. There's a wall between most people and clinicians, but we get to move around that."

"We've navigated through these things skillfully ourselves, and we let them know that what we do is 100% confidential," he said. "We try and provide this safe place for them to land to help them see the landscape of what resources are available. All this can happen over a long conversation, several conversations or in 30 seconds."

Walsh and Pursell have "immersed" themselves in the helping services in their region.

They also completed a six-month training program to become community health workers and continue to seek education on mental health and substance use issues.

From left, Aaron Walsh, CHW, and James Pursell, CHW, CPS, are Laborers recovery specialists with the Greater St. Louis Construction Laborers' Welfare Fund. Walsh and Pursell frequently visit jobsites to talk about the LEAN STL program and mental health.

"We are regularly going to treatment centers, visiting psychiatric centers, trying to understand and build relationships so that when somebody is struggling, we're not just handing them a number," Pursell explained.

They may be on the call with the member when they contact a treatment center or meet them at a facility, depending on what the member needs. "We know how many times they're going to see a therapist in the week. We're visiting them to make sure that this is going the way it should," Pursell said.

Advice for Others

It's challenging to develop a new program, so modeling LEAN STL after an existing one was helpful, Marburger said. She cautioned that, even though the St. Louis program had full board support, getting approval from a board can be a big hurdle because not everyone understands the challenges related to mental health and substance use.

Marburger and Pursell emphasized that the program is a team effort, noting that the peer specialists meet with Marburger daily to discuss their work and get advice.

Marburger also warned that self-care is important for the peer specialists, who must take difficult phone calls. "This is a big ask of them, and we are asking them to keep their phones on 24/7 to take phone calls at one o'clock, two o'clock in the morning or go out at night and meet somebody in a treatment center."

Numbers Tell a Story

The fund is compiling data on contacts with the program and regularly reports to the board. In the first quarter of 2024, LEAN STL contacts included 970 phone calls, 1,179 text messages, 17 emails and 127 in-person meetings, representing interactions with more than 400 members as well as their dependents and spouses. Marburger also breaks down data by geographic area and whether it is a call related to mental health or substance use.

Now that the program has been in operation for more than a year, she has also begun analyzing claims data. In the first year of operations (March 2023 to February 2024), mental health claims, including those from inpatient treatment centers and for outpatient care, increased nearly 30% compared with the same time frame for the previous year.

"One of the first things that Massachusetts told us is if you see an increase in your treatment center claims, don't feel like this program is failing. This program is working because you're getting those members into the treatment that they need, and clearly our program is working," Marburger said.

While the numbers tell a successful story, Pursell and Walsh have their own accounts of LEAN STL's impact. Members have called from their trucks and immediately burst into tears when the supporters answer. Pursell recalled that one call came from a police officer who was with a member and said he could either go into treatment or jail.

And then there was a call for help from a wife who was in an emergency room with her husband as he was being treated for alcohol poisoning. "She had already tried a few phone calls and was having no luck. She didn't know where to go, what to do. Her focus needed to be with her spouse," Pursell said. "I'm not here to pat ourselves on the back. I'm just a human being with some lived experience, but we immediately got her husband placed in a treatment center. This woman couldn't thank me enough for being there."

heard on community | dependent life insurance benefits

Your peers in the employee benefits community can be a helpful resource when you're investigating whether your benefit offerings are competitive or might need to be updated. Discussions on Foundation Community, like this one about dependent life insurance benefits, provide detailed information on the range of offerings among plan sponsors.

the question

We are taking a look at our dependent life insurance coverage level this year to ensure that we are still comfortable with the amount. Industry surveys don't typically capture dependent life benefit offerings, so we don't have much data to support where we are today and then whether a change is necessary. I'm curious whether anyone is willing to share whether they still offer dependent life insurance coverage and, if so, what the coverage amount is.

the conversation

We offer it on a voluntary basis, 100% paid by the employee. It is a pretax benefit deduction. The employee can elect up to five times their annual salary with a maximum of $250,000 and cover their spouse up to 100% of their election. Rates are age-banded based on the employee's age. They can elect child(ren) coverage for $10,000 for each child.

We do not offer employer-paid dependent life to the majority of employees, but we do have one union plan that offers a $2,000 benefit. However, we do offer voluntary dependent life at the following levels:

- Spouse: Increments of $5,000 up to $100,000 with a guaranteed issue of $50,000 at hire. At open enrollment, they can elect up to $10,000 (two levels) additional without underwriting.
- Child: Increments of $2,000 up to $10,000. No underwriting on this product regardless of enrollment. Full coverage starts at birth.

Our organization offers voluntary life insurance for spouses and children. The employee must purchase voluntary life insurance for themselves (basic life is employer-paid for the employee at one times their annual salary); then, the employee can purchase a spouse supplemental life plan of up to half of the employee's supplemental life policy. The limit for the spouse plan is a guaranteed issue (GI) amount of up to $50,000 and maximum election is $75,000 (including GI amount). For dependent children (under 26 years old), it's either a $5,000 or $10,000 policy.

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Managing the Risks and Costs of Autism Coverage

by | **Nick Welle** and **Hannah Demsien**

The prevalence of autism spectrum disorder makes it likely that every employer-sponsored health plan will eventually have a participant seeking coverage for high-cost treatments for their children. Health plans have several options to help control costs while providing access to treatment.

The increasing prevalence of autism spectrum disorder (ASD) among children in the United States and the high cost of treatment are creating new challenges for health plans. Plans are also facing heightened scrutiny from the Department of Labor (DOL), which has placed new focus on laws limiting a plan's ability to implement cost-saving measures in connection with ASD treatments. In addition, coverage of ASD treatments is a common target for litigation.

However, employers and plan sponsors can take measures to help lower costs within the bounds of the law while still ensuring that their plan participants are offered competitive, comprehensive medical benefits.

TABLE

Identified Prevalence of Autism Spectrum Disorder

Year	Birth Year	Combined Prevalence per 1,000 Children (Across CDC Reporting Sites)	This is About 1 in X Children
2020	2012	27.6	1 in 36
2018	2010	23.0	1 in 44
2016	2008	18.5	1 in 54
2014	2006	16.8	1 in 59
2012	2004	14.5	1 in 69
2010	2002	14.7	1 in 68
2008	2000	11.3	1 in 88
2006	1998	9.0	1 in 110
2004	1996	8.0	1 in 125
2002	1994	6.6	1 in 150
2000	1992	6.7	1 in 150

Source: Centers for Disease Control and Prevention (CDC).

Background

ASD is a developmental disability characterized by impairments in social interactions and repetitive patterns of behaviors, interests or activities that can cause a wide array of difficulties in social interaction, communication and participation in daily life.[1] ASD generally begins before age three and can last throughout a person's life.[2] It is a widespread condition among children in the U.S., affecting nearly one in every 36 children[3] across all racial, ethnic and socioeconomic groups.[4] The number of children diagnosed with ASD has been rising steadily, as shown in the table compiled from data from the Centers for Disease Control and Prevention (CDC).[5]

From 2011 to 2017, health plan spending increased six times as much for children ages three to seven with ASD as for children without ASD, largely from spending related to behavioral interventions such as applied behavioral analysis (ABA), an intensive one-on-one therapy.[6] There is no single treatment for autism, but in addition to ABA, treatments include (but are not limited to) other types of behavioral therapy, medication and speech-language therapy. A discussion of the benefits and disadvantages of specific types of ASD treatments is beyond the scope of this article.

One in seven children with ASD covered under an employer-sponsored health plan received at least $20,000 in services in 2017, and nearly 6% of children with ASD incurred at least $50,000 in expenditures in 2017.[7] This is a significant cost for employer-sponsored health plans as well as for families with a child diagnosed with ASD. Without coverage of ASD services by health plans, many families would be unable to afford the ASD treatments that provide their diagnosed children with the tools necessary to interact appropriately with the world around them.

Mental Health Parity Risks

Generally, the Mental Health Parity and Addiction Equity Act (MHPAEA) requires health plans that offer mental health and substance use disorder (MH/SUD) benefits to offer them roughly on an equal basis to medical and surgical (M/S) benefits. In other words, MHPAEA generally restricts the ability to place limitations on ASD treatments that are more stringent than limitations placed on treatments for comparable M/S conditions. In response to recent laws, regulations and guidance, the DOL has increased its scrutiny on limitations or exclusions of ABA therapy and other types of ASD treatments.

For fully insured plans, the risk in connection with MHPAEA compliance is generally held by the insurer; however, for a self-insured plan, the legal onus is placed on the plan sponsor. A plan that fails to cover ASD services appropriately in accordance with MHPAEA could be required to amend the terms of the plan and reprocess denied claims. Furthermore, denials for coverage of ASD treatments are a potential target for lawsuits by plan participants under the Employee Retirement Income Security Act (ERISA) or MHPAEA. In addition to MHPAEA, fully insured plans also must comply with state mandates for autism coverage in many states.

In a July 2023 report to Congress, the DOL (in coordination with the Department of Health and Human Services and the Department of the Treasury) highlighted several enforcement actions taken against plans with exclusions of ABA therapy or other ASD services.[8] The DOL provided one example of an enforcement action in which a plan had a blanket exclusion on ABA therapy.[9] The plan removed the exclusion after being contacted by the DOL, but rather than covering ABA therapy, the plan instead pended all ABA therapy claims and imposed new treatment limitations on the coverage of ABA therapy, including review of provider notes and treatment plans. After further DOL action, the plan removed these limitations on ABA therapy coverage. Several service providers were contacted by the DOL in connection with ABA therapy coverage exclusions under plans they administered, and they ultimately removed such exclusions from the plans.[10]

As a first step regarding ASD coverage, plan sponsors should consider reviewing the plan documents and ensuring that there are no blanket exclusions of treatments for ASD in general or specific exclusions for ABA therapy. These types of blanket exclusions likely violate MHPAEA and could result in DOL enforcement action. Given the significant risk involved, plan sponsors should consider adding coverage under their plans for ASD treatments in general and ABA therapy specifically if these items are not currently covered.

Risk Management

Given the DOL's focus on enforcement in connection with ASD treatments and the risks of litigation in connection with denials of ASD treatments, what actions can plans take to help manage the costs involved with ASD treatments? Options are outlined below, with a focus on utilization management options for self-insured plans.

1. Medical Management

One option for plans to help address costs and ensure that use of ASD therapies is appropriate is to impose medical management conditions. Medical management conditions are used to confirm that services are medically necessary, appropriately prescribed and clinically efficient. *Prior authorization*, which requires approval from the plan before a service will be covered under the plan, is a common form of medical management. Another form of medical management is concurrent review. *Concurrent review* is a process for review of the extension of a previously approved ongoing course of care.

However, under MHPAEA, any medical management methods must be applied in parity as between comparable medical and mental health benefits. If a plan chooses to impose prior authorization requirements upon ABA therapy, for example, in order to remain compliant with MHPAEA, it likely needs to impose the same or more stringent prior authorization requirements upon M/S services comparable to ABA therapy. Medical management limitations are an area of DOL focus in its MHPAEA audits. Employers and plan sponsors should review the terms of their health plans carefully, considering what covered services are similar to

takeaways

- One in 36 children in the United States has autism spectrum disorder (ASD), and the number of children diagnosed with ASD has been rising steadily.
- From 2011 to 2017, health plan spending increased six times as much for children ages three to seven with ASD as for children without ASD, largely from spending related to behavioral interventions such as applied behavioral analysis (ABA) therapy.
- Denials for coverage of autism treatments are a potential target for lawsuits by plan participants under the Employee Retirement Income Security Act (ERISA) and the Mental Health Parity and Addiction Equity Act (MHPAEA).
- Options for reducing the risk of litigation related to ASD treatments while managing costs include imposing equitable medical management requirements and visit limitations as well as offering care navigation services and expanding provider networks.
- Data analytics may help plans predict future plan costs in connection with ASD services.

ASD treatments and how imposing medical management conditions on ASD treatments and analogous medical services will impact participants and the health plan as a whole. Given DOL scrutiny, plan sponsors should think twice before imposing severely limiting medical management requirements.

2. Care Navigation

Some insurers and third-party administrators (TPAs) offer care navigation programs for ASD. The insurer or TPA contacts members about an ASD care navigation program based on the member or their dependent incurring certain claim codes under the plan, which indicates that ASD services are relevant. These programs help families who have children with ASD navigate the range of treatment options, assist with finding in-network providers, provide information regarding education and other programs, and guide members to other ASD resources outside of the plan. Employers and plan sponsors may want to consider adding these types of care navigation programs to assist members in finding the best ASD treatment options for their families. These programs should generally be voluntary for members to participate in to avoid potential MHPAEA and other compliance concerns.

3. Provider Network Arrangements

The high cost of ASD treatments may be due, in part, to a lack of in-network providers that have negotiated rates with the TPA or insurer that is administering the health plan. Plan sponsors can consider discussing with their TPA or insurer what other network options might be available to make more in-network providers of ASD services accessible to employees. Plan sponsors should also consider adding an inquiry of this nature to any requests for proposals when seeking new TPAs or insurers if the health plan has existing ASD claims. In addition, using in-network providers helps to ensure that the providers are appropriately qualified to provide ASD treatments, since providers must generally meet specific credentialing standards to be admitted to a network. A strong in-network body of ASD treatment providers in combination with a care navigation program that helps guide members toward in-network solutions should help plans manage utilization of these services. However, this solution may offer limited relief if there is a shortage of providers in the plan's geographic region.

4. Data Analytics

TPAs may be able to include ASD services in their high-cost claimant reports that identify large claims incurred under the plan. Adding ASD services to these reports would provide plan sponsors with a line of sight into ASD episodes of care under the plan to understand the costs and help better predict future plan costs. Plan sponsors should ensure that any information included in these reports has been de-identified in accordance with the Health Insurance Portability and Accountability Act (HIPAA). Individual names and identifying information are not needed for the plan to manage costs, and making the reports de-identified mitigates privacy related risks of the employer holding sensitive health information.

5. Visit Limitations

Another option for plans to help reduce costs and ensure that the use of costly ASD therapies is appropriate is to impose visit limitations on ASD therapies, as applicable. *Visit limitations* are quantitative limits on the number of times a service may be received under the plan. Visits exceeding the limit are either not covered under the plan or will require prior authorization.

As with medical management, under MHPAEA, any visit limitations must be applied in parity as between comparable medical and mental health benefits. So, for example, if a plan chooses to impose a monthly visit limit of 20 visits on cognitive behavioral therapy treatment for ASD, the same visit limit (or a more restrictive visit limit) would likely need to be applied to comparable M/S services. Before implementing a visit limit, plan sponsors should consider the impact on plan members currently receiving ASD treatments and assess what medical services might act as an analogue so the plan remains in parity. This type of limitation on treatments is also under scrutiny right now by the DOL, so plans should consider implementing other

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options before imposing visit caps on ABA therapy and other ASD treatments.

6. High-Deductible Health Plan Options

Adding high-deductible health plan (HDHP) options to the health plan is another strategy to consider if the plan sponsor does not already have HDHP coverage. As plan sponsors are likely aware, an HDHP requires participants to pay a higher deductible amount before full plan benefits start. Participants who are enrolled in an HDHP will pay for a larger portion of the cost of any ASD services upfront before the plan starts covering the cost of such services.

