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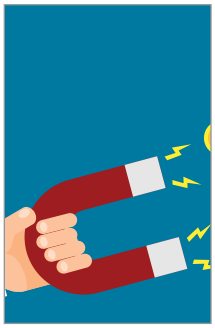

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contributors

Employers that offer family planning benefits, such as adoption assistance and coverage of fertility treatments, will likely have a leg up on their competition when recruiting employees, suggests attorney **Erin E. Shick**. She advises that plans offering such benefits should make sure they are aware of important compliance considerations and tax implications. Shick is a member of the pension, benefits and executive compensation practice at Dentons law firm in Cincinnati, Ohio.

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Yes, it's possible to share TMI (too much information) in employee benefits communications, authors **Jennifer S. Abrams** and **Joanna M. Pineda** point out. Abrams, an employee benefits attorney, and Pineda, a communications expert, share strategies for creating clearer employee benefit plan communications while avoiding oversharing. Abrams is a partner at SWB, P.C. Counsellors at Law in Berwyn, Pennsylvania, and Pineda is the chief executive officer and chief troublemaker at Matrix Group International, Inc., a digital marketing agency in Arlington, Virginia.

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A growing number of states have launched automatic individual retirement account (auto-IRA) programs for residents who do not have access to employer-sponsored retirement plans. **Samuel A. Henson, CEBS,** the chief legal officer/partner for retirement plans at Creative Planning in Overland Park, Kansas, discusses the requirements that affect employers within the states that have started auto-IRA programs.

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Nondiscrimination testing is a necessary but complicated part of operating a health and welfare plan. Authors **Hannah Chernov** and **Jessica Waltman**, who specialize in compliance at MZQ Consulting, LLC, in Pikesville, Maryland, provide an overview of federal nondiscrimination requirements for health and welfare plans and describe how testing works.

Occasionally, a health and welfare plan may mistakenly pay too much to participants, putting the plan at risk for a fiduciary breach or Internal Revenue Code violation. In the second article of a two-part series on benefit plan overpayments, attorneys **Sharon M. Goodman** and **Zachary Gaines** review the options that plans have for recouping welfare overpayments. Goodman is a principal at Slevin & Hart, P.C., where Gaines is an associate.

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Terry Davidson, CEBS
Chief Executive Officer

Get in the "Back to School" Mindset

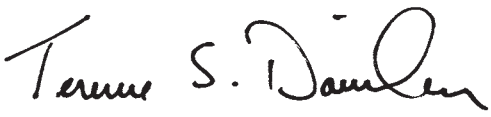
While International Foundation members educate themselves year-round, I can't help but associate the fall with going back to school. And the excitement of our largest educational event—the Annual Employee Benefits Conference—just around the corner helps solidify that feeling.

This fall is especially exciting as we embark on a new partnership with the Wellness Council of America (WELCOA). The International Foundation has cultivated a long history of championing workplace wellness, and we are thrilled to be aligning with the nation's premier wellness organization. WELCOA's annual Summit takes place in late September in San Diego, and I can't wait to meet the nation's leading thought leaders there.

Both events explore various approaches to creating a healthy workplace culture. WELCOA's Summit will provide the science and inspiration to take yourself and your organization to a higher level. At the Annual Conference in Boston, you'll learn about emerging benefits that can help achieve these goals. One such benefit getting a renewed look is family planning benefits (coverage of fertility services, adoption assistance, etc.). In this issue's cover article, attorney Erin E. Shick offers some important considerations for employers offering these benefits.

Other topics covered in this issue include plan communications, state automatic individual retirement account (auto-IRA) programs, nondiscrimination testing and recouping benefit overpayments for health and welfare plans.

There are so many options to find that "get back to school" mindset with WELCOA and the International Foundation. I hope you enjoy this issue, and I hope to see you in San Diego or Boston!



Terry Davidson, CEBS
Chief Executive Officer

benefit trends

three takeaways from the corporate benefits departments survey

Kathy Bergstrom, CEBS
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Tyler Lloyd
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by | **Kathy Bergstrom, CEBS, Jenny Gartman, CEBS,** and **Tyler Lloyd**

A sizable portion of corporate benefits departments have expanded their staffs over the last five years, but many are also outsourcing a greater percentage of their benefits functions. Among those functions, absence and disability management is presenting a significant challenge for benefits professionals.

These are three of the key trends revealed in the *Corporate Benefits Departments: Staffing* survey conducted by the International Foundation of Employee Benefit Plans. The survey drew 231 responses from corporate benefits professionals and industry experts across the United States.

Staffing

Nearly four in ten (38%) respondents said the size of their benefits department has increased either somewhat (30%) or significantly (8%) in the past five years. This compares with 17% who said the size of the benefits department has decreased somewhat (14%) or significantly (3%).

The ratio of human resources (HR) or benefits staff to employees varies by employer size, the survey shows, with smaller companies (under 500 employees) having a larger staff-to-employee ratio than larger companies. Overall, the ratio of HR staff to employees is 1.87 while the ratio of benefits staff to employees is 0.64.

The survey offered respondents the chance to respond to open-ended questions. While anecdotal, these comments offer a glimpse into some of the reasons behind the trends.

One respondent commented, "Our benefits function has traditionally been understaffed. That has not changed, and [it] is becoming even more difficult to justify additional headcount."

Another said, "I have the sense that companies overall are running too lean with benefits staffing. There is a lack of recognition at the C-levels of just how intense benefits administration is. In fact, we lost a head count, and I've had to take on more administrative duties at the director level to make up for this."