Conclusion

ASD is a widespread developmental disability affecting a large number of children across the U.S. The prevalence of ASD makes it likely that every employer-sponsored health plan will eventually have a participant seeking coverage for high-cost ASD treatments such as ABA therapy for their children.

Employers and plan sponsors face the risk of action by the DOL or lawsuits if they exclude coverage of ASD in general or specific treatments like ABA therapy under the terms of the plan. Plan sponsors have a range of options to help control costs but should ensure that plan provisions comply with MHPAEA, ERISA and other applicable laws.

Endnotes

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.* American Psychiatric Association; 2013.
2. Centers for Disease Control and Prevention (CDC). "What is Autism Spectrum Disorder?"
3. CDC. "Prevalence and Characteristics of Autism Spectrum Disorder Among Children Aged 8 Years—Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020." *Morbidity and Mortality Weekly Report (MMWR).*
4. Id.
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6. Scott D. Grosse et al. "Spending on Young Children With Autism Spectrum Disorder in Employer-Sponsored Plans, 2011-2017." *Psychiatric Services.* January 1, 2021; 72(1): 16–22.
7. Id.
8. *MHPAEA Comparative Analysis Report to Congress,* July 2023.
9. Id. at 44-45.
10. Id.

bios

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Casting Decis

The Plan Sponsor's

Federal law offers minimal guidance on the appropriate methods for the selection, monitoring and removal of benefit plan trustees. However, plan sponsors should be mindful of ERISA's fiduciary duties and provisions of the Taft-Hartley Act when performing these functions.

ions:

Duties to Appoint, Monitor and Remove Trustees

by | **Sharon M. Goodman** and **Andrew T. Mills**

Who can serve as an employee benefit plan trustee and for how long? When can a trustee be removed from a board of trustees?

Although federal law offers minimal guidance on the topic, these are basic questions that boards of trustees and the entities that appoint trustees should revisit occasionally to ensure that their plan documents and procedures don't run afoul of the law.

Sponsors of all employee benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) are required to have plan assets held in trust and governed by one or more trustees.[1] This article will describe the duties for the entities appointing ERISA plan trustees in selecting, monitoring and removing such trustees, particularly for jointly administered multiemployer plans, and it will offer practical considerations for any entity tasked with this responsibility.

takeaways

- Generally, the method under which employee benefit plan trustees are appointed and removed is defined in a plan's trust agreement. Neither the Employee Retirement Income Security Act (ERISA) nor the Taft-Hartley Act provide a required method for appointment or removal.
- The appointing entity must comply with ERISA's fiduciary duties in deciding upon the method by which trustees are appointed and removed, appointing those trustees and monitoring their performance.
- For multiemployer plans, two general categories of trustee appointment and removal procedures that are more likely to be struck down by the courts include provisions that entrench trustees in their position through lifetime appointments and provisions that impair the union and employer association's equal representation on the board.
- Appointing entities should confirm that an intended appointee is not disqualified from holding the position. For example, no person who has been convicted of certain felonies may serve as a trustee.
- The Department of Labor has held that ERISA's fiduciary duties apply to the selection and retention of a trustee by an employer and its board of directors.

Background

What Is a Plan Sponsor?

Under ERISA, the entity responsible for establishing and maintaining an employee benefit plan is the "plan sponsor."[2]

- In a single employer plan, the plan sponsor is the employer.
- In a multiemployer plan, while the plan often is established by one or more employer associations and employee organizations/labor unions, the plan sponsor is generally a joint board of trustees.[3]

Multiemployer Plans

For a jointly administered multiemployer plan, the Taft-Hartley Act of 1947 requires that, if a union representative has any control over the plan assets (such as by appointment as a trustee), employers and employees that participate in the plan must be equally represented on the joint board of trustees.[4] This one-sided requirement (a plan could be employer-dominated) is described by the courts as designed "to protect the interests of the employees from exploitation by unscrupulous union officials."[5] The requirement reflects a sentiment that emerged among employers at the time that the Wagner Act of 1935 had given unions an unfair advantage. The labor union(s) whose members participate in the plan and the largest employers or employer association(s) whose employees participate in the plan typically have the power to appoint and remove their respective trustees of a multiemployer plan. This article will focus on the duties of labor unions and employers when exercising that power.

When performing actions to establish, amend or maintain the plan, most courts agree that the trustees are performing settlor or plan sponsor functions and, thus, are *not* subject to ERISA's fiduciary duties, including the duty to act in the sole interest of the participants and beneficiaries. However, when performing actions to administer the plan or exercising discretionary authority with respect to management of the plan, the trustees wear their fiduciary hats, and their actions *are* subject to ERISA's fiduciary duties. As a result of this distinction, the entities that have the power to appoint trustees can fall into different roles, depending on the terms of the trust agreement and the actions taken. The implications of this distinction are described in detail below.

Appointment, Removal and Monitoring of Trustees for Taft-Hartley Plans

Generally, the method under which trustees are appointed and removed

is defined in a plan's trust agreement. Neither ERISA nor the Taft-Hartley Act provides a required method for appointment or removal, but most multiemployer plans give those powers to the sponsoring union and employer association respectively.[6]

The act of initially deciding upon or subsequently amending the trustee appointment and removal provisions of a plan's trust agreement is generally a settlor function performed by the employer (for a single employer plan) or by the bargaining parties or the board of trustees (for a multiemployer plan).[7] However, even while maintaining that this is a settlor function not governed by ERISA's fiduciary duties, some courts have held that certain methods for the appointment and removal of trustees are inconsistent with ERISA and have struck them down.[8] Courts have also struck down similar provisions under the equal representation requirement of the Taft-Hartley Act.[9]

Two general categories of trustee appointment and removal procedures that are more likely to be struck down by the courts are (1) provisions that entrench trustees in their position through lifetime appointments and (2) provisions that impair the union and employer association's equal representation on the board and allow one (most often the union) to dominate management of the plan.[10]

Unlawful Entrenchment

In 1985, the Department of Labor (DOL) issued an opinion letter concerning a multiemployer plan's trust agreement that allowed the union to appoint a trustee for life and permitted the trustee to be removed only for misfeasance or incapacity.[11] DOL noted that, pursuant to ERISA's fiduciary duties of loyalty and prudence, trustee conduct must be subject to oversight on behalf of plan participants and beneficiaries.[12] The trustees fail to fulfill this obligation if the appointing entity can remove the trustee only due to misfeasance or incapacity, DOL stated. While limited terms may be appropriate, DOL said, a lifetime term in which a trustee is not freely removable violates ERISA.[13] The *theory of unlawful entrenchment* stems from this opinion letter, and many courts have cited it in striking down trust provisions that insulate trustees from removal by the party that appointed them.[14]

The test to determine whether unlawful entrenchment exists is whether a plan permits the removal of a trustee "on reasonably short notice under the circumstances so the plan would not become locked into an arrangement that may become disadvantageous."[15] Under this test, courts have struck down trust provisions that give trustees a lifetime appointment and allow them to be removed only for cause as well as provisions that give trustees limited terms but effectively do not permit removal during that term under any circumstances.[16] The principle underlying these unlawful entrenchment cases is that a trustee must be subject to the appointing entity's monitoring of their performance and removal in order to ensure that the trustee is complying with their fiduciary duties under ERISA.

This monitoring should include whether the trustee fulfills their duty to act with prudence and for the exclusive benefit of the participants and beneficiaries of the plan. Ignoring a trustee's performance could result in the plan sponsor being liable for a breach of fiduciary duty as a co-fiduciary to the trustee.

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Violations of the Equal Representation Requirement Under the Taft-Hartley Act

The other instance in which courts will strike down the method for appointment or removal of trustees is when the equal representation requirement of the Taft-Hartley Act is violated. Section 302(c)(5) of the Taft-Hartley Act generally mandates that employees and employers participating in a benefit plan be equally represented on the joint board of trustees.[17]

In enforcing the Taft-Hartley Act's equal representation requirement, the legislative history and the courts have focused on the potential for union abuse rather than employer abuse.[18] Federal law does not prohibit employers, either through an employer association or not, from creating and maintaining a benefit plan for their employees in which no union is represented in its administration. The requirement that employees be equally represented on a plan's board of trustees comes into play only if the plan is

jointly trusteed with union representatives. (A plan with multiple nonbargained participating employers that is not jointly sponsored with a union is known as a *multiple employer* plan, as opposed to a *multiemployer* plan.)[19]

Thus, several courts and commentators have stated that the purpose of the Taft-Hartley Act's equal representation requirement is to prevent the *potential* for unions to abuse the power they would hold if the plan were left to their sole control; the requirement is not meant to prevent only *actual* abuse.[20] For example, the Eighth Circuit has held that an active union member who sometimes acts as an employer contributing to the plan and sometimes as an employee of other contributing employers cannot serve as an employer trustee, even if there is no evidence that the trustee abused their position.[21] While the details of the role are important, any trustee appointment procedures should be designed to avoid having individuals who serve a material role with both the union and employer perform a dominant role in the appointment of employer trustees or serve as an employer trustee.[22]

In another case, the trustees amended the trust to add a rival employer association to the plan and authorized it to appoint half of the employer trustees.[23] This occurred after the original employer association had removed from its membership a trustee who the association had previously appointed to the plan's board of trustees. After his removal from the association, that employer trustee sided with the union trustees in adopting the amendment to add the rival employer association. There, the Third Circuit held that the trust amendment violates the equal representation requirement of the Taft-Hartley Act because it could allow the union trustees to speak with one voice while the employer trustees' voice would be divided and diluted due to the conflict between the two employer associations.[24] However, the court noted that not all arrangements in which two employer associations are each responsible for appointing a share of the employer trustees would violate the Taft-Hartley Act; it only held that the equal representation requirement is violated "when employer trustees representing a rival association not a party to the original trust agreement are added to the board without the consent of the original employer association."[25]

The principle illustrated by these examples is that, in a jointly administered multiemployer plan, employers that contribute to and employees who participate in the plan must have equal representation on the board of trustees without the "real possibility" of abuse.[26] Anything that impairs this safeguard by giving the union influence in the selection of an employer trustee could run afoul of the Taft-Hartley Act and may be struck down by a court.

Accordingly, unions, employers and trustees on jointly administered boards of multiemployer plans should consider these examples when establishing or amending the trust's appointment and removal procedures and when deciding who may serve as a union or employer trustee.

Persons Who Are Statutorily Prohibited From Serving as a Trustee

In addition to ensuring compliance with the fiduciary duties under ERISA and the equal representation requirement under the Taft-Hartley Act, plan sponsors must comply with Section 411 of ERISA, which provides that no person who has been convicted of certain felonies may serve as a fiduciary of a plan, including as a trustee.[27] The types of convictions that bar service as a trustee under ERISA include felony convictions under federal and state criminal laws relating to financial and property crimes, crimes involving bodily harm to another person, and crimes relating to labor and employment practices.[28] Plan sponsors that intentionally violate this mandate are subject to fines up to $10,000 or imprisonment of up to five years.[29] Accordingly, as part of its due diligence in fulfilling its appointment duties, the appointing entity should confirm that an intended appointee is not disqualified from holding the position. This also is part of monitoring whether trustees become subject to this bar after appointment.

Application to Single Employer Plans

Although the Taft-Hartley Act typically is not applicable to most single employer benefit plans (because they usually are not jointly governed with union representatives on the board), these principles still apply to an employer's selection of a trustee. In its guidance *Supplementing ERISA Interpretive Bulletin 75-5,* DOL clarified that ERISA's fiduciary duties apply to the selection and retention of a trustee by an employer and its board of directors.[30] Like the opinion letter discussed above, the guidance also provides that the plan sponsor should review the performance of trustees at reasonable intervals "to ensure that their perfor-

mance has been in compliance with the terms of the plan and statutory standards, and satisfies the needs of the plan."[31] The appropriate timing and method of reviewing trustee performance may vary depending on the particular plan at issue and other facts and circumstances.[32] Section 411 of ERISA also applies to single employer plans to ensure that an individual is not (and does not become) disqualified from holding the position.

Thus, even in the context of a single employer plan, the appointing entity's duties do not end after the trustee is seated. Instead, the entity's duty to monitor continues throughout a trustee's term. This mirrors the unlawful entrenchment cases for multiemployer plans. As mentioned previously, a trustee's performance must be subject to review and potential removal by the plan sponsor. Failure to review a trustee's performance could result in the plan sponsor being liable for a breach of fiduciary duty as a co-fiduciary to the trustee.[33] In the case of a single employer plan, this means that the employer itself could face liability.

Conclusion and Practical Considerations

Other than the prohibition on appointing trustees who have been convicted of certain felonies, the law does not specify who may serve as a trustee of an employee benefit plan or the exact method by which trustees are appointed or removed. However, the appointing entity must comply with ERISA's fiduciary duties in deciding upon the method by which trustees are appointed and removed, appointing those trustees and monitoring their performance. The following represent important items to include in a review of a plan's policies.

- **Ensure compliance with the Taft-Hartley equal representation requirement for multiemployer plans.** Employees and employers participating in a benefit plan must be equally represented on the joint board of trustees.
- **Avoid lifetime terms.** A trustee must be subject to the appointing entity's monitoring of their performance and removal in order to ensure compliance with that trustee's fiduciary duties under ERISA.
- **Establish procedures for appointment and removal of trustees.** The trust agreement should have clear procedures to identify the specific party that has authority to appoint and remove a trustee (typically at any time and without a showing of cause). Plan sponsors should be mindful of when entities change—such as when an employer association dissolves or a local union merges with another—and keep the trust agreement up to date.
- **Document the decision-making process (by written appointment by the authorized entity).** This will create a clear record (also typically reflected in the meeting minutes) to document when a trustee has been added or removed.

Key Concepts for Employee Benefit Plans

- **Plan sponsor:** In a single employer plan, the plan sponsor is the employer. In a multiemployer plan, while the plan often is established by one or more employer associations and employer organizations/labor unions, the plan sponsor is generally a joint board of trustees.
- **The theory of unlawful entrenchment:** Unlawful entrenchment may exist if a trustee is appointed to a lifetime term allowing them to be removed only for cause, or if they are appointed to a limited term but removal is not permitted during that term.
- **Equal representation:** The Taft-Hartley Act mandates that employees and employers participating in a benefit plan be equally represented on the board of trustees.
- **Fiduciary duties:** Governed by the Employee Retirement Income Security Act (ERISA), these duties include the duty to act in the sole interest of the participants and beneficiaries. When performing actions to administer an employee benefit plan or exercise discretionary authority with respect to management of the plan, trustee actions are subject to ERISA's fiduciary duties.
- **Settlor functions:** These actions are not subject to ERISA's fiduciary duties and include actions to establish, amend or maintain an employee benefit plan.