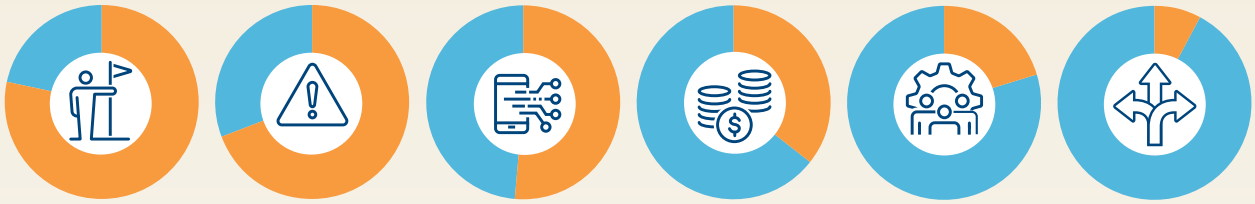
A few other respondents pointed to the pandemic as a factor in increased benefits workload as well as stepped-up compliance requirements. "During the pandemic, our jobs were asked to do so much more to care for and support our colleagues and organizations. Compliance requirements continue to increase. Personally, I don't think leadership understands or appreciates the depth and breadth of what a benefits team is expected to know and provide services to support."

Outsourcing

More than one-third (35%) of respondents said they have increased outsourcing over the past five years either somewhat or significantly. Very few respondents (4%) said outsourcing has decreased, while 61% said the level of outsourcing has stayed the same. Respondents cited expertise, risk, technology and costs as the top four reasons for outsourcing benefits functions.

The average percentage of benefits functions that include outsourced is 39.6%. The most outsourced functions are administration of employee assistance programs (EAPs), Consolidated Omnibus Reconciliation Act (COBRA) compliance, pharmacy benefits, flexible spending accounts (FSAs), retirement benefit payments and health savings accounts (HSAs).

Top Reasons for Outsourcing Benefits Functions



"Benefits teams in large companies (5,000-plus) are moving from managing tactical benefits administration to being more strategic," one respondent commented. "Benefits strategy decisions are becoming more and more influenced by attraction/retention challenges and by organizational desire to be more diverse, equitable and inclusive by meeting the needs of employees. Tactical benefits administration are more likely to be outsourced or handed over to shared service units within the organization, with benefits teams maintaining oversight to ensure compliance."

Absence and Disability Management

Somewhat predictably, rising health care costs are the biggest challenge facing benefit departments, but nearly 40% also identified absence and disability management as a key challenge.

The last five years or so have increased the complexity in this area. A growing number of state and local governments are passing paid leave laws mandating employers to offer both paid sick leave and paid parental leave, which forces organizations with multiple locations to navigate a patchwork of different requirements.

One respondent said their organization is segregating leave administration into a single position. Another mentioned that there is a need for leave administrators to process family or medical leave pay in states that now offer paid leave. They also are seeing more paid leaves outside of Family and Medical Leave Act qualifying reasons, such as parental leave.

The pandemic also had an impact on this area, with one respondent commenting that they have seen more activity in this area since the pandemic.

"With the return to hybrid in-person work after the COVID shutdown, we are experiencing a higher level of disability claims relating to stress and anxiety. These claims often take longer for approval from our vendor for short-term disability benefits, often leaving the employee in a limbo status for months."

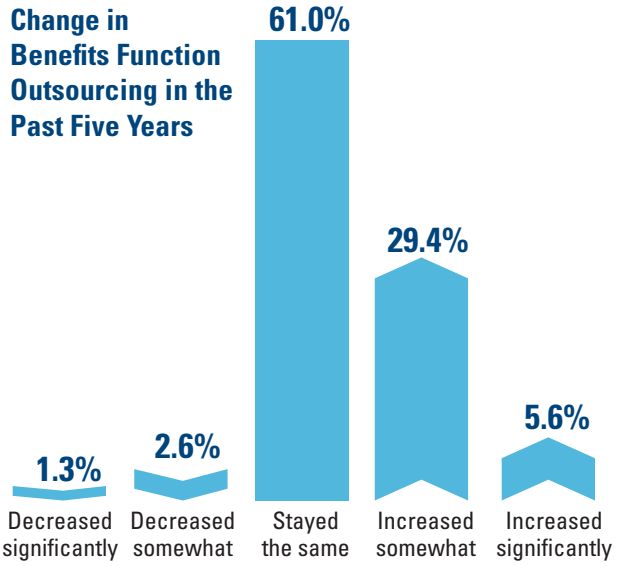
Corporate Benefits Departments: Staffing is available at www.ifebp.org/research. For more survey highlights, see the Quick Look on page 10.

quick look

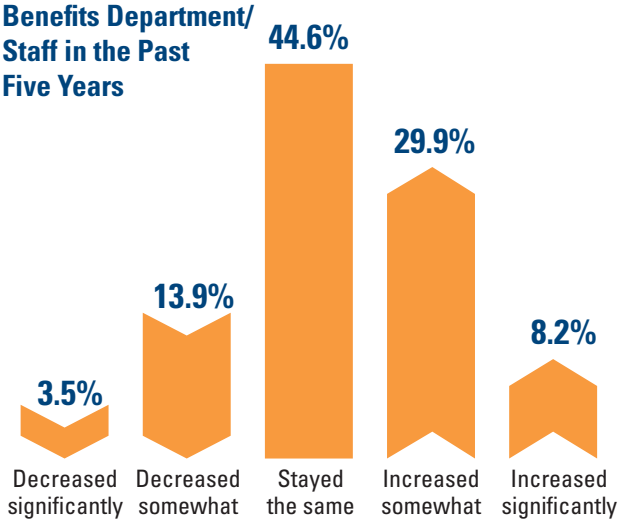
corporate benefits departments staffing

More than three-fourths (77%) of companies have a dedicated benefits department or dedicated benefits personnel, while benefits are handled by one or more persons in the human resources (HR) department for 23% of companies, a recent International Foundation survey shows. Data in *Corporate Benefits Departments: Staffing* reveals that the median number of HR employees who work on benefits is 2.0 or 3.5, depending on whether the organization has a dedicated benefits department or dedicated benefits personnel. The survey drew responses from 231 corporate benefit professionals and industry experts and contains benchmarking data on staffing, responsibilities, outsourcing, trends and challenges. Following are some additional survey highlights.