Endnotes

1. 29 USC §1103(a).
2. See 29 USC §1002(16)(B).
3. Id.
4. 29 USC §186(c)(5)(B).
5. *Denver Metropolitan Assoc. of Plumbing v. Journeyman Plumbers & Gas Fitters Local No. 3 & Pipefitters Local No. 208,* 586 F.2d 1367, 1374-75 (10th Cir. 1978) (citing Arroyo v. United States, 359 U.S. 419, 425-426 (1959)).
6. See 29 USC §1103(a).
7. See *Detroit Terrazzo Contrs. Ass'n v. Bd. of Trs. of the B.A.C. Local 32 Ins. Fund,* 71 Fed. Appx. 539 (6th Cir. 2003) (holding that "in amending the Trust Agreement, the Trustees were not acting as fiduciaries").
8. See, e.g., *Levy v. Local Union No. 810,* 20 F.3d 516, 519 (2d Cir.1994) (holding that trust agreements that excessively protect trustees from removal violate ERISA because they insulate trustees from responsibility for failure to carry out their fiduciary duties); *Partenza v. Brown,* 14 F. Supp. 2d 493 (S.D.N.Y. 1998); *Teamsters Local No. 145 v. Kuba,* 631 F. Supp. 1063 (D. Conn. 1986) (holding that trustees' decision to amend the trust agreement to only permit trustee removal for "proper and just cause" violated their fiduciary duties under ERISA); *Mobile, Ala.-Pensacola, Fla. Bldg. & Constr. Trades Council v. Daugherty,* 684 F. Supp. 270 (S.D. Ala. 1988) (holding that trust agreement provision providing for lifetime appointment of trustees violates ERISA); see also U.S. *Dep't of Labor, Pension and Welfare Benefit Programs, Opinion Letter 85-41A* (Dec. 5, 1985) ("the Department is generally of the view that a lifetime term of appointment for a pension fund trustee would be inconsistent with ERISA's fiduciary responsibility provisions").
9. See, e.g., *Associated Gen. Contractors of Essex Cty., Inc. v. Laborers Int'l Union of N. Am.,* 559 F.2d 222 (3d Cir. 1977) (holding that amendment to trust agreement changing the employer association responsible for appointing trustees violated 29 U.S.C. § 186(c)(5)).
10. Furthermore, there are some individuals who are statutorily prohibited from holding the position of trustee. See 29 USC §1111(a) (providing that persons convicted of certain felonies may not serve as a plan trustee).
11. U.S. Department of Labor, Pension and Welfare Benefit Programs, *Opinion Letter 85-41A* (December 5, 1985).
12. Id.
13. Id.
14. See e.g., *Partenza v. Brown,* 14 F. Supp. 493 (S.D.N.Y. 1998); *Teamsters Local 145 v. Kuba,* 631 F. Supp. 1063 (D.Conn. 1986); *Mobile, Ala.-Pensacola, Fla. Bldg. & Constr. Trades Council v. Daugherty,* 684 F. Supp. 270 (S.D.Ala. 1988).
15. Supra note 11.
16. See e.g., *Levy v. Local Union No. 810,* 20 F.3d 516 (2d Cir. 1994); *Partenza v. Brown,* 14 F. Supp. 493 (S.D.N.Y. 1998); *Teamsters Local 145 v. Kuba,* 631 F. Supp. 1063 (D. Conn. 1986); *Mobile, Ala.-Pensacola, Fla. Bldg. & Constr. Trades Council v. Daugherty,* 684 F. Supp. 270 (S.D. Ala. 1988).
17. 29 USC §186(c)(5).
18. *NLRB v. Amax Coal Co.,* 453 U.S. 322, 341-42 (1981) ("Equal representation was required, not to satisfy employer demands for a voice in benefit fund administration, but to insure that money paid for the welfare of employees actually was used for that purpose.").
19. See 29 USC §1060.
20. *Associated Gen. Contractors of Essex Cty., Inc. v. Laborers Int'l Union of N. Am.,* 559 F.2d 222, 227 (3d Cir. 1977) (quoting *Quad City Bldrs. Assoc. v. Tri City Bricklayers Union No. 7,* 302 F. Supp. 1031, 1035 (S.D.Ia. 1969) ("The question before the district court was not whether there had been union abuse of the trust funds under the amendments, or even whether there would be, but rather whether union domination of the fund is 'a very real possibility.'").
21. *Quad City Bldrs. Assoc. v. Tri City Bricklayers Union No. 7,* 431 F.2d 999 (8th Cir. 1970).
22. Id. at 1004.
23. *Associated Gen. Contractors of Essex Cty., Inc. v. Laborers Int'l Union of N. Am.,* 559 F.2d 222 (3d Cir. 1977).
24. Id.
25. Id.
26. See id. at 227; *Quad City Bldrs. Assoc. v. Tri City Bricklayers Union No. 7,* 431 F.2d 999, 1003 (8th Cir. 1970).
27. 29 USC §1111(a).
28. Id.
29. 29 USC §1111(b).
30. 29 CFR §2509.75-8.
31. Id.
32. Id.
33. See 29 USC 1105.

bios

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CRACKS IN THE FOUNDATION

A Global Perspective on Pay Equity

by | **Edward Gow**

Marginalized groups and women may encounter invisible barriers that hinder their personal and professional development. The author delves into the worldwide gender wage gap and the lack of female representation in managerial and corporate positions.

The gender wage gap has gained recognition globally, and many governments have recently enacted pay transparency and equity legislation to address the longstanding disparity between men and women regarding pay.

Global employers may need to adjust their policies to ensure that they comply and should continue to monitor developments worldwide. Employers that embrace pay transparency may find that these policies improve pay for women and help increase female representation in managerial and corporate positions, thus breaking the glass ceiling.

The Global Gender Wage Gap

In 1839, the French author Amantine Lucile Aurore Dupin, best known by her pen name George Sand, used the phrase "Une voûte de cristal impenetrable" (an impenetrable crystal vault) in her play *Gabriel*, one of the earliest attempts to describe the invisible barriers through which marginalized groups can see elite positions they cannot reach. "I was a woman; for suddenly my wings collapsed, ether closed in around my head like an impenetrable crystal vault, and I fell . . . ." The statement, a description of the heroine's dream of soaring with wings, has been interpreted as a feminine Icarus tale of a woman who attempts to ascend above her accepted role.[1]

Fast forward 185 years and many women still grapple with an unseen barrier that can hamper personal and professional growth—the presence of the "glass ceiling"[2] within the workforce. The global gender wage gap and lack of representation in managerial and corporate roles expose this unseen barrier.

Highlighting this, the Organization for Economic Co-operation and Development (OECD) has analyzed its 38 member countries and found that the gender wage gap stands at 13% globally.[3] In addition, a 2022 report by Catalyst highlights the need for more women in managerial positions, showing that women account for only 26% of all CEOs and managing directors globally.[4] A noticeable disparity persists, although there has been an increase from 15% in 2019. According to the Census Bureau, about 42% of managers in the U.S. are women, and 31.7% of top executive positions were held by women in 2021.

An annual study conducted by McKinsey and LeanIn .Org, titled *Women in the Workplace,* has reported on efforts to address disparity for the last nine years. The 2023 report found that for every 100 men promoted and hired to managerial positions, only 87 women experienced the same professional ascent. Women of color fared worse, representing 73 opportunities for advancement for every 100 promoted men.[5]

This raises the question, why are women overlooked for promotions? Sheryl Sandberg, LeanIn.Org founder and chief operating officer, and Rachel Thomas, LeanIn.Org president, explained, "These are all workers at the entry level—They haven't built long track records, they all have similar work experience and they were all good enough to be hired in the first place. There's no good reason why so many more men than women are being tapped for promotions, only a bad one—bias. Because of the 'broken rung,' men end up with 62% percent of manager jobs while women hold just 38%. From then on, it's impossible for women to climb fast enough to catch up."[6]

As the broken rung impedes women's progress toward entry-level managerial positions and perpetuates the issue of unequal pay by keeping women in low-paying positions, there is hope the glass ceiling will break once the broken rung is addressed.

takeaways

- Despite significant time passing, many women continue to face the "glass ceiling" in personal and professional growth, evidenced by the global gender wage gap and underrepresentation in managerial roles.
- Pay transparency and pay equity measures may help foster an inclusive and equitable work environment, emphasizing the need for equal pay for equal work.
- Pay transparency tools include disclosure of pay ranges, a detailed compensation structure, the inclusion of salary information in job postings, antiretaliation provisions and prohibition on asking for salary histories from job candidates.

The Role of Pay Transparency

Promoting women earlier in their careers is in the hands of employers, but the government can also play a significant role by creating rules and regulations around pay transparency, which can help foster openness and clarity regarding salary information within the professional landscape. *Pay transparency* has become the key term when discussing work around equal pay in the workforce. When reported on, pay transparency can encompass three key components of the equal pay movement: pay transparency, pay equity and pay equality. These initiatives aim to promote fairness, equity and accountability in compensation practices.

While the following policies may help close the gender wage gap, they can also assist other marginalized groups that have experienced wage disparities.

Pay Transparency

When reviewing the three terms in context, pay transparency refers to the tools employers can use. These tools can be voluntarily implemented or regulated by a government and include some or all of the following components.

- **Disclosure of pay ranges:** This policy requires employers to disclose salary information and provide a salary range for a position. By providing this transparency, current employees and potential candidates understand the compensation range for a particular role.
- **Detailed compensation structure:** An organization establishes and communicates a comprehensive structure that typically includes the factors and criteria used in determining pay, such as experience, skills, location and performance metrics. When established and communicated correctly, these structures help employees understand and trust the compensation practices.
- **Salary information in job postings:** Including salary information in job postings provides individuals ap-

plying for a position with clear visibility into the pay ranges and helps them make informed decisions.

- **Antiretaliation provisions:** To create an environment conducive to open discussions about pay, antiretaliation provisions protect employees who engage in conversations or inquiries about compensation. This encourages a culture of transparency without fear of adverse consequences.
- **Salary history:** This policy prohibits an employer from asking for salary history from a candidate.

Pay Equity

Adding in the components of pay equity helps bring in a measured approach and includes structured reporting, audits and penalties if metrics are not met/reduced. Pay equity practices build on transparency rules to hold companies accountable for reducing the gender pay gap.

- **Equal pay audits:** Regular audits identify and rectify gender or other pay disparities within their organizations. These audits involve a thorough examination of pay practices, identification of gaps and the development of strategies to close them.
- **Reporting requirements:** This practice involves mandates to share pay-related information with government agencies. This may include data on gender-based wage gaps or overall salary distributions broken down by demographic categories.
- **Compensation statements:** These detailed statements for employees may include a breakdown of individual compensation components—such as base salary, bonuses and benefits—offering employees a comprehensive view of their total remuneration package.
- **Penalties:** Monetary fines can be imposed if key metrics are not met in the equal pay audits or reporting requirements.

Pay Equality

Pay equality is often the desired outcome of implementing pay transparency tools and pay equity reporting. Pay equality is based on the concept of parity in compensation for work of equal value. This principle advocates that men and women should receive equal remuneration for performing identical or substantially similar roles. It extends the concept to encompass situations where individuals engage in entirely different occupations, provided that the work can be demonstrated as equivalent value based on objective criteria.

The crux of pay equality lies in the assurance that both women and men receive commensurate compensation for their contributions to the workforce. This extends beyond job titles and considers an evaluation grounded in measurable criteria, which includes various job-related factors such as working conditions, qualifications, skills and levels of responsibility.

Governments worldwide have reviewed the concept of "work of equal value" in national legislation. The OECD provides a framework in its documentation to guide countries in establishing and refining their policies on pay equality.[7]

Following the outlined criteria ensures that the evaluation of job roles is based on merit and essential job-related attributes rather than subjective factors. This approach fosters fairness and equity in compensation practices but mitigates the potential for gender-based wage disparities.

Countries and governing bodies worldwide have recognized the gender pay gap and written legislation to address the issue, detailed below.

European Union

The European Union (EU) is taking one of the most significant steps with the Pay Transparency Directive, signed into law in spring 2023. At a minimum, the law will apply to companies with more than 100 full-time employees, part-time employees and contractors. Member states have until June 2026 to incorporate the directive into national legislation. Once fully implemented, the Pay Transparency Directive will set the baseline that an EU member country must follow. A country can enforce stronger regulations, but at a minimum, a company operating within the EU must comply with the requirements set forth by the Pay Transparency Directive. The directive is the first of its kind on a regional basis. As multinational employers put policies and reporting practices in place for the EU, a global policy would be a natural rollout.

Basics of the European Union directive include the following.

Pay Transparency

- **Salary history:** Employers are prohibited from asking candidates about their pay history.
- **Salary information in job postings:** An employer must provide a pay range in the job posting.

- **Disclosure of pay ranges:** An employee is entitled to information about pay ranges upon request.
- **Antiretaliation provisions:** Employers cannot penalize employees who discuss their pay.
- **Compensation statement:** When requested, an employer must provide a comparison of the employee's pay to the average pay by gender and categorically classified by comparable employees.

Pay Equity

Pay equity measurement reports will also be required, along with the pay transparency tools. These reports will be required to disclose key metrics illustrating the pay gap between workers, categorized by gender and the categorical classification the employee is tied to. Companies will need to maintain a gender pay gap below 5%, and employees can request their company's pay gap measurement reports. The outlined gender pay gap reporting requirements must include the overall gender pay gap, median gender pay gap, and the proportion of female and male workers receiving complementary or variable components. In addition, reporting should include the proportion of workers who received a pay increase upon returning from maternity, paternity and parental leave, categorized by gender.

More pay equality guidance will be provided, but eventually, under the EU directive, companies must define categories of employees based on objective criteria (e.g., effort, skills, responsibilities and other characteristics specific to the job). The concept of equal pay for equal work will apply, and employees providing the same value of work should be paid equally. Requirements and guidance for defining worker categories will be released in the coming years.

Pay Transparency in the U.S. and Canada

United States

The journey toward pay transparency in the U.S. began with enacting the Equal Pay Act of 1963, which aimed to address gender-based wage discrimination. Most recently, the Equal Employment Opportunity Commission (EEOC) reporting requirements took a significant step in 2016. The EEOC implemented a revised EEO-1 form, mandating that private employers with over 100 employees report pay data by gender, race and ethnicity. While no fines are associated, the overarching objective of these and other measures was to bolster pay transparency and proactively identify potential discriminatory pay practices, fostering a more equitable and accountable work environment.

Executive actions and government interventions have aimed to enhance transparency and address discriminatory pay practices. The National Labor Relations Act gave employees the right to unionize and implemented an antiretaliation law, making it illegal for an employer to retaliate against an employee who talks about pay. Outside of this, no other federal laws govern pay transparency tools, pay equity measurements or pay equality.

Various states have expanded on the National Labor Relations Act and have written pay transparency tools into state law, adding to the complexity of compliance. Employers in California, Connecticut and Maryland may not request salary histories from job applicants and must disclose salary details to employees and in job postings. Multiple other states have included at least one of these requirements in state law.

Canada

Canada's efforts toward fostering pay transparency began with early recognition of gender-based wage disparities. The era of the 1970s through the mid-1980s was marked by activism by advocates for women, racialized groups, persons with disabilities, and Aboriginal peoples who were organizing politically and raising demands that the inequality they experienced be addressed.[8] During this time, the Canadian Human Rights Act was enacted and the Employment Equity Act received royal assent. The Canadian Human Rights Act was the first federal human rights law in Canada and the first federal law to protect against discrimination, and the Employment Equity Act was set up to remove systemic barriers from the workforce for women, indigenous peoples, persons with disabilities and members of visible minorities.[9]

In recent years, Canada has made strides toward enhancing pay transparency. As of this writing, British Columbia has the most robust pay transparency legislation, requiring employers to include expected pay ranges in job reporting and provide a pay transparency report.[10] Other provinces have implemented reporting requirements for gender pay gaps and have pay transparency legislation pending enactment.

Transparency Problems

While pay transparency regulations are forming worldwide, some existing

implemented pay transparency policies have been studied. The American Economic Association[11] tested the impact of pay transparency on the University of California employees after the state of California made salaries public in 2010. In the test, the association randomly chose a subset of employees and informed them of a new website that listed the pay for all university employees. The research found that employees earning below the median salary for their pay unit and occupation tend to report lower pay and job satisfaction, while those earning above the median do not report significantly higher satisfaction. In addition, below-median earners are more likely to consider looking for a new job, whereas above-median earners show no such inclination.

The 2022 *Harvard Business Review* article "The Unintended Consequences of Pay Transparency"[12] suggests pay transparency leads to a compression of pay bands. A study found that average compensation for city managers in California fell by about 7% in 2012 after the state made their pay transparent beginning in 2010.

Often, managers and supervisors become employees' first point of contact to discuss and negotiate their pay. Supervisors are more likely to negotiate and approve individual perks for employees to keep critical employees motivated and performing their best. Globally, this can include requests for career development, supplemental health benefits, housing allowances, etc., not offered to other employees. Since these arrangements are not in the form of salary, they can increase nontransparent remuneration, thus going against pay equity.

Summary

The combination of pay transparency and pay equity measures may assist employers in their efforts to create an inclusive and equitable work environment by addressing systemic disparities and fostering a culture of fairness in compensation practices. However, pay transparency tools cannot close the wage gap alone. Employers may want to examine their promotion activities and policies to ensure that women are in the pipeline for advancements to more senior positions. Talented women may be overlooked, thus diminishing an organization's intrinsic advantage. Many multinational companies will need to comply with the EU Pay Transparency Directive, creating an opportune time to adopt the policies globally. Regardless, if governed by new laws, companies should consider whether women are being paid fairly for work of equal value.

bio

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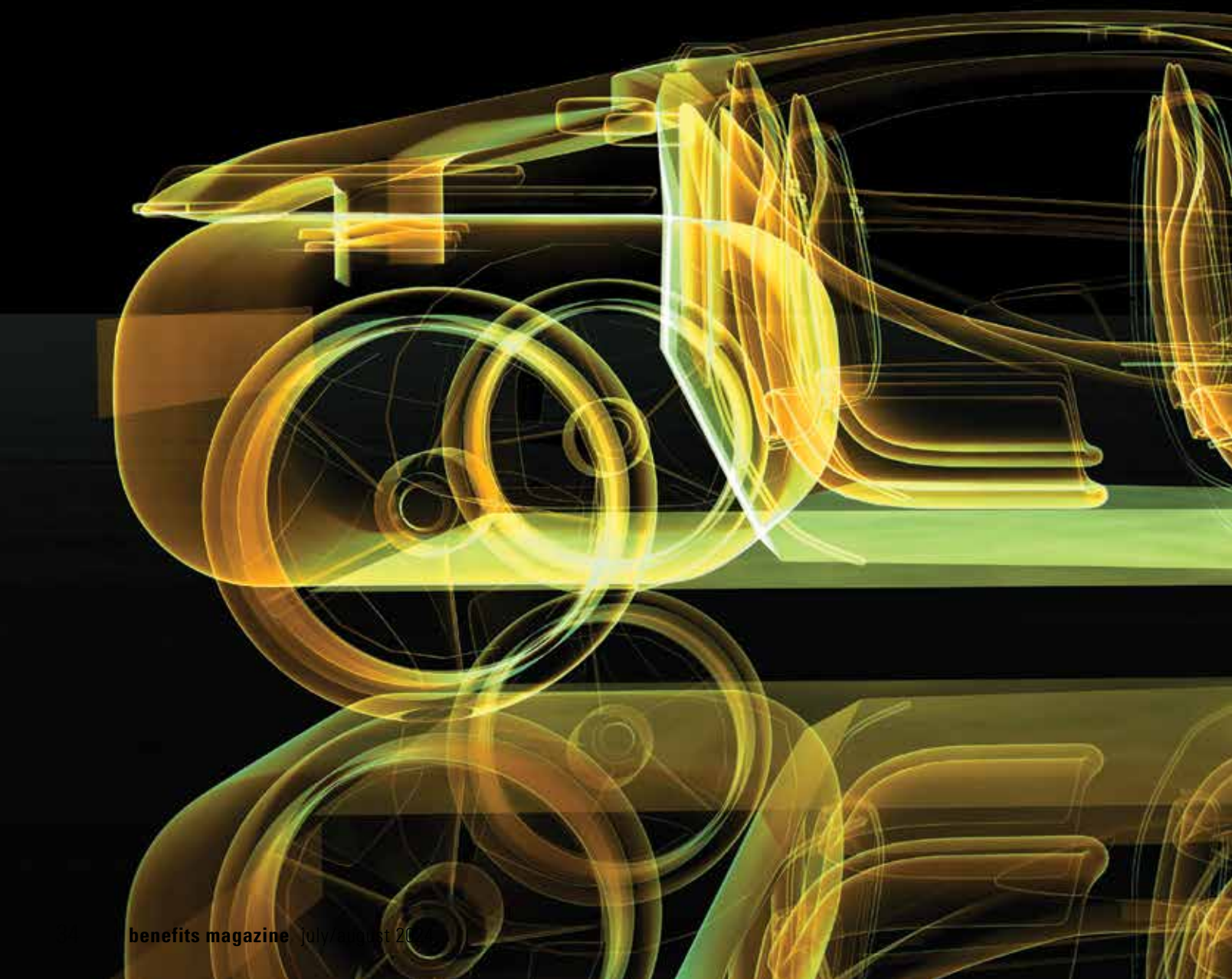
CUSTOM-

Designing a Financial Wellness Program That Fits

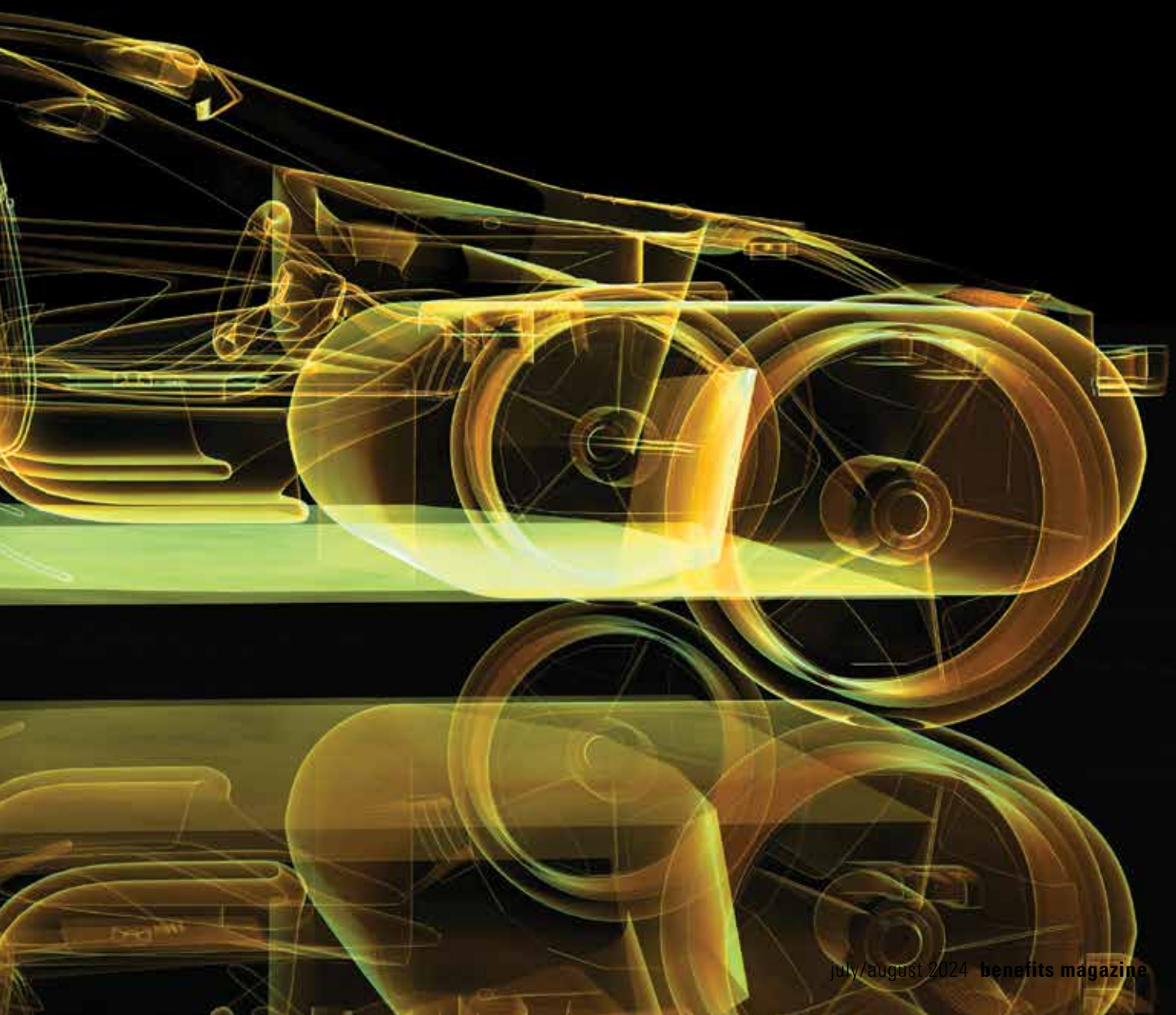


BUILT:

the Needs of Your Workforce

Employers that gain an understanding of the unique financial needs and goals of their workforce can design and implement a more meaningful financial wellness program.

by | **Jeanie Justice**



What does financial wellness mean for your employees?

For some, it is the freedom from constant worry of living paycheck to paycheck and wondering how to make ends meet. For others, financial wellness means curating a comfortable retirement. Achieving either of these goals can create financial stress along the journey.

Workplace financial wellness programs can address both of those objectives and multiple other financial issues. Taking the time to understand your employee population and their unique needs and goals goes a long way toward supporting and improving employee financial well-being and creating an engaged workforce.

The Impact of Financial Stress

According to Verywellmind.com, "financial stress is emotional tension that is specifically related to money."[1] The level of emotional tension around financial stress can be greatly influenced by circumstances, including a person's geographic location, life stage, culture or upbringing.

While it's common to worry about finances from time to time, chronic stress and worry can severely affect a person's well-being. A 2023 CNBC survey found that "more than 70% of Americans feel financially stressed," and recent inflation is no help.[2] According to a recent *Forbes* article, although inflation has come down since 2022, consumers are "still feeling the pinch of higher prices" since they remain up significantly compared with before the pandemic.[3] When comparing prices from January 2020 with those in December 2023, food prices are up 25%, energy (such as gas, diesel and other motor fuels) is up 26% and shelter services (e.g., rent, water, garbage, etc.) are up by 21%. These inflated prices—for even basic living expenses—can substantially influence employee financial stress.

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Prolonged financial stress can cause heath issues such as stomachaches, headaches and exhaustion. It can also create mental health issues including anxiety and depression. According to the American Psychological Association (APA), "chronic stress causes wear and tear on the body and can disrupt almost all of the body's processes," putting people at increased risk for heart disease, heart attack, high blood pressure and stroke.[4] It can also suppress the body's immune system, making it harder to recover from illness. For employers, employee financial stress can result in decreased productivity and increased use of sick days as well as a negative impact on their bottom line.

Prolonged financial stress can cause physical health issues such as stomachaches, headaches and exhaustion. It can also create mental health issues including anxiety and depression.

Employers that work to support employee financial well-being may reverse these trends and see an increase in employee engagement and job satisfaction in addition to reduced turnover. All of this can enhance the employer's brand and reputation and—ultimately—its profits.

Identifying the Needs of Your Population

To assess the needs of your employees and design a financial wellness program that fits those needs, start by gathering information through the following steps.

1. Assess your population and identify gaps. Start by analyzing your employee demographic data. Examples of questions to ask include:

- Are employees mostly exempt or nonexempt workers?
- Do employees live in rural communities with little access to services?
- Is the workforce made up of mostly young workers who are new to the workforce or an aging population who will retire soon?
- Do you have a large population of lower wage workers?

You can also gather data on retirement plan participation, such as what percentage of employees are participating and

whether they are contributing enough to earn a matching contribution.

2. Ask employees! Collecting employee feedback via focus groups and/or surveys can be an effective way to learn what is causing employees financial stress and what they need to achieve financial wellness. Surveys don't have to be complicated. The following examples of key questions can go a long way to helping you understand employee needs.

- How would you rate your current financial situation (using a scale)?
- Do you have a budget in place to manage your expenses?
- Do you have an emergency fund to cover unexpected expenses?
- Do you know how much you want to save for retirement?
- Do you have significant debt or student loans?
- What resources would help you to feel more financially secure?

takeaways

- Employers that work to support employee financial well-being may see an increase in employee engagement, job satisfaction, productivity and performance, and they may experience reduced absenteeism and turnover.
- Before embarking on a financial wellness program, employers should start by assessing their workers' needs. Analyzing data and collecting employee feedback through focus groups and/or surveys can help identify those needs.
- The most viable program options can vary depending on the employee population. A younger population may benefit from education on topics such as budgeting and emergency savings, while an older population may need information about maximizing funds in retirement.
- Delivery methods and resources for financial wellness programs include webinars, in-person meetings, targeted marketing materials, access to experts and employee champions.
- Employers should measure participation and look at changes in behavior and employee satisfaction to gauge program effectiveness.

Determine Viable Program Options

Viable options for programming can vary greatly, based on your assessments. Following are some examples.

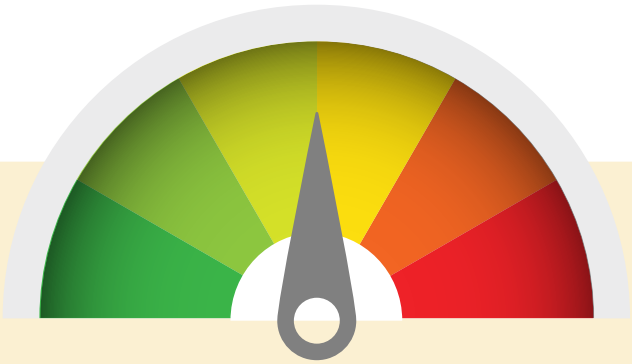
- A mostly young workforce may benefit from more early-life education on topics such as budgeting and saving for emergencies. Many retirement plan consultants include this type of education with the other services they provide for organizations or will offer them for an additional fee. Alternatively, employers may choose to offer reimbursement or provide free access to a budgeting or financial planning app.
- An aging population may benefit from support with how to prepare for retirement, enroll in Medicare or maximize their funds in retirement. Again, employers may be able to leverage their retirement plan administrator or consultant or another vendor (such as a benefits broker) to provide these services. Third-party vendors that specialize in providing Social Security and Medicare services to employees are another option.
- Access to online services or bringing resources, such as a financial planner, to the workplace may help support employees who live in rural areas and may have limited resources within their own communities. Providing access to a budgeting app or offering virtual financial planning sessions might assist these employees.
- For low-wage earners struggling with inflation, basic financial services can be essential to their financial well-being. Topics might include how to track expenses and create a budget, ways to save small amounts to help create an emergency fund or strategies for reducing expenses (such as shopping for lower car insurance rates). These resources can be provided via a variety of methods such as one-on-one support, group classes or access to free virtual resources and apps, depending on the needs of these workers.