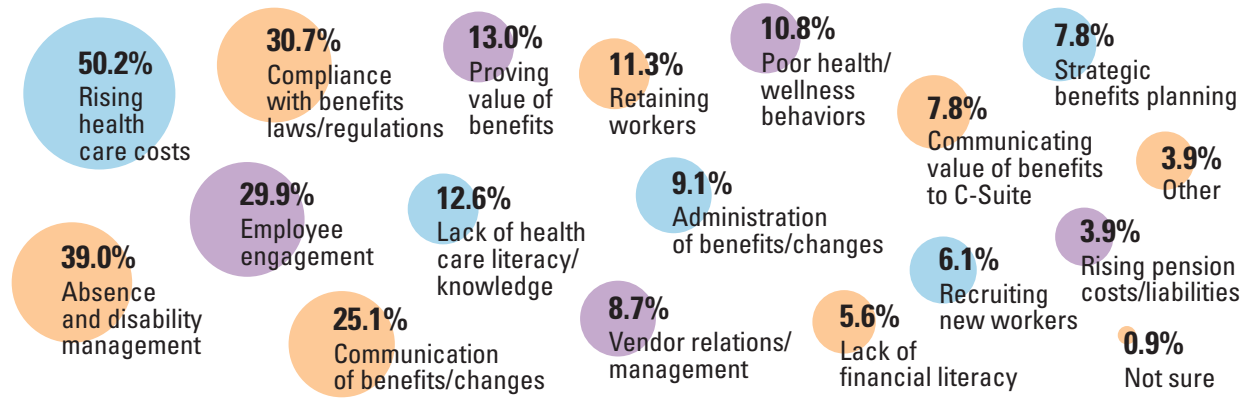
Change in Benefits Function Outsourcing in the Past Five Years



Change in Size of Benefits Department/ Staff in the Past Five Years



Greatest Challenges Facing Benefits Departments



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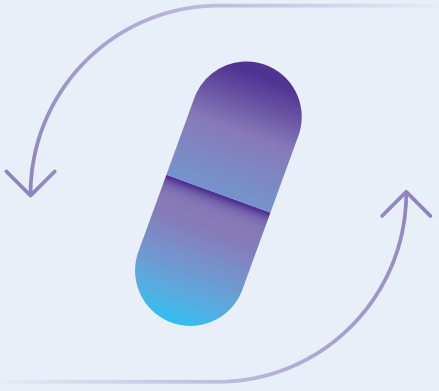

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what's working | building better behavioral health care

Kristina Guastaferri
Administrator,
Mid-America Carpenters Regional Council (MACRC) Benefit Funds,
Chicago, Illinois

by | **Kathy Bergstrom, CEBS**

When Kristina Guastaferri, a multiemployer benefits fund administrator, had difficulty finding an in-network psychiatrist to address some mental health struggles within her own family, she realized it was time for a change.

"It just clicked," recalled Guastaferri, who is administrator of the Mid-America Carpenters Regional Council (MACRC) Benefit Funds in Chicago, Illinois. "If I can't find a qualified provider that my family is comfortable with seeing, I can't imagine what our plan participants—those working and retired carpenters—are experiencing. I do this every day, so that started the wheels in motion."

Guastaferri began talking to the health fund's board of trustees and its benefits committee about expanding access to mental health and substance use care. The MACRC health fund covers 48,000 lives, including members and their families who live in northeastern Illinois as well as retirees throughout the United States. "I knew what we needed to do. It was time to expand our mental health care options for working and retired carpenters and their families."

Expanding Access: Three Points

MACRC health plan members now have three key points of access to mental health and substance use care:

1. Near-Site Health Centers

The MACRC near-site health center in suburban Chicago offers behavioral health services in addition to physical health services. The center has a full-time licensed clinical social worker on staff as well as a wellness coach. "We wanted to have a licensed, experienced professional in our near-site health center to meet the needs identified by our medical director. People were struggling, and our medical team was not equipped to do much more than listen. Having a mental health professional on site is a key component for introducing mental health support. If our other providers recognize symptoms of mental health or substance use struggles in a patient who is visiting the health center for other services, my expectation is that every effort is taken to initiate direction to our mental health professional," Guastaferri explained. "It can be a softer approach, such as a medical provider saying a few words at the end of an appointment: 'Do you have a few minutes? I'd like to walk you down the hall to meet an associate. Please consider setting aside time to speak with him about some of the concerns you confided to me.'"

MACRC is also working with other construction trades through the Midwest Coalition of Labor to open four additional near-site facilities in the Chicago area. Eligible participants can access care at the multitrade clinics, including mental/behavioral health services. All services provided at the near-site health centers are available at no cost to eligible MACRC health plan participants.

2. Integrated Member Assistance Program

In January 2022, the health plan partnered with a new vendor, Lyra Health, to manage its employee assistance program (EAP), referred to as the Member Assistance Program (MAP). The health plan increased the number of free, annual in-person or virtual sessions from six to 12. Participants have access to coaches as well as licensed professionals, depending upon the severity of their issues. "Some people just need an opportunity to talk to someone," said Guastaferri. "A mental health coach is appropriate for certain situations. In other cases, when a mental health condition is present, a licensed professional is necessary."