Based on the information gathered and the determination of what employees need, you can begin to develop a program that supports employees where they are. Once you've identified the areas of focus—and there may be many—you can rank the needs and start with the most critical, which will depend largely on the results of your assessments and surveys as well as the company's budget. You might find that some needs can be addressed easily with basic financial education or by offering flexible work options that might provide relief from high gas prices and/or child-care expenses.

Resources and Delivery Methods

After identifying key focus areas, the next step is to determine resources and delivery methods. Examples of platforms for education include the following.

- **Webinars** allow more flexibility for organizations that have employees in many locations and/or have a large remote population. Webinars can be an effective tool for any organization since sessions can be recorded and posted for those who were unable to attend or for ongoing access to the information.
- **In-person meetings** provide opportunities for personal interactions and can build a sense of community and collaboration among participants. This method can be highly effective for small groups or when personal interaction would be beneficial. For example, communicating a new financial program to employees in person would provide a forum for discussion and questions in real time and an opportunity to interact with other participants, perhaps gaining even more insight into new programs.
- **Targeted marketing materials** (delivered via email, text or home mailing) can be an effective way to provide information to employees without disrupting the workday and can be consumed by the recipient when it's convenient. This material can provide reminders about an employer's financial resources as well as information about new benefit offerings and other tools and resources.
- **Access to experts** is an option for offering individualized financial information. For instance, access to a financial planner can help employees learn about their own



Evaluate and Adjust

Every initiative benefits from evaluating its effectiveness, and financial wellness programs are no exception. Here are some key metrics you might consider when evaluating your program:

- **Employee engagement:** Measure participation rates in the financial wellness offerings. Additional feedback from those who have accessed the program may be useful in determining the cause of low participation and provide information about how to adjust the program to make it more valuable.
- **Employee behavior:** Measure changes in employees' financial knowledge and behavior over time. Options include reviewing participation rates in the retirement program or in financial tools offered to employees. You can also conduct ongoing surveys to solicit input on future offerings and track changes in the type of requests (e.g., requests may go from the basic budgeting education to how to plan for retirement).
- **Employee satisfaction surveys:** Most employers offer some type of employee satisfaction survey (if yours doesn't, consider doing so). Questions related to benefits and financial well-being can determine whether increased satisfaction is due to these programs. Alternatively, the company can provide surveys specific to the financial wellness offerings to determine overall satisfaction with the plan.
- **Other measures:** Look at whether health care costs or sick time usage have decreased and productivity and retention have improved since the financial wellness program was introduced. It may indicate that employees feel healthier, have less financial stress and are more satisfied at work.

Based on the evaluation results, consider making changes to target areas with the most impact or to adapt to changing needs. For instance, low participation in a program may indicate that the offering is complicated or difficult to access. If so, explore solutions for simplifying the program or making it easier to navigate. Or, if the program is not producing the results expected (e.g., increased participation in the retirement plan), consider alternate approaches such as changing from in-person meetings to virtual offerings or offering incentives to participate. Working toward a comprehensive program will be an ever-evolving effort as job markets, workforces and employee demographics change.

finances and work toward financial goals specific to them.

- **Employee champions** can help communicate and educate employees regarding company resources and the financial wellness program. These champions may boost buy-in and usage of financial programs.

Whether you choose to use internal resources or external partners to deliver education depends on what kind of expertise is needed as well as the organizational budget. There are several financial wellness or education vendors, but you can also look to current partners to provide resources, such as benefit brokers, vendors or even employees within the organization, such as human resources, payroll or finance experts. For example, your retirement plan vendor may offer free webinars or other materials to educate employees on tax advantages of retirement savings or how investment fund choices may differ as you age.

Ensuring Success

Even if you're certain that your financial wellness program will be well-received by employees, there are almost always obstacles that can hinder even the best laid plans. The following steps can help minimize the risk of failure.

1. **Ensure that you have senior leadership buy-in:** It's important to have senior leadership buy-in both for financial support as well as to help promote your ideas. If you don't, your initiative will likely never get off the ground; even midlevel management is important to have on board to help market your efforts to their employees.
2. **Prepare, prepare, prepare:** Whether you use internal or external resources, meeting with vendors and colleagues to discuss needs in detail and working collaboratively to build or review the material will help ensure that the delivery is aligned with the needs. Employees who attend a disjointed or disappointing webinar will likely opt out of the next opportunity.
3. **Follow up:** Once you have delivered an educational opportunity, find out how it was received; this can be critical to making improvements for the next time it's offered.

bio

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Conclusion

Any organization can offer financial wellness to its employees, no matter the size or the budget. If you are thinking about starting a financial wellness program, start by engaging your employees and learning what they need and want. It may go a long way to achieving and maintaining a satisfied, and financially healthy, workforce.

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Using these five strategic levers may help self-funded health plan sponsors provide plan members with access to medications that improve their health while ensuring the sustainability of their prescription drug plans.

A Five-Lever Framework for Pres

by | **Nina Lathia, Ph.D.,** and **Lauren Vela**

cription Drug Savings

Drug spending is a top concern for self-funded health plans. And rightly so, given that the median list price of drugs approved by the U.S. Food and Drug Administration (FDA) in 2022 was $222,000.[1] This trend isn't likely to abate: From 2008 to 2021, launch prices for new drugs increased exponentially by 20% per year, outstripping price growth for other health care services. In fact, spending on drugs is the fastest growing item in employer health budgets, which is unsustainable. These increased costs are often passed on to plan members through premium increases and higher out-of-pocket (OOP) costs.[2]

Many plans outsource the management of their drug formularies to a pharmacy benefit manager (PBM). However, one of the challenges of working with PBMs is that they may operate based on incentives that are misaligned with the interests of the plans and the plan members they serve. For example, rebate agreements between manufacturers and PBMs can incentivize favorable formulary placement of high-priced drugs over lower priced alternatives that are therapeutically equivalent. PBMs might also engage in spread pricing by reimbursing pharmacies at a lower cost than what they charge the plan and retaining the difference.

Employers and plan sponsors have responded by implementing cost-containment measures such as restricting access to expensive drugs, increasing employee premiums and raising OOP costs to save money. Some have implemented alternative funding programs, whereby coverage for select drugs is excluded, sending plan members to manufacturers' patient assistance programs.[3] But these measures can alienate plan members if they can't get the drugs they need to manage their health conditions. Or they may decide to forgo taking their medications because they can't afford their copayments. This can have a domino effect, leading to higher health care costs in the future if their health further deteriorates.

Self-funded plans have the power and the legal obligation to look for different strategies because, under the Employee Retirement Income Security Act (ERISA), they are fiduciaries and must employ due diligence for responsible cost management of their plan. Pulling the following five powerful levers can help reduce drug spending and improve plan member health.

Lever 1: Comparative Effectiveness

Comparative clinical effectiveness refers to whether a drug is more effective than the existing treatment alternative. Establishing a drug's comparative clinical effectiveness requires data from studies that have evaluated multiple treatment options, including the current standard treatment for a particular condition. Many drugs approved by the FDA are no more effective than currently available treatments. Although it reviews evidence on drug quality, safety and effectiveness, the FDA does not evaluate comparative effectiveness or clinical value. And, unlike other countries, the United States does not have an independent agency that evaluates the comparative clinical effectiveness or cost-effectiveness of newly approved drugs. This issue was highlighted in a recent study that found more than 20% of the 206 drugs approved in the U.S. between 2017 and 2020 were either refused marketing authorization or not recommended for reimbursement in other countries because of unfavorable benefit-to-risk profiles, uncertain clinical benefits or unacceptably high prices.[4]

Furthermore, many new drugs go on to have safety problems after the FDA has approved them. Of the 222 drugs approved between 2001 and 2010, 71 were withdrawn from the market, required a "black box" warning about their safety or necessitated a safety announcement about newly discovered risks.[5]

Bottom line: Plans should make independent decisions about a drug's comparative clinical effectiveness and excluding or limiting access to drugs that provide no therapeutic benefit over and above lower cost treatment options. By doing this, plans can reduce wasteful drug spend, avoid safety problems and reduce costs.

A comprehensive evaluation of a drug's comparative effectiveness will necessarily also include cost-effectiveness. *Cost-effectiveness* refers to the trade-offs between the costs and health benefits of a drug. By considering a drug's cost effectiveness, plans can systematically assess the drug's value as well as directly compare its value to other drugs used to treat different diseases.

Results of a cost-effectiveness analysis are reported as the *incremental cost-effectiveness ratio (ICER)*, which is the ratio of the difference in costs between two drugs being compared with the difference in clinical outcomes between the two drugs. The ICER should be the basis of consideration when a plan or its vendor negotiates drug prices to ensure that the plan is achieving value for its drug spend. The Institute for Clinical and Economic Review conducts cost-effectiveness assessments of many new drugs and makes its reports publicly available on its website.[6]

Here's a key point: The *cost* of a drug is what the plan pays for it, whereas the *cost-effectiveness* of a drug is the improvement in health the patient gets in return for what is paid for the drug. Considering a drug's cost-effectiveness is what's important when determining its *value* to plan members. Comparative effectiveness informs decisions about which drugs to cover at what levels.

To ensure that plan members are receiving clinical and economic value from the organization's pharmacy benefits plan, payers should consider:

1. Requiring vendors to consider comparative clinical effectiveness and cost-effectiveness as part of their drug formulary decision-making and procurement pro-

takeaways

- To combat rising prescription drug prices, employers and plan sponsors may want to consider strategies other than restricting access to expensive drugs or increasing plan member premiums and out-of-pocket costs.
- Plans should consider implementing steps to ensure that the comparative clinical effectiveness of a drug is considered in prescribing decisions. This helps plans to systematically assess the drug's value as well as directly compare its value with other drugs used to treat different diseases.
- Interventions such as academic detailing, just-in-time physician information and peer comparison letters can help prevent inappropriate prescribing by health care providers.
- Engaging plan members in prescription drug decisions can help reduce waste. Plans also should ensure that members have access to pharmacists who can provide comprehensive medication management.

cesses and request descriptions and evidence of their processes. Plan sponsors might consider working with a third-party vendor specializing in formulary management with aligned incentives to implement comparative effectiveness processes independently.

2. Establishing appropriate oversight of the pharmacy benefit plan, including a transparent contract in place with fair drug prices and meaningful performance guarantees, along with an optimized approach to procuring high-cost drugs. It may not be in the plan's best interest to have one vendor performing all formulary design, network management, care management and administrative tasks.

Five Levers

These five levers can help self-funded health plans reduce prescription drug spending and improve plan member health.

1. **Comparative effectiveness:** By making independent decisions about a drug's comparative clinical effectiveness and excluding or limiting access to drugs that provide no therapeutic benefit over and above lower cost treatment options, plans may reduce wasteful drug spend, avoid safety problems and reduce costs.
2. **Prescribing habits:** Interventions such as academic detailing, just-in-time physician information and peer comparison letters can help curb inappropriate prescribing.
3. **Health equity:** By easing the economic burden of drug costs for members of underserved populations or those with special needs, plans may decrease the risk of a deterioration in plan members' health status that would likely require additional care such as emergency room visits. This may ultimately result in cost savings for the health plan.
4. **Plan member engagement:** Ensuring that plan members understand the plan's agenda to provide them with the best clinical outcomes at the best value can lead to less waste of resources, implementation of patient-centered solutions and improved health equity.
5. **Comprehensive medication management (CMM):** This clinical service helps to ensure that every plan member receives the right drug (most effective, lowest cost therapy) at the right time, as well as the required ongoing clinical support to assure success with their drug therapy.

Lever 2: Prescribing Habits

Encouraging evidence-based decisions about which drugs to reimburse based on comparative effectiveness data is often better for members, but plans must also consider prescribers' perceptions related to these reimbursement decisions. Ideally, trusted providers will prescribe cost-effective and comparatively superior drugs. But plan sponsors can also influence the prescribing habits of health care providers. The following three interventions have been shown to help curb inappropriate prescribing.

1. Academic detailing, unlike detailing provided by pharmaceutical manufacturers, is unbiased and includes information about cost and comparative effectiveness. When doctors are presented with results of clinical studies and information about drug cost, they will often adjust prescribing habits.[7]
2. Just-in-time physician information involves presenting physicians with access to prices of medications and potential alternatives before or during the time a prescription is written. There is some evidence to demonstrate that access to list prices of medications during prescribing may change prescriber choices.[8]
3. Peer comparison letters are letters emailed to health care providers informing them that they're outlier prescribers, relative to their peers, of certain medications that are potentially being used inappropriately. These letters encourage providers to review their prescribing patterns and indicate that their prescribing is under review.[9]

Plans may want to identify vendors and health systems that understand the importance of influencing prescribing habits and prioritize working with vendors that offer services such as real-time benefit checks that provide information on drug price transparency, including patient OOP costs, and therapeutic alternatives

at the point of prescribing. Making efforts to decrease inappropriate prescribing through interventions directed at health care providers will likely ensure better member experience because drug selection comes from the trusted provider and not the employer's administrator.

Lever 3: Health Equity

Plans achieve health equity when all participants have a fair opportunity to attain their highest level of health. Pharmacoequity, a key component of health equity, is achieved when all plan members have affordable access to high-quality medications that improve their health.[10]

Recent evidence has demonstrated that inequities in access to medications continue to persist in employer-sponsored prescription drug plans, with a considerable number of employees reporting that they've experienced cost-related nonadherence to medications. This behavior includes skipping doses, taking less medication and delaying filling a prescription (or not filling a prescription at all) in the name of saving money.[11]

Plans may use several strategies to address these types of cost-related inequities, beginning with ensuring that cost-sharing requirements and other aspects of the pharmacy benefits plan aren't obstacles to medication adherence and don't cause undue hardship for lower income plan members (e.g., not being able to afford drug cost sharing). Collecting data on these inequities helps plans to understand which plan members are most affected and target strategies accordingly. For instance, plans might develop communication campaigns that speak to underserved populations, increase options for access to drug therapies in challenged geographies and/or develop specialized clinical programs for plan members with special needs. By easing the economic burden of drug costs for these plan members, plans may decrease the risk of a deterioration in plan members' health status that will likely require additional care such as emergency room visits and ultimately result in cost savings for the health plan.

Lever 4: Plan Member Engagement

Plan sponsors should consider partnering with plan members to ensure that they understand the plan's agenda and provide them with the best clinical outcomes at the best value. Plans can develop their own communication effort or work with vendors to help plan members appreciate the results of decisions based on comparative effectiveness research. This will demand a "high-touch" and personalized effort involving the member and ideally the member's prescriber (e.g., identifying individual member needs and providing easily accessible communication channels such as phone calls or text messages), and it is critical to increase member trust and satisfaction with the process. In such an effort, a member who receives a new prescription may receive a phone call or text message with additional information about the drug.

Meaningful engagement can lead to less waste of resources, implementation of patient-centered solutions and improved health equity. Informed plan members will likely prefer evidence-based care resulting from shared decision making with their health care provider, rather than access to every available drug. For example, plan members may not always prefer treatments that provide modest clinical benefits, particularly if they're associated with bothersome side effects or financial burdens.[12]

There are many sources of information (or in some cases misinformation) about drugs available to plan members (e.g., the internet, direct-to-consumer TV ads) that are likely to influence their views or perceptions of a particular therapy. Given this landscape, it's imperative that plan members have access to objective data on drug therapies presented in a way that is understandable and actionable to them.

Lever 5: Comprehensive Medication Management

Plan members can have access to the highest quality medications, but if they're not using them appropriately, they're unlikely to experience any health benefits and are also at high risk for medication-related problems (MRPs). MRPs are very expensive for health plans and plan members: It's been estimated that the cost of non-optimized medication therapies in the

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Education

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U.S. in 2016 was $528 billion, representing 16% of all health care expenditures.

Plans should ensure members have access to pharmacists who can provide comprehensive medication management (CMM) either through on-site clinics, relationships with community pharmacies or virtual access to specialized call centers equipped with members' clinical data. CMM is a clinical service ensuring that every plan member receives the right drug (most effective, lowest cost therapy) at the right time, as well as the required ongoing clinical support to assure success with their drug therapy.

Not only does CMM contribute to optimizing a plan member's medication therapy, but it increases access to primary care services, addresses health inequities, improves chronic disease management, reduces overall health care costs, and enhances patient satisfaction and experience with the health care system.[13]

Using these five strategic levers can help self-funded health plans provide plan members with access to drugs that improve their health while ensuring the sustainability of the drug plan.

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bios

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Defendant Acted Arbitrarily and Capriciously in Denying Mental Health Benefits

The U.S. Court of Appeals for the Tenth Circuit reverses and remands the district court's judgment in a suit related to residential treatment coverage for mental health and substance abuse issues.

Background

The plaintiffs include a plan participant of an employer-sponsored health care plan who is claiming coverage for his dependent son, who is covered under the plan and who received care at a residential treatment center for mental health and substance abuse issues. The defendant is the insurer that administered the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs brought this suit against the defendant, alleging the denial of benefits was arbitrary and capricious. The plaintiffs appealed from an entry of judgment in the defendant's favor. On appeal, the plaintiffs challenged the district court's ruling that the defendant's decision to deny benefits was not arbitrary and capricious and that it complied with ERISA. The plaintiffs also challenged the defendant's view that the plaintiff dependent's substance abuse was "secondary" as opposed to "central" to his mental health condition.

The plan provides that the defendant has discretion to decide whether the benefit plan will pay for any portion of the cost of a health care service. The plan covers services for mental health and substance abuse and specifically covers treatment at a residential treatment facility, but services must be "medically necessary" to be covered.

Court: U.S. Court of Appeals for the Tenth Circuit

Decision: The defendant wrongfully ignored the plaintiff son's evidence of substance abuse and treatment in its denial of residential treatment benefits, and the case is remanded to the district court.

The defendant uses specific guidelines tailored to services for mental health and substance abuse to determine whether the plan will cover these services. These are known as "The Mental Health Guidelines and Substance Abuse Guidelines."

The plaintiff dependent was diagnosed with attention-deficit/hyperactivity disorder and anxiety disorder from age seven to 13 and prescribed medication while regularly meeting with a clinical psychologist. By high school, he was habitually experimenting with drugs, leading to an overdose and, at age 17, he was admitted for inpatient mental health and substance abuse treatment. Expressly, the plaintiff-beneficiary was admitted for "attention-deficit/hyperactivity disorder," "alcohol use disorder" and "unspecified depressive disorder."

During the plaintiff dependent's treatment program, he underwent a psychological evaluation. Regarding his substance use history, the psychologist portrayed the plaintiff dependent's extensive drug use as a coping mechanism for his mental health struggles and determined that he was likely to act out again in the future. The psychologist diagnosed the plaintiff dependent with moderate to severe cannabis use disorder and moderate to severe alcohol use disorder. Because of this diagnosis, the psychologist strongly recommended that the plaintiff dependent continue treatment at an inpatient residential facility with access to substance use treatment. He was then admitted to another residential treatment center with access to substance abuse treatment. The treatment plan at this residential treatment center included specific treatment goals related to the plaintiff dependent's cannabis use disorder and substance use dependence.

The defendant initially covered treatment at the second residential treatment center but, after two weeks, denied further residential treatment

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BENEFIT DENIAL

Denying Mental Health Benefits
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benefits on the basis that the plaintiff dependent could be effectively treated at a lower level of care. The defendant denied coverage for any residential treatment moving forward and recommended that the plaintiff dependent be discharged to intensive outpatient therapy. The defendant based this decision on the mental health guidelines, determining that the treatment being recommended for the plaintiff dependent's anxiety disorder was not consistent with generally accepted standards of medical practice. After several appeals and denials that did not address the plaintiff dependent's claims regarding substance abuse issues and only focused on the mental health guidelines, the plaintiffs appealed in court.

Arguments and Discussion

The plaintiffs argue that the defendant's decision to deny benefits was arbitrary and capricious because the plaintiff dependent's substance abuse issues were not considered or addressed when benefits were denied. Under the arbitrary and capricious standard, the court upholds the administrator's determination so long as it is made on a reasoned basis and supported by substantial evidence. In its review, the court highlights that the record showed that the plaintiff dependent had been receiving treatment for both substance abuse issues and mental health issues, and despite the plaintiffs' insistence for the defendant to apply both substance abuse and mental health guidelines in its review, the defendant solely evaluated under the mental health guidelines. The court further highlights the plaintiffs' bevy of evidence for the second reviewer to consider in the administrative appeal, including the substance abuse guidelines. Still, once again, the defendant denied the benefits without mention of or reference to the substance abuse issues or guidelines.

The defendant argues that despite the evidence of substance abuse, the plaintiff dependent's continued treatment was not "medically necessary" and additionally argues that his substance abuse did not need to be addressed because it was not a "primary driver" for his admission. The court finds that this argument misplaces the focus of the case, which is the presence of independent ground for coverage. The court also disposes of the argument that substance abuse had to be a "primary driver" of the plaintiff dependent's treatment, as the court has never used such language or placed any weight on a "primary driver" for a participant or dependent's treatment.

Therefore, the court finds that the record is replete with evidence of the plaintiff dependent's substance abuse and treatment and that the defendant is not justified in shutting its eyes to his entitlement to benefits based on his substance abuse. Accordingly, the court reverses and remands the judgment of the district court.

Ian C. et al. v. UnitedHealthcare Insurance Co., No. 22-4082 (Tenth Cir., December 5, 2023).

Court Reverses Reclassification of Disability Benefits for Former NFL Player

DISABILITY BENEFITS

The U.S. Court of Appeals for the Fifth Circuit reverses the district court's judgment in a suit related to the reclassification of disability benefits in favor of the defendant plan fiduciaries.

Background

The plaintiff is a former National Football League (NFL) player who participated in the NFL's retirement plan, which provided disability pay to eligible disabled NFL players. The defendants include the plan administrator, sponsor, the plan committee and plan advisors. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff brought this suit against the defendants, alleging that their denial of disability benefits was an abuse of discretion under ERISA. The defendants appeal from entry of judgment in the plaintiff's favor. On appeal, the defendants raise several challenges, but the court discusses the only one that is dispositive: that the plaintiff cannot show that changed circumstances entitle him to reclassification to top-level active football benefits.

The defendants challenge the district court's finding that the plaintiff is entitled to a reclassification of his disability benefits because there is no evidence of changed circumstances warranting a reclassification. Under the ERISA-governed plan, a player who has already been awarded total and permanent benefits is not eligible for another category of benefits unless the player shows clear and convincing evidence that, because of changed circumstances, the player is eligible for a benefit under a different category of total and permanent benefits.

The plaintiff's NFL career came to an end in 2006 following a series of concussions, and as a participant in the plan, the plaintiff applied for and received "line of duty" benefits in 2010. In 2014, after the Social Security Administration (SSA) found him entitled to disability benefits, the plaintiff submitted a claim for reclassification and was granted total and permanent benefits under the "Inactive A" category. The plaintiff was not granted total and permanent benefits under the "Active Football" status because he did not become totally and permanently disabled until after his disability began, long after his NFL career ended.

Two years later, in 2016, the plaintiff submitted a claim for reclassification under the "Active Football" status to receive substantially more disability benefits than he received under the "Inactive A" category. To support his reclassification request, the plaintiff submitted the same documentation he submitted in 2014, and the plan committee denied the request because (1) there was no evidence of changed circumstances since his 2014 disability benefit award, (2) the requested reclassification was outside the plan's stated 42-month limitation period and (3) the SSA determined that the plaintiff's disability onset date was in December 2008, which is not shortly after the date of the first football disability (i.e., presumably a 2004 concussion). Relevant on appeal is the first reason—the absence of changed circumstances.

Arguments and Discussion

The defendants argue that because the plaintiff is unable to demonstrate changed circumstances from 2014 to 2016, the plaintiff is not entitled to reclassification of his disability benefits. During the plaintiff's appeal to the board in 2016, the plaintiff acknowledged his need to demonstrate a

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Court: U.S. Court of Appeals for the Fifth Circuit

Decision: The fiduciaries of an NFL retirement plan used a reasonable and fair definition of "changed circumstances" when they denied a higher level of disability benefits to a former player.

Court Reverses Reclassification of Disability Benefits
continued from previous page

change in circumstances but did not attempt to do so and asked the board to waive the requirement of changed circumstances. Therefore, the court finds that he forfeited any claim to changed circumstances at the administrative level. Moreover, the court confirms that the record presently shows no change in circumstances that would entitle the plaintiff to reclassification.

To the contrary, the plaintiff argues that he presented evidence of changed circumstances by pointing to a 2012 doctor report he included in his 2016 application and pointing out new disabilities he included in his 2016 application, such as affective disorder and significant memory and attention problems. Because the plaintiff did not raise these circumstances with the board as a basis for the changes in circumstances in 2016, the court is unable to consider them in its determination.

Additionally, the court is unable to consider the doctor's report because it is from 2012 and cannot be used to show changed circumstances from 2014 to 2016. The plaintiff attempted to introduce other evidence of changed circumstances in his brief to this court such as testimony from his ex-wife claiming he "flipped the switch" and "became someone [she] did not know anymore" from 2014 to 2016. These arguments are likewise forfeited because the plaintiff did not raise them to the board.

Furthermore, the plaintiff argues that the board cannot rationally rely on changed circumstances to deny him reclassification because the district court found that the board never adhered to a defined interpretation of changed circumstances. The court finds that there is superficial merit to this argument. Still, the variations of definitions by the district court are not significant and because the plan instrument gives the board absolute discretion to construe plan terms, the court will uphold the board's denial. The court finds that denial based on the board's definition of changed circumstances was a reasonable and fair reading of the phrase.

Accordingly, the court finds that the board did not abuse its discretion in denying reclassification due to the plaintiff's failure to show a change in circumstances from 2014 to 2016, and therefore, the court reverses and remands the judgment of the district court.

Cloud v. The Bert Bell Pete Rozelle NFL Player Retirement Plan, No. 22-10710 (Fifth Cir., October 6, 2023).

Plan Sponsor's Denial of Severance Benefits Upheld Based on Termination for Cause

The U.S. District Court for the Southern District of Ohio granted the defendants' motion for summary judgment related to claims for denial of severance benefits, finding that the decision was not arbitrary or capricious.

Background

The plaintiff is the former vice president and chief digital officer of an electric company that sponsored and maintained a severance plan during his employment. The defendants include the employer as a sponsor of the plan and the plan itself. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff brought this suit against the defendants, asserting that he was improperly denied the severance benefits to which he was entitled under the plan. Under the plan, an eligible employee will not be eligible to receive severance benefits if the employee is terminated for cause. The defendants moved for summary judgment on the basis that the plaintiff's termination was for cause and, therefore, he was not eligible for benefits. The court reviews for an abuse of discretion and will uphold the defendants' decision if it results from a deliberate principled reasoning process and is supported by substantial evidence.

The plaintiff became vice president in 2018 and eligible for the plan in 2019. Two weeks after the plaintiff became a participant in the plan, an internal investigation into the defendant company's credit card charges was conducted. It was discovered that the plaintiff's secretary had been charging numerous personal expenses to the company card, which the plaintiff approved. In an audit the following year, it was discovered that the plaintiff's secretary had the third highest number of charges on the company credit card and that these personal expenses had been processed and approved by the plaintiff as business-related.

The plaintiff was interviewed about the expenses, and his employment was suspended by the defendant company for the remainder of the investigation. As part of the investigation, the defendant company attempted to collect the plaintiff's company-issued cell phone but discovered that the phone's contents were intentionally wiped. Based on these facts and circumstances, the defendant company terminated the plaintiff three days later and subsequently denied his request for severance benefits. The defendants concluded that the plaintiff was not entitled to benefits because he was terminated for cause. The plan provides that a plaintiff will be terminated for cause where they have commissioned an act of willful misconduct, fraud, embezzlement or dishonesty in connection to the employee's duties to the company and materially violates any of the rules of conduct of behavior provided by the company.

Arguments and Discussion

The defendants argue that the plaintiff's termination was for cause because the plaintiff materially violated the rules of conduct when he failed to supervise his secretary's corporate credit card use appropriately and was willfully dishonest by wiping his company-issued cell phone during an internal investigation. The defendants argue that their refusal to provide severance benefits is justified because the plan does not warrant the provision of benefits to employees terminated for cause. In their motion for summary judgment, the defendants argue that the evidence presented justi-

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Court: U.S. District Court for the Southern District of Ohio

Decision: A former company executive is not entitled to severance benefits because he was terminated for cause after violating the defendant employer's code of conduct.

SEVERANCE

Court Rules Plaintiffs' Claims Time-Barred by Benefit Plan's One-Year Limitation Period

STATUTE OF LIMITATIONS

The U.S. District Court for the District of Utah grants the defendant's motion to dismiss the plaintiffs' claim for mental health benefits due to the statute of limitations.

Background

The plaintiffs include a participant who is covered by an employer-sponsored group health plan who filed suit on behalf of themself and their covered dependent child. The defendant is the insurance company that serves as the claims administrator for the plan. The self-insured plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs sought payment of medical expenses incurred in connection with the plaintiff dependent's mental health treatment at a residential treatment facility. The defendant denied the plaintiffs' claims for payment. The plaintiffs bring this action alleging wrongful denial of claims and seek repayment.

Arguments and Discussion

The defendant moves for dismissal on the grounds that the claims are barred by a one-year statute of limitations period set forth in the plan. In response, the plaintiffs argue that (1) there is an alternative provision in the plan that provides a three-year limitations period; (2) the language in the plan is ambiguous as to which limitation provision governs and, therefore, the terms should be construed against the plan; or (3) the first claim should not be dismissed at the motion to dismiss stage because of this ambiguity.