Another key element of the MAP is its integration with the health plan's medical benefits, Guastaferri explained. If a participant exhausts the 12

free sessions while seeing a licensed professional, they can continue that level of therapy under the medical benefits—subject to deductible and coinsurances. Most importantly, this means that an individual can continue treatment sessions with the same provider. While there is value in any EAP/MAP, without medical plan integration, individuals who exhausted their free sessions for the year but still need help generally have to start over and find another therapist, often paying 100% out of pocket for services.

The MAP also offers a medication management option, work-life balance resources, a resource library and a learning library. A key aspect of the new MAP is its virtual capabilities, the need for which was further amplified during the COVID-19 pandemic. "There are people who cannot leave their homes for a variety of reasons who still need care, so the virtual component was essential when seeking a new partner," Guastaferri commented. "In addition, many carpenters travel a significant distance for work. A virtual visit can occur during a lunch hour, or a telephonic visit can happen after work on the way home. Flexibility is essential."

3. *Mental Health Included in PPO Benefits*

The MACRC health plan previously carved out mental health benefits from its medical preferred provider organization (PPO) plan and had a narrow network of mental and behavioral health providers and facilities for 15 years. "The network was an impediment to finding care," Guastaferri stated. "No one should have to wait five months to see a psychiatrist."

The health plan administrative leaders concluded that the best way to expand access to care was to partner with the PPO network provider, used for medical benefits, and add access to the mental/behavioral health professionals and facilities.

Tearing Down Stigmas

Mental Health Ambassadors

In addition to expanding access to mental health services, MACRC also is working to destigmatize seeking

help for mental health issues and substance use. When Guastaferri made a presentation describing the expanded mental health benefits at a meeting of elected Carpenters Union delegates, she shared her personal story. "I called for ambassadors to come forward and share their stories, and they did. And, as a result of that, we were able to begin a library of videos and articles," she said. This is one of the areas in the development of resources in a program called Tools for Life.

The MACRC Benefit Funds' landing page prominently displays a link to a mental health resources page that includes stories from eight carpenters who talk about their experiences with alcohol, substance use, post-traumatic stress disorder (PTSD), relationships and more. Some are featured in videos, but the stories are also shared through an audio recording and written accounts.

Guastaferri stressed the importance of members being able to see themselves in the mental health stories. "While I can talk about the benefits—to be able to hear a carpenter say, 'I've struggled and I've come out the other side. You can too. Just ask for help.' I think that's the beginning of something that can become bigger as we continue to work to reduce stigma around behavioral health issues."

Although the ambassadors do not represent a formal peer support program, Guastaferri is confident that a member in need could approach one of the ambassadors for help if the opportunity arose. The website also directs plan members to internal and external mental health resources. The funds are reinforcing the mental health message in emails and benefits presentations and on social media.

Mental Health Training

In August, local union representatives of the MACRC also heard a presentation from Lyra Health about the "Notice and Respond" approach to mental health. The approach seeks to help union business leaders notice when someone may be struggling with a mental health and substance use issue and learn how to begin a dialog.

Every local union leader left the meeting with a stack of wallet cards containing health plan benefit information and emergency phone numbers (including the 988 Suicide and Crisis Lifeline) to carry with them or keep at the local union office. "If they see somebody in need or hear about something, they have that resource in their back pocket," Guastaferri said.

Tools for Life

The member mental health stories are part of a larger "Tools for Life" program created by the MACRC Benefit Funds. The program also includes financial education that will become required curriculum in the apprenticeship program as well as a component that looks at the whole self. "For example, construction work is hard on the bodies, so we want to be able to educate people about the importance of taking care of themselves," Guastaferri said. The fund is conducting some trial programs with virtual musculoskeletal therapy programs as a part of that effort.

Measuring the Impact

Health plan leadership is collecting data to assess the impact of the new programs. That will include account registrations with Lyra Health, the number of mental health visits through the MAP and PPO network data from the near-site health centers.

One way to measure whether the fund is reaching enough members will be to compare utilization with national statistics, Guastaferri said. "We all know that probably one in five of us is going to experience some type of mental health need in our lifetime," she noted, adding that about one in 25 adults lives with a serious mental illness, such as schizophrenia, bipolar disorder or major depression.

"The health plan trustees recognize the importance of creating multiple access points to mental and behavioral health care," Guastaferri concluded. "I believe we have accomplished this and made progress in reducing the stigma around seeking help, particularly through our ambassador program—Tools for Life."

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When creating and operating family planning benefits—such as adoption assistance and coverage of fertility services and surrogacy expenses—employers and plan sponsors need to consider several tax and compliance issues.

More Than Meets the Eye:

Offering Family Planning Benefits

by | **Erin E. Shick**

In this era of difficulty surrounding attracting and retaining top talent, organizations may want to consider adding family planning benefits to their arsenal of recruitment and retention tools.

According to the World Health Organization, one in six people globally is affected by infertility.[1] One survey showed that 60% of women in the United States said they would opt for a company that offers fertility benefits over a company that doesn't.[2] The International Foundation of Employee Benefit Plans 2022 *Employee Benefits Survey* found that more than half of employers with 5,000 or more employees offer fertility benefits.[3] It is becoming a benefit that employees at companies of a certain size are starting to expect.

Employers that don't offer family planning benefits may think they are in the clear if they haven't received any requests for these types of benefits. The problem is that even if employees are struggling with infertility and want these benefits, they may not feel comfortable asking because infertility is somewhat of a taboo topic in our society. Only 15% of adults say they are comfortable discussing fertility in the workplace. Because of this, employers may also be unaware of the stress and anxiety infertility is causing among employees.[4]

While the number of employers and plans offering robust and comprehensive family planning benefits is growing, as they say, "No good deed goes unpunished." Employers and plan sponsors need to consider several tax and compliance issues when creating and operating these benefit programs. This article is intended to provide an overview of some of those potential hazards.