Court: U.S. District Court for the District of Utah

Decision: A health plan's one-year statute of limitations on ERISA claims is unambiguous; therefore, the plaintiffs' claims for mental health benefits are dismissed as time-barred.

The court first turns to the plan's language to determine what limitation governs the claim. Ambiguity exists where a plan provision is reasonably susceptible to multiple meanings or where the definition of a term is uncertain. To determine whether a plan is ambiguous, the court considers what a reasonable person in the position of the plan participant would have understood the words to mean. First, the court addresses the plaintiffs' first claim. The court highlights the plan's provisions, with one provision stating, "You have the right to bring a civil action in federal court under ERISA Section 502(a)(1)(B) within one year of the appeal decision," and another stating that participants "may not take legal action against us to receive benefits . . . later than three years after the date the claim is required to be furnished to us."

The plaintiffs argue that because the "three-year" clause contains a header entitled "Legal Action," it is more likely to receive attention from the average plan participant. The plaintiffs next argue that because the one-year limitation contains permissive rather than mandatory language, it is less likely to be understood by participants to limit when claims can be brought. Finally, the plaintiffs argue that because the plan language is ambiguous, the provisions should be construed against the plan and the three-year provision should be used to process the claim.

The court finds it unnecessary to consider the plaintiffs' final argument as the court does not find the plan ambiguous. The court disagrees with the plaintiffs' first argument that permissive language or the position of the two clauses creates an ambiguity. The court finds that the plan provides a clear interpretive rule for understanding the relationship between both provisions and destroys any tension between them. Specifically, the court emphasizes the final paragraph of the plan, which contains the header "Reservation of Discretion-

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Plaintiffs' Claims Time-Barred

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ary Authority," which further indicates that regarding the determination of questions arising under the plan, a specific limitation or exclusion will override more general benefit language.

The court finds that by applying this rule, effect can be given to both provisions as follows: (1) the one-year limitation may apply to claims brought under ERISA Section 502(a)(1)(B), while (2) the three-year catchall provision applies to other benefits claims. The court states that because the plan mandates that actions to receive benefits generally may not be brought later than three years after the claim is required to be furnished, that fact does not erase the more specific preceding limitation that ERISA Section 502(a)(1)(B) actions, in particular, must be brought within one year of an appeal decision.

Consequently, the court finds no ambiguity in the plan and concludes that a reasonable plan participant would understand that a claim brought under ERISA Section 502(a)(1)(B), like the plaintiffs' claim, is covered under the one-year statute of limitation. Accordingly, the court grants the defendant's motion to dismiss because the plaintiffs' claim is time-barred.

B.M. v. Anthem Blue Cross & Blue Shield, No. 1:22-cv-00098-JNP-JCB (D.Utah, January 31, 2024).

Plan Sponsor's Denial of Severance Benefits Upheld

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fies the plaintiff's termination for cause and, therefore, he is not entitled to receive severance benefits.

The plaintiff proffers numerous arguments against the defendants' motion for summary judgment, which the court finds meritless. The plaintiff argues that the plan has a significant conflict of interest, but the court finds that the plaintiff offers no evidence to support his allegations of a conflict. The plaintiff also argues he was not given a written explanation for his termination, which the court responds is not required by the plan or the law.

The plaintiff further argues that the for-cause evidence was generated after he sought severance benefits. This argument does not move the court and points out that the conduct underlying the decision occurred before the plaintiff was officially terminated. The plaintiff then argues against a finding that the termination was for cause and disputes that the conduct committed constitutes cause under the plan. The court disagrees with the plaintiff's challenge that the termination was arbitrary or capricious.

Accordingly, because the court does not find that the defendants acted arbitrarily or capriciously when terminating the plaintiff and because his for-cause termination precludes the plaintiff from receiving severance benefits, the court grants the defendants' motion for summary judgment.

Kramer v. American Electric Power Executive Severance Plan et al., No. 2:21-cv-5501 (S.D.Ohio February 5, 2024).

Disability Plan Cannot Enforce Subrogation Rights Against Attorney

SUBROGATION

The U.S. District Court for the District of Rhode Island rules in favor of the defendant attorney in a suit by a disability benefits plan to enforce its subrogation rights related to the recovery of settlement proceeds in a third-party lawsuit.

Background

The plaintiffs include a disability benefit plan sponsored by an employer and the employer. The defendants include the plan participant and the plan participant's attorney. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The defendant plan participant was injured in a car accident and recovered damages from a third party as a result of such an accident. The plaintiffs brought this suit seeking reimbursement of disability benefits paid to the defendant plan participant resulting from the same accident. The plan provides for recovery of disability benefits from a participant when the participant has recovered damages from a third party.

After receiving her settlement proceeds, the defendant plan participant allegedly disappeared before the plaintiffs could serve her. ERISA allows a plan to pursue equitable remedies to enforce a plan's provisions, and the plaintiffs now seek to enforce an equitable lien against the settlement proceeds. An *equitable remedy* involves recovery from a specific and identifiable pool of funds to which the plaintiffs have established an entitlement. The essence of an equitable recovery is that the claimant seeks to recover a particular fund or property in the defendant's possession, not simply general compensation from the defendant.

Court: U.S. District Court for the District of Rhode Island

Decision: A disability plan cannot enforce its subrogation rights because it failed to prove that proceeds from the defendants' settlement with a third party still exist.

Arguments and Discussion

The defendant attorney argues that an equitable recovery is impossible because the settlement money is no longer in his possession. The defendant attorney claims that the funds received from the settlement were used to pay the law firm's operating expenses, and because they are no longer in his possession, there can be no equitable recovery. To determine the existence of an equitable remedy, the court places the burden of proof on the plaintiffs who claim entitlement, and to prove a right to recovery, the plaintiffs must prove that the funds exist.

The court finds that the plaintiffs did not attempt to prove that the settlement funds were not used for operating costs. The court discusses the plaintiffs' lack of effort to subpoena any bank statements or take a deposition on the issue and the plaintiffs' failure to take legal action to pursue reimbursement until six months after the settlement funds were paid out. The court finds that the plaintiffs should have been more proactive in safeguarding their ability to recover from the settlement proceeds and have failed to carry their burden in proving the settlement funds still exist for which their lien could be enforced.

Accordingly, the court enters judgment for the defendants because the plaintiffs fail to show the existence of the settlement proceeds they claim entitlement to as an equitable remedy.

Verizon Sickness & Accident Disability Benefit Plan for New England Assoc. v. Rogers et al., No. 1:21-cv-00110-MSM-PAS (D.R.I., January 29, 2024).

Court Refutes Argument That Underperforming Investment Fund Shows Fiduciary Breach

The U.S. Court of Appeals for the Western District of Wisconsin grants the defendants' motion to dismiss for failure to state a claim in a suit for breach of fiduciary duty related to retirement plan investments.

Background

The plaintiffs include a class of former participants of a 401(k) retirement plan sponsored by their former employer. The defendants include the company, the plan's board of trustees, the plan's administrative committee and other plan fiduciaries. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs bring this suit against the defendants, alleging breaches of their fiduciary duties under ERISA. Specifically, the plaintiffs claim that the defendants imprudently retained investments in a suite of target-date funds (TDFs) despite its poor performance and the availability of other, better-performing TDFs. TDFs are an investment option offered by the plan.

Arguments and Discussion

The defendants all maintain the 401(k) retirement plan in one capacity or another. They are allegedly also responsible for selecting, monitoring and retaining the service providers that provide investment advice, recordkeeping and other administrative services. The defendants offered the plaintiffs, as an investment option, TDFs that were the third most popular on the market when proposed as an option. The offered TDFs were also the plan's qualified default investment alternative (QDIA). Because the TDFs were assigned QDIA status, the plaintiffs' contributions were automatically invested in the TDFs. This resulted in almost half of the plan's assets being invested in the TDFs. The plaintiffs allege that the performance of the TDFs paled in comparison with other TDFs available during the period. Specifically, the plaintiffs identify four other TDFs and compare their returns to the returns with the TDFs selected by the defendants.

The defendants contend that even if the plaintiffs' allegations are true, they do not show that the defendants acted imprudently under ERISA. According to the plaintiffs, the defendants committed a breach of their fiduciary duty because the TDFs they selected ultimately underperformed compared with competitors. Essentially, the plaintiffs infer that the defendants breached their fiduciary duty because they failed to have the hindsight to know that the TDFs would have underperformed. The court disagrees.

The court finds several reasons why the plaintiffs' allegations fail to show that the defendants breached their fiduciary duties. In determining whether plan fiduciaries failed to be prudent when an investment option underperforms, courts look at the context in which the decision was made, including available alternative investments. The courts look to comparable investment options that a prudent option would have considered, including those that hold similar securities, similar investment strategies, and a similar risk profile to the investment chosen by the fiduciary. The court finds that the plaintiffs fail to provide a comparable investment option for which the TDFs selected by the defendants may be compared and find it insufficient to merely provide any TDF just because it performed well. The court also disagrees with the plaintiffs' argu-

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Court: U.S. Court of Appeals for the Western District of Wisconsin

Decision: A class of former 401(k) plan participants failed to provide a comparable TDF to sufficiently state their claim that the defendants imprudently retained investments in a suite of TDFs offered by the plan.

FIDUCIARY DUTIES

Claims of Fraud and Misrepresentation of Insurance Policies Not Preempted by ERISA

PREEMPTION

The U.S. District Court for the Southern District of Florida denies the defendant's motion to dismiss for failure to state a claim, finding that ERISA does not preempt the plaintiff's claims.

Background

The plaintiff is a participant in a group long-term disability (LTD) insurance policy. The defendant is the insurance company that insures and administers the policy.

The plaintiff purchased the group LTD insurance policy as supplemental disability coverage to another disability policy she maintained to increase her total monthly benefits. The two policies did not contain an offset for benefits payment by the other policy.

As part of an acquisition, the defendant's predecessor, another life insurance company, acquired the supplemental disability coverage. In the acquisition, the plaintiff was advised in a letter that her basic insurance plan would remain the same. Based on the representations in the letter, the plaintiff paid the premiums for coverage under the impression that her policy was not changing despite her insurance being acquired by the defendants. Later, the defendant's predecessor terminated the plaintiff's original policy and wrote a new policy. Unbeknownst to the plaintiff, the new policy was not identical to the plaintiff's original policy, and the latest policy contained an offset for any other individual disability insurance benefits. As a result of the new policy, the plaintiff would not be able to apply for benefits under both policies. The defendant subsequently acquired its predecessor and took over the supplemental group LTD policy.

After years of paying the premiums to her group life insurance and individual disability insurance, the plaintiff became disabled and submitted claims under both policies. The defendant approved the plaintiff's disability claim but, in accordance with the new policy, reduced the plaintiff's benefits based on the benefits received under the individual disability insurance policy.

Court: U.S. District Court for the Southern District of Florida

Decision: The plaintiff's claims that an insurance company fraudulently induced her to accept a new LTD policy are not preempted by ERISA and may continue.

Arguments and Discussion

The plaintiff now alleges claims of fraudulent inducement and negligent misrepresentation. The plaintiff's main argument is that the defendant's predecessor made misrepresentations to induce her to accept the new policy. Particularly, the plaintiff contends that the new policy provided significantly less coverage than the plaintiff's original policy despite the defendant representing that her coverage would remain the same. The defendant moves to dismiss the plaintiff's complaint, arguing that her claims are preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

A state law relates to an ERISA plan if it is connected to or refers to such a plan. While courts routinely find that state law claims against an insurer to recover benefits relate to an ERISA plan and are therefore preempted by ERISA, this is not always true for fraudulent inducement claims. The court also notes that not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan.

The court finds that the allegations in the plaintiff's complaint do not relate to an ERISA plan. Crucial to the court is that the plaintiff's allegations of fraudulent inducement, misrepresenta-

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Court Limits Scope of Depositions and Denies Additional Discovery Request

STOCK PLANS

The U.S. District Court for the Northern District of Illinois grants in part and denies in part the plaintiff's motion to compel discovery on how the value of unit appreciation rights was calculated.

Background

The plaintiff is a former employee and participant in an equity appreciation plan. The defendants include the plaintiff's former employer and the owner of the employer company. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff resigned from the defendant company when his unit appreciation right (UAR) benefits under the plan were 60% vested. When the plaintiff attempted to redeem his UARs upon his resignation, the defendant owner, who was the sole member/shareholder of the company and sole manager of the plan, informed the plaintiff that his UARs had not appreciated in value since they were issued and that the plaintiff was not entitled to any payment.

Arguments and Discussion

The plaintiff filed suit and argues that the defendants arbitrarily manipulated the UAR valuation to deprive him of any financial benefit upon redeeming his UARs. The plaintiff bases these contentions on the undated valuation that valued the company between $33 and $38 million, the valuation and redemption of a 40% interest in 2021, one day before the plaintiff resigned, at $2,000 per unit/share; and a UAR award granted to another employee in 2021 in which he received 100 UARs valued at $4,308 per UAR.

The plaintiff seeks additional discovery outside of the administrative record into the alleged conflict of interest that the plaintiff claims the defendant owner has as both the manager of the plan, which makes him the decision maker as to the value of the plaintiff's UARs, and the sole member/shareholder of the defendant company. The plaintiff argues that the defendant owner financially benefits from denying the plaintiff any redemption value in his UARs. The plaintiff claims that the defendant owner's dual role in the company gives rise to a structural conflict of interest and raises the question of the reasonable valuation method used to determine the value of the UARs.

The defendants argue that the plaintiff is not entitled to any additional discovery because the plan gives the defendants discretionary authority to determine the UAR valuation, triggering ERISA's deferential arbitrary and capricious standard of review. The court disagrees with the defendants and finds that the circumstances in the case give rise to a clear conflict of interest and permit additional discovery. The court highlights how the defendant owner was the sole manager of the equity plan and personally made all decisions about the valuation of the plaintiff's UARs and all other valuations the plaintiff utilized in his case.

The court also emphasizes how the defendant owner benefits financially from denying the plaintiff any redemption value for his vested UARs as the company's sole owner. Based on these details, the court finds a conflict of interest in the valuation of the plaintiff's UARs and permits limited discovery into this conflict to determine whether the conflict impacted the defendants' calculation of

continued on next page

Court: U.S. District Court for the Northern District of Illinois

Decision: The plaintiff former employee may take depositions of the owner of his former employer as well as a former member/shareholder in a dispute over the value of the employee's unit appreciation rights in an equity plan, but the scope of the depositions and discovery of certain facts is limited.

Court Limits Scope of Depositions

continued from previous page

the redemption price for the plaintiff's UARs. The court limits the scope of discovery permitted, taking into account the discretion that the Seventh Circuit affords plan administrators and ERISA's goals of inexpensive and expeditious resolution of disputes.

Additionally, the court will permit the plaintiff to take two depositions: one of the defendant owner and the other of a former member/shareholder of the company. The court also limits the scope of the depositions and prevents the discovery of facts surrounding the sale of the defendant owner's company which occurred more than a year after the plaintiff's UAR redemption request. By limiting the scope, the court attempts to balance concerns for a deferential standard of review and the limited discovery of relevant information proportional to a case's needs.

Accordingly, the court grants in part and denies in part the plaintiff's motion to compel discovery.

Van Bergen v. Fastmore Logistics, LLC, et al., No. 1:2021-cv-05796 (N.D.Ill., January 22, 2024).

Court Refutes Argument

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ment that alternative TDFs performed better than the defendants' chosen TDFs because the alternative TDFs have different growth potentials.

Accordingly, the court finds that none of the plaintiffs' allegations show a breach of the defendants' fiduciary duty, so it grants the defendants' motion for dismissal for failure to state a claim.

Abel v. CMFG Life Ins. Co., No. 22-cv-449-wmc (W.D.Wis., January 26, 2024).

Claims of Fraud and Misrepresentation

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tion and related consumer protection claims against the defendant are based on representations made in the letter. In sending the letter, the court found that the defendant's predecessor was not acting as an ERISA entity but as the seller of an insurance product. The court emphasizes that the plaintiff's allegations do not pertain to the denial or reduction of her benefits, as she agrees with the interpretation of the policy, but rather, she challenges the representations the defendant made about the policy itself. The court sees no reason to immunize the defendant from liability for fraud because the defendant's predecessor was not acting in its capacity as an ERISA entity when it sent the letter.

Accordingly, the court denies the defendant's motion to dismiss because the plaintiff's claims are solely about fraud and misrepresentation in the sale of insurance policies and, therefore, are not preempted by ERISA.

Silverman v. Sun Life & Health Insurance Co., No. 1:22-CV-22339 (S.D.Fla., January 24, 2024).

Washington Update

IRS Issues Guidance on Exception to 10% Tax for Distributions to Terminally Ill Participants

In December 2023, the Internal Revenue Service (IRS) issued Notice 2024-2 to provide additional guidance on provisions under the SECURE 2.0 Act of 2022. In addition to guidance on other provisions, the notice specifically offered additional information on withdrawals for terminally ill employees who qualify for the 10% early withdrawal tax waiver.

Effective for distributions on or after December 2022, terminally ill participants who take an early distribution will not be subject to the early withdrawal tax. This exception applies to distributions from any tax-qualified retirement plan, including defined benefit plans, 403(b) plans and individual retirement accounts (IRAs). The exception is not applicable to governmental 457(b) plans. Note that a participant must otherwise be eligible to take a distribution under the plan's terms.

For participants who qualify, there is no limit to the amount they may withdraw from their account, and participants who are eligible can recontribute amounts to an employer's plan that accepts rollovers. Qualified participants may also recontribute the distribution to an IRA.

To qualify for this new exception, the participant must obtain certification from a doctor of medicine or osteopathy who is legally authorized to practice medicine and surgery in the state where the certification is made. The certification must be made prior to the early distribution, and the participant may not qualify retroactively.

The certification must include the following.

- The name and contact information of the doctor or osteopath who is writing the certification
- A statement that the participant's illness or physical condition is terminal and death can reasonably be expected in 84 months or less after the certification is made
- A description of the evidence used to determine that the participant has a terminal illness
- The date the evidence was reviewed or examined and the date the certification was signed
- The signature and attestation by the physician that they drafted the narrative based on their examination of the patient or their review of the evidence the patient provided

Plans are not required to provide this distribution exception, but even if plans opt not to offer the feature, terminally ill participants may still take advantage of it. Participants who receive an otherwise permissible in-service distribution that meets the requirements for the terminally ill exception may treat their in-service distribution as a terminally ill distribution on their tax return. By treating the distribution as a terminally ill distribution, the participant can avoid the 10% early withdrawal tax, even if the plan did not provide the exception.

Notice 2024-2 provides an extended deadline to plan sponsors who wish to amend their plans to apply the terminally ill distribution exception. For nongovernmental and non-collectively bargained plans, the deadline to adopt SECURE 2.0 amendments is December 31, 2026. For collectively bargained plans and governmental plans, the deadline to adopt SECURE 2.0 amendments is December 31, 2028 and December 31, 2029, respectively.

The notice is available at www.irs.gov/pub/irs-drop/n-24-02.pdf.

foundation | news

Foundation Webcasts: Timely, Trendy and Free

Whether you're looking for in-depth information on the latest employee benefit trends or searching for strategies to help you comply with new regulations, you can turn to International Foundation webcasts for timely, quality information.

Webcasts are a free International Foundation member benefit. Live and recorded sessions are available in a flexible, easy-to-access format so that you can view them when and where you want. Watch a webcast at your desk, or pull your team together for a group training session. Along with the presentation, you'll also get access to additional relevant resources including articles, surveys and blog posts, handpicked by Foundation staff.

The Foundation produces dozens of new webcasts each year, featuring high-quality speakers presenting answers and solutions to retirement, health and welfare, and other benefit topics.

Here's a sampling of recorded webcasts now available to attend:

- Oncology Offerings—Designing the Best Possible Benefit
- Around the World in 60 Minutes: How Multinational Employers Can Optimize Global Benefits
- Wake-Up Call: The Unseen Impact of Sleep Deprivation
- Employers' Critical Role in Fighting the Obesity Epidemic
- The Loneliness Epidemic: How Did We Get Here and Where Do We Go From Here?
- SECURE 2.0 Act—Get the Most out of Your Plan.

Visit www.ifebp.org/webcasts to register for an upcoming webcast or attend a recorded session.

Coming Up

Annual Wellness Summit
August 26-29, 2024
Chicago, Illinois

This summer, the Foundation's two partner organizations—Wellness Council of America (WELCOA) and the National Wellness Institute (NWI)—are joining together to present the Annual Wellness Summit. Thought leaders, experienced practitioners and industry experts in wellness will provide you with inspiration and practical solutions to take your wellness program to the next level, while an exhibit hall and on-site receptions offer opportunities to make new connections.

You can find more details, including the session schedule, at **www.ifebp.org/annual-wellness-summit**.

News You Can Use

Find your next great hire by posting your organization's job openings on the International Foundation's Jobs in Benefits site. For a reasonable fee, job posters receive the benefit of listing on this targeted site, inclusion in our daily *Today's Headlines* e-newsletter and distribution to thousands of subscribers of our daily new jobs alerts. Exposure can be further boosted by purchasing a featured job listing, which includes postings on our social media.

As a job seeker, you can sign up for daily emails notifying you of new job postings and explore our Career Resource Center containing resources and tools for advancing your career in benefits.

Visit **www.JobsInBenefits.com** to get started.

Connect, Collaborate and Learn at the 70th Annual Employee Benefits Conference

With sessions covering hot topics in health care, retirement, apprenticeship plans and more, the International Foundation's 70th Annual Employee Benefits Conference will provide you with the perspective you need to effectively run your benefit plan.

This year's conference takes place November 10-13, 2024 in San Diego, California. The slate of keynote speakers includes a presidential historian and a nationally known economist as well as experts on artificial intelligence and data analytics—important and emerging tools in benefit plan management.

In addition, Lisa Gomez, assistant secretary of the Department of Labor (DOL), will join the conference on Monday morning, November 11, for an update from the DOL.

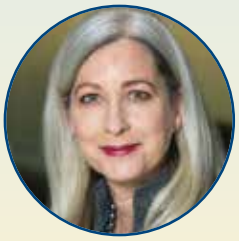
After you've been inspired and informed, you can take your pick of more than 120 educational sessions ranging in level from basic to advanced in ten different tracks.

You can further extend your learning through connecting and collaborating with more than 5,000 other attendees at the conference. The Annual Conference provides multiple opportunities for networking and sharing ideas with your peers, whether it's in the exhibit hall, at the Hospitality Hub or anywhere in between.

Visit www.**ifebp.org**/usannual for more details, including session descriptions.

SUNDAY, NOVEMBER 10
History Lessons From Epic Presidential Races
Jon Meacham
Presidential historian and Pulitzer Prize–winning author

MONDAY, NOVEMBER 11
The AI-Powered Organization
Mike Walsh
Global nomad, futurist and best-selling author



TUESDAY, NOVEMBER 12
Economic Update
Marci Rossell
2022 Annual Conference attendee-favorite speaker, expert economic forecaster, former CNBC chief economist and co-host of "Squawk Box"

WEDNESDAY, NOVEMBER 13
Moneyball: The Art of Winning an Unfair Game
Billy Beane
Former executive vice president of baseball operations for the Oakland Athletics and senior advisor to owner John Fisher

Hospitality Hub

Don't miss your chance to connect with fellow attendees, grab a snack, unwind with a massage or update your LinkedIn profile with a headshot! The Hospitality Hub will be open throughout the conference, ready for your visit! Check out www.ifebp.org/usannual for a full listing of Hospitality Hub events, including a special gathering for administrators, quick Q&A sessions and more!

plan | ahead

July 2024

15-16 Benefit Communication and Technology Institute
Denver, Colorado
Virtual option available
www.**ifebp.org**/benefitcomm

22-24 Advanced Investments Management (Wharton)
San Francisco, California
www.**ifebp.org**/advinv

22-24 CONNECT Global Employee Benefits and Workforce Strategies Summit
Chicago, Illinois
www.**ifebp.org**/CONNECT

23-25 Designing Curriculum to Close the Skills Gap
Brookfield (Milwaukee), Wisconsin
www.**ifebp.org**/skills-gap

29-Aug 2 Certificate in Global Benefits Management
Boston, Massachusetts
www.**ifebp.org**/globalcertificate

29-Aug 2 Certificate Series
Boston, Massachusetts
www.**ifebp.org**/certificateseries

30-Aug 2 Certificate of Achievement in Public Plan Policy (CAPPP®): Pensions and Health Parts I and II
Boston, Massachusetts
www.**ifebp.org**/CAPPP

August 2024

14 Women's Well-Being at Work
Virtual Conference
www.**ifebp.org**/womensvc

19-21 Certificate in Canadian Benefit Plans
Toronto, Ontario
www.**ifebp.org**/canadacert

26 Annual Wellness Summit—Preconference
Chicago, Illinois

27-29 Annual Wellness Summit
Chicago, Illinois
www.**ifebp.org**/annual-wellness-summit

September 2024

14-19 Certificate Series
Nashville, Tennessee
www.**ifebp.org**/certificateseries

15-18 43rd Annual ISCEBS Employee Benefits Symposium
Nashville, Tennessee
www.**ifebp.org**/symposium

Visit www.**ifebp.org**/education for a complete and updated listing of International Foundation educational programs, including online workshops and webcasts.

October 2024

9 Mental Health in the Workplace
Virtual Conference
www.**ifebp.org**/mentalhealthvc

14-15 Collection Procedures Institute
Washington, D.C.
www.**ifebp.org**/collections

70TH ANNUAL
EMPLOYEE BENEFITS CONFERENCE

November 10-13, 2024
San Diego, California
Virtual option available.

In-Person Preconference:
November 9-10
www.**ifebp.org**/usannual

New Trustees Institute—Level I: Core Concepts
November 9-11
www.**ifebp.org**/newtrustees

Trustees Institute—Level II: Concepts in Practice
November 9-10
www.**ifebp.org**/trusteeslevel2

Certificate of Achievement in Public Plan Policy (CAPPP®): Pensions and Health Part II
November 9-10
www.**ifebp.org**/CAPPP

Trustees Masters Program (TMP)
November 9-10
www.**ifebp.org**/tmp

TMP Advanced Leadership Summit
November 10
www.**ifebp.org**/tmpsummit

[schedule subject to change]

benefit fringe

new demands drive new voluntary benefit offerings

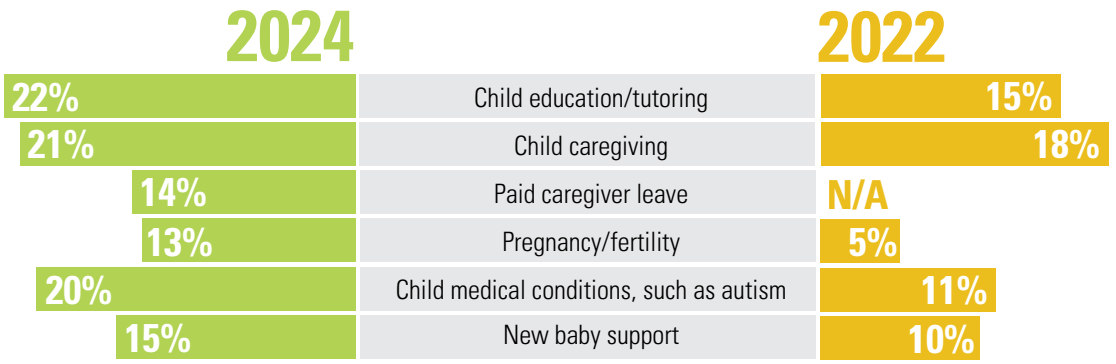
Recognizing that benefit needs vary by factors including stage of life, gender and more, roughly two-thirds (67%) of employers plan to offer greater personalization and choice in their voluntary benefit offerings, a recent survey shows. The *2024 Wellbeing and Voluntary Benefits Survey* from Buck, a Gallagher company, reveals that 86% of employers agree that voluntary benefits are key to their well-being strategy. Other survey highlights include the following.

Fastest Growing Voluntary Benefits*

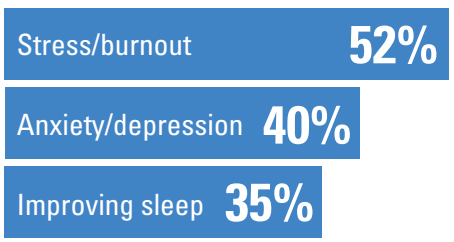
- Long-term care
- Emergency savings
- Caregiving
- Financial coaching
- Critical illness
- Cancer support and savings
- Identity theft protection
- Pet insurance
- Hospital indemnity
- Student loan support

*Biggest change in the percentage of employers offering between 2022 and 2024.

Employee Interest in Family-Forming and Dependent Resources



Employees Want Support for These Areas of Well-Being



72%

of employers plan to address employee financial well-being in 2024.

Source: Buck, a Gallagher company.
2024 Wellbeing and Voluntary Benefits Survey. Fifth Edition.

International Foundation
OF EMPLOYEE BENEFIT PLANS

18700 West Bluemound Road
Brookfield, WI 53045

Register by August 12 to receive the early registration rates. Visit www.ifebp.org/symposium.

43RD ANNUAL

ISCEBS Employee Benefits Symposium

September 15-18, 2024

Grand Hyatt Nashville | Nashville, Tennessee

CEBS COMPLIANCE APPROVED

Two of the Conference Headliners

The Truth About AI, Jobs, Employment and Generations at Work

Dr. Peter Cappelli
Academic Director, CEBS Program,
Professor of Management
The Wharton School of the University of Pennsylvania
Philadelphia, Pennsylvania

Driving Diversity, Equity, Inclusion and Belonging Through Employee Benefits

Patricia Jesperson
Chief Curiosity Officer
EmployeeEXP
Minneapolis, Minnesota

In addition, the Symposium brings the "greatest hits" of U.S. Legislative Update and U.S. Legal Update, outlining critical issues impacting benefit plans.

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