Fertility Benefits and Surrogacy

Arguably the most commonly requested family planning benefit is infertility benefits. That is understandable since in vitro fertilization (IVF) can cost $20,000 per round, and egg freezing can cost $10,000 or more.[5] Workers look to their group health plan for coverage for these expensive services and can sometimes find no coverage or significant gaps in coverage. More than 80% of people who undergo fertility treatments have little to no insurance coverage.[6]

Family Planning Benefits on the Rise

The International Foundation of Employee Benefit Plans has been tracking fertility and family-forming benefits over the past seven years.

According to *Employee Benefits Survey: 2022 Results,* 40% of U.S. organizations, including multiemployer plans, public employer plans and single employers, offer fertility benefits (an increase from 30% in 2020). In addition:

- 28% cover fertility medications (8% covered in 2016, 14% in 2018, 24% in 2020)
- 30% cover in vitro fertilization (IVF) treatments (13% in 2016, 17% in 2018, 24% in 2020)
- 16% cover genetic testing to determine infertility issues (11% in 2018, 12% in 2020)
- 17% cover non-IVF fertility treatments (6% in 2016, 11% in 2018, 11% in 2020)

The survey also showed that the prevalence of adoption-related benefit offerings, including paid adoption leave and financial assistance, also is increasing:

- 34% offer paid adoption leave (19% offered in 2016, 21% in 2018, 27% in 2020)
- 19% offer financial assistance with adoption (17% offered in 2016, 2018 and 2020)

Fully Insured Group Health Plans

Some states have attempted to regulate infertility benefits by requiring group health insurance plans to provide benefits for IVF and fertility preservation. According to the National Infertility Association, as of June 2022, 20 states had passed fertility insurance laws. Fourteen of those laws required IVF coverage, and 12 states require coverage of fertility preservation for *medically induced infertility,* which occurs when a medical treatment for another condition, such as cancer, causes infertility.[7] However, because of Employee Retirement Income Security Act (ERISA) preemption issues, none of these state laws applies to group health plans that employers self-insure. In addition, sponsors of fully insured plans in states that do not mandate coverage have little to no flexibility as it relates to plan design and may have a fully insured group health plan that offers no coverage for fertility services.

Self-Insured Group Health Plans

Plans that do self-insure can choose to offer fertility benefits as part of their major medical programs, but there are no laws requiring them to do so. Some third-party administrators (TPAs) that administer self-insured group health plans may consider fertility treatments as not "medically necessary" and not cover them at all—or the coverage may have significant gaps. For example, the plan may cover IVF but not the injections needed to complete the IVF cycle. Employers that want to ensure that the gaps are filled need to work very carefully with their TPAs to review their plan design and administration, which can be a tedious process. Sometimes the TPAs are still unwilling or unable to offer or cover some services. For example, a major medical plan cannot provide coverage for certain services using pretax premiums because of the Internal Revenue Code, as discussed further below. Ultimately, even if a plan sponsor believes it is providing broad-based infertility coverage, the participant may still receive unexpected denials of coverage that a plan sponsor may never become aware of.

Vendors and Combined Family Planning Packages

To combat gaps in coverage, some employers seek out fertility benefit vendors to carve out some fertility and family-forming services, but other services remain integrated with the existing group health plan, where applicable. These programs wrap around the existing group health plan and typically bundle a variety of services—fertility, egg preser-

vation, surrogacy and adoption—into one program. The problem with the bundled model is that the tax implications vary by service and by who receives the service. As a result, plan sponsors need to work closely with counsel to examine each service and discuss the appropriate tax treatment. These vendors will work with plan sponsors to accommodate their preferred tax treatment, but that requires plan sponsors to understand what the tax implications are.

"Medical Care" and Tax Treatment

One of the most complicated questions is what constitutes "medical care." Although it seems straightforward, tax-favored treatment (e.g., receiving services pretax or through pretax premiums) is granted only to expenses that constitute medical care under Code Section 213(d).[8] Medical care under Section 213(d) includes amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body."[9] The Internal Revenue Service (IRS) defines medical care under Section 213(d) very narrowly.

In January 2021, the agency issued a private letter ruling (PLR)[10] in response to a request for an opinion on the deductibility of medical costs and fees arising from IVF procedures, gestational surrogacy and related items. The individuals requesting the letter were a married same-sex male couple. The couple in question wanted to use the sperm from one husband (Taxpayer A) and the egg from the other husband's sister (Taxpayer B) to implant in a gestational surrogate (an unrelated party). The expenses involved in this arrangement included medical expenses directly related to both spouses, egg retrieval, medical expenses of sperm donation, sperm freezing, IVF medical costs, childbirth expenses for the surrogate, surrogate medical insurance related to the pregnancy, legal and agency fees for the surrogate, and other medical expenses arising from the surrogacy.

Citing tax court opinions, IRS held that tax-favored medical expenses have always been defined narrowly. The taxpayers argued that IVF, surrogacy and related costs "affected the structure or function of the body," but IRS held that the expenses would not be incurred to treat a medical condition and were therefore not tax-deductible. When considering the deductibility of IVF, the taxpayers themselves (or in this case, plan participants) must have a defect that prevents them from naturally conceiving children.[11] This conclusion has significant implications for the LGBTQ+ community.

takeaways

- Family planning benefits include coverage of fertility preservation, infertility treatment and surrogacy expenses as well as adoption assistance.
- Forty percent of U.S. organizations offer fertility benefits, including employers with more than 500 employees. But more than 80% of people who undergo fertility treatment have little to no insurance coverage.
- Some states require fully insured group insurance health plans to provide benefits for in vitro fertilization and fertility preservation. These state laws do not cover self-insured group health plans, and some self-insured fertility coverage has significant gaps.
- Other options for providing overage include carving out fertility services and contracting with a fertility benefit vendor as well as setting up a health reimbursement account to cover fertility benefits.
- Proper tax treatment and what constitutes medical care are complicated questions surrounding fertility benefits.
- Adoption assistance programs are another way to help employees grow their families. These benefits typically reimburse employees for qualifying expenses related to the cost of adoption.

The LGBTQ+ Community

In the PLR, IRS cited an 11th Circuit case, *Morrissey v. United States*,[12] where a male in a same-sex union wanted to deduct the costs he incurred to retain, compensate and care for the woman serving as egg donor and gestational surrogate of his child. In that case, Morrissey conceded that while he was not medically infertile, he was effectively infertile because he was homosexual. The court concluded that the expenses were not deductible because the taxpayer's own function in the reproductive process was to produce healthy sperm, which he remained able to do without the IVF and surrogacy procedures.

Using this rationale, IRS concluded that as it relates to the request, the expenses associated with the sperm donation and freezing were considered medical costs, but costs and fees related to the egg donation, IVF procedure and gestational surrogacy did not qualify as deductible medical expenses.

This precedent means that large portions of the family-building process for the LGBTQ+ community are not eligible for tax-favored treatment. In the situation involving two same-sex married partners, the expenses associated with the eggs or sperm of one partner can be covered under the

group health plan but not the expenses associated with using donor eggs or sperm because the couple is not medically infertile (but is effectively infertile). In contrast, an opposite-sex couple experiencing medical infertility would likely find most of their medical costs relating to IVF procedures deductible. Logically, both an opposite-sex medically infertile couple and a same-sex couple would not be able to directly conceive a child together, but there are different tax implications according to IRS.

Even more complicated for plan sponsors is the fact that Section 1557, which applies to many health insurers and some TPAs, prohibits discrimination on the "basis of sex."[13] The Office for Civil Rights (OCR) within the Department of Health and Human Services (HHS) announced that its interpretation of "on the basis of sex" includes discrimination on the basis of sexual orientation and gender identity. This decision was in light of the *Bostock v. Clayton County*[14] case where the Supreme Court held that the Title VII ban on sex discrimination bars workplace discrimination because someone is gay or transgender.

This leaves plan sponsors in a particularly difficult situation with more questions than answers. Do plan sponsors want to potentially run afoul of Title VII and provide different tax treatment within the group health plan to LGBTQ+ employees? Do employers want to deal with the publicity of that potential Title VII suit? If they treat LGBTQ+ and heterosexual employees the same with regard to the tax treatment of fertility benefits, what are the ramifications from IRS? Would the qualified status of the Section 125 plan be compromised? Would a TPA covered by Section 1557 even agree to administer a benefit pretax or after-tax based on the sexual orientation of the participant?

Again, there are a lot of questions with no good answers. Employers and plan sponsors likely need to seek the help of qualified legal counsel to help parse through the questions above and determine the best approach for their plan participants and the plan.

Imputing Income and After-Tax Treatment

Eventually, plans get to the point where some services need to be taxed. For example, irrespective of the LGBTQ+ issues discussed above, surrogacy expenses can never be a tax-favored benefit. One way to deal with the tax implications of non-tax-deductible benefits is to have employees pay premiums for the non-tax-favored benefits posttax. However, typically with family planning benefits, the employer pays the entire premium for the family planning benefits, or an employee pays a portion of the premium for major medical care and the family planning benefits are included. If an employee can have surrogacy expenses reimbursed as part of a family planning benefit that is bundled with the major medical plan, it does not make sense to pay the medical plan premiums posttax because most of the services that the premium covers are eligible for tax-favorable treatment. As a result, many employers choose to impute the value of the surrogacy services received or the amount reimbursed to the employee as income. By imputing the services or reimbursement as income, the benefits are added as W-2 income, which requires the employee to pay federal, state and FICA taxes as applicable on the value of the benefits. Although most plan sponsors take this approach, imputing income can be challenging to coordinate with payroll and difficult for employees to understand.

Reimbursement From Other Accounts

Health flexible spending accounts (FSAs) and health savings accounts (HSAs) are typically used to cover the basics like pregnancy tests, ovulation tests, electronic ovulation tracking devices and at-home hormone testing. However, they can also be used for IVF treatment. In addition, some companies have set up health reimbursement accounts (HRAs) to cover fertility benefits. A fertility HRA is a popular option when the employer offers a fully insured group health plan and wants to offer fertility coverage but has little to no control over the fully insured plan design. However, FSAs, HSAs and HRAs are all tax-favored reimbursement

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accounts, so they are subject to the same IRS limitations discussed above and can only reimburse "medical care" as defined by IRS.

Adoption Assistance Benefits

In addition to fertility benefits, many employers provide adoption assistance benefits to prospective parents looking to grow their families through adoption. The utilization of the benefit is typically low, but it can really help employees who are going through the adoption process since domestic private adoptions can cost more than $40,000 and international adoptions cost upwards of $50,000.[15] An adoption benefit plan typically reimburses employees for qualifying expenses related to the cost of adoption (e.g., adoption agency fees, legal fees, placement fees and travel expenses related to the adoption). Not surprisingly, plan sponsors administering an adoption assistance program have some complicated tax considerations.

Tax Implications

Any reimbursement for adoption services needs to be included in the employee's income unless there is a tax exclusion. IRS establishes the maximum amount of employer-provided adoption assistance that can be excluded from an employee's income. For the 2022 tax year, the maximum dollar amount is $14,890. However, the exclusion (and potential adoption tax credit) is subject to a phaseout depending on the taxpayer's modified adjusted gross income (MAGI). For the 2022 tax year, the MAGI phaseout begins at $223,410 and ends at $263,410. Individuals may be able to both claim the income exclusion for amounts reimbursed by the employer and claim the adoption tax credit for any amounts unreimbursed by the employer. Any amounts reimbursed over the maximum dollar exclusion (factoring in the MAGI phaseout) need to be treated as income to the employee.

Employers offering an adoption assistance benefit should strongly encourage participants taking advantage of the program to seek assistance from their own tax professionals regarding the implications and intersections of the adoption tax credit and adoption income exclusion. In addition, employers need to assess each reimbursement on a case-by-case basis in determining whether and to what extent it needs to be included in the employee's income.

Conclusion

This article is in no way meant to dissuade employers from considering offering family planning benefits to employees. These benefits can promote employee loyalty and retention as well as positively impact employee morale, health and mental well-being. The pitfall is that because employers and plan sponsors may consider family planning benefits to be "societally good," they assume that there are no compliance issues and can offer it to all employees on a tax-advantaged basis. Since that is not the case, employers should work closely with legal counsel to ensure compliance.

bio

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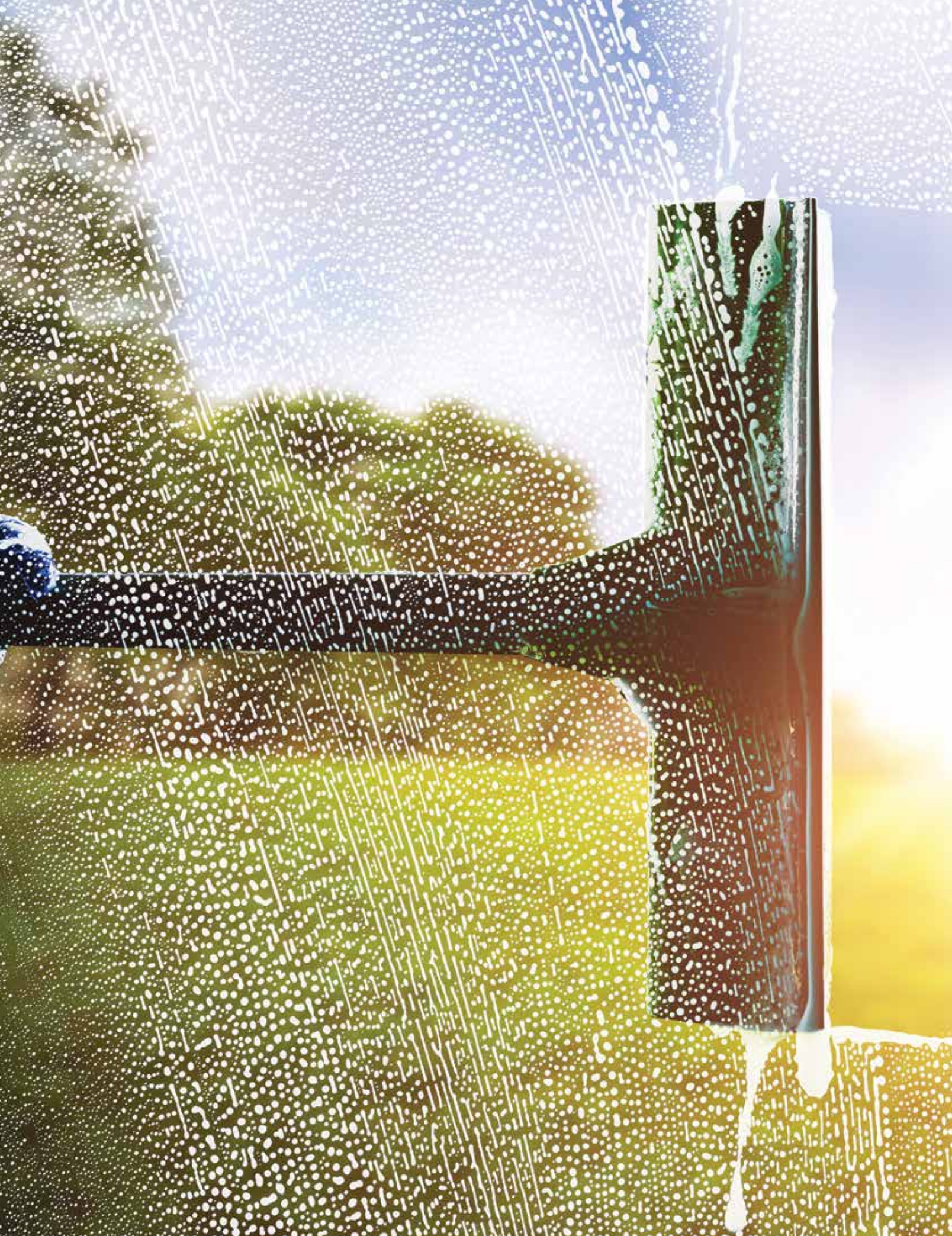

How to Be Fully Transparent—

Can Funds Overshare in Participant Communications?

by | **Jennifer S. Abrams** and **Joanna M. Pineda**

Creating effective employee benefits communications is often a tough task. The authors share strategies for communicating to be understood while avoiding oversharing.

"The single biggest problem in communication is the illusion that it has taken place."

– George Bernard Shaw, Nobel Prize–winning playwright

We've all been there. Either we've overshared something with our co-workers or friends, or we've been the recipient of "too much information" (TMI). Think of your uncle who has to tell you about the details of every doctor appointment he had last month or the best friend who shares too much information about her love life.

So, can you overshare at work? Can you overshare when it comes to benefits communications?

The answer is yes. Think of the employee benefit fund manager who blames a previous manager for mismanagement or a trustee who explains that a specific board vote was not unanimous. While it's imperative that communications with your participants be authentic, credible and transparent, it is possible to overshare and create confusion and misunderstandings.

Benefits Communications Are Hard

First, let's all admit that benefits communications are hard. Why? Let's name some of the reasons.

- There are dozens of required communications, including guidance on when and what to communicate.
- Benefits communications are often really long, with lots of legal jargon, that participants mostly don't read (let's admit this here).
- When participants do read their summary plan descriptions (SPDs), explanations of benefits (EOBs) or "red zone" notices, they often get confused and feel like the fund is not being honest about their benefits.

With that in mind, following are some recommendations for communicating to be understood, while avoiding oversharing.

Communicate to Be Understood

The No. 1 rule when sending out communications to participants: Communicate to be understood. This means that you must comply with all the regulations and guidelines about benefits communications. For example, when you deny a claim, you must provide a specific reason for the denial. Your EOBs must follow a very specific format.

But everyone knows that the requirements around communications aren't enough to guarantee that your participants actually understand their benefits (e.g., recent changes approved by the trustees, changes to your drug formulary or changes in eligibility requirements).

Rule No. 2: Meld required communications with helpful communications. What does this look like? You can try the following.

- Include a cover memo with your required communications. While there is no substitute for required communications, a cover letter can summarize the legally required communications in more plain English (or whatever language you provide the communications in). You should ensure that cover letter summaries explain the highlights of the required communication without contradicting its contents.
- Record a video that explains the communications. The video can be a conversation between your board chair and your attorney, with the board chair explaining benefits changes and the attorney explaining the communication, or it can be a cartoon explainer video. Remember that there is a segment of the population that

takeaways

- Employee benefits communications are often long and confusing and contain a lot of jargon. It is also difficult to convince participants to read plan communications.
- The most important rule when creating benefits communication is to communicate to be understood. Melding required communications with helpful communications is one way to increase comprehension among participants.
- It is easy to overshare, however, when creating benefits communications. Common examples of oversharing include placing blame on someone for an unfortunate situation and providing too many details about the decision-making process.
- Conducting a "nurture" campaign that consists of six to ten emails when plan participants first become eligible for benefits may improve their benefits knowledge and help them make informed decisions.

strongly prefers to watch videos over reading text; cater to this audience with explainer videos.
- Create a set of frequently asked questions (FAQs). Try to anticipate the questions you'll get from participants and then answer them in plain language as part of your cover memo or as an appendix.

What Does Oversharing Look Like?

In all of these communications, you must not cause panic, create fear or sow confusion. Common examples of oversharing include:

- Blaming somebody, anybody, for whatever unfortunate situation has to be communicated. Not only does it not benefit participants to blame individuals or organizations for having to make difficult decisions, you might cause legal issues for your organization by doing so.
- Providing too many details about your decision-making process. Even if a board vote was contentious, when the vote is done and the new policy has been approved, that's all you need to communicate. Do not talk about how difficult the process was, how the board was split, etc.
- Assuring participants that they "won't need to pay anything." These assurances may be given when a participant calls the fund office and asks about a balance bill. Unless your staff knows with 100% certainty that the participant does not need to pay anything, they should not make this type of promise.

How Do You Avoid Oversharing?

Oversharing often happens when whoever is doing the communicating has not received the proper guidance and training. Following are some recommendations.

- Train your staff and leadership on how to respond to questions, how to counteract negative or hostile communications/behavior, and how to deliver tough messages.
- Anticipate questions by developing a list of questions that your staff and leadership might encounter.
- Conduct role-playing exercises. Almost everyone needs practice responding to questions, so allow your team to practice in a safe environment where they can get good feedback and guidance.
- Get guidance from your attorney about how to make your communications clearer. Most attorneys will view communications that foster greater understanding as good, as long as you meet all the compliance requirements.

Is It Better to Communicate Less?

Some organizations have taken the approach that less communication is better to minimize risk and avoid opportunities for oversharing. This isn't a viable approach.

Not communicating with your participants or only sending out the absolute minimum requirements could leave

bios

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them feeling confused about what they're supposed to know and lead to a lack of trust in the fund.

Educate Your Participants

Educated participants take charge of their benefits, have the confidence to ask questions and make informed decisions. Sending your participants more print mail and more email isn't necessarily going to make them more educated. Instead, consider conducting a "nurture campaign" when plan participants first become eligible for benefits. This campaign might consist of six to ten emails that:

- Introduce the participant to the fund
- Explain their benefits over several emails
- Define terms, acronyms and legal concepts
- Detail the types of communications they should expect to receive
- Offer resources for learning more
- Provide contact information for different types of inquiries and issues.

Action Plan

There's a fine line between being candid and sowing confusion, as there is between transparency and oversharing.

If you want to improve your communications with participants without oversharing, start with a few steps. Here are some recommendations:

- Inventory your communications. What communications are you already sending out? Which communications are required? Do you have a schedule for sending out these communications?
- Meet with your staff to determine FAQs regarding benefits. Come up with responses to those questions and train your staff and leadership to answer with those responses. Create an FAQs page on your website. Consider an explainer or FAQ video; start with one.
- Meet with your attorneys to confirm what you can and cannot share with participants.
- Add a cover memo to your more complicated required communications.
- Train your staff and leadership to communicate effectively with participants. Explain what oversharing looks like and give them specific examples so they know the types of communications that would be considered oversharing.

Good luck in your communications journey with your participants!

"Excellent communication doesn't just happen naturally. It is a product of process, skill, climate, relationship and hard work."

– Pat McMillan, author

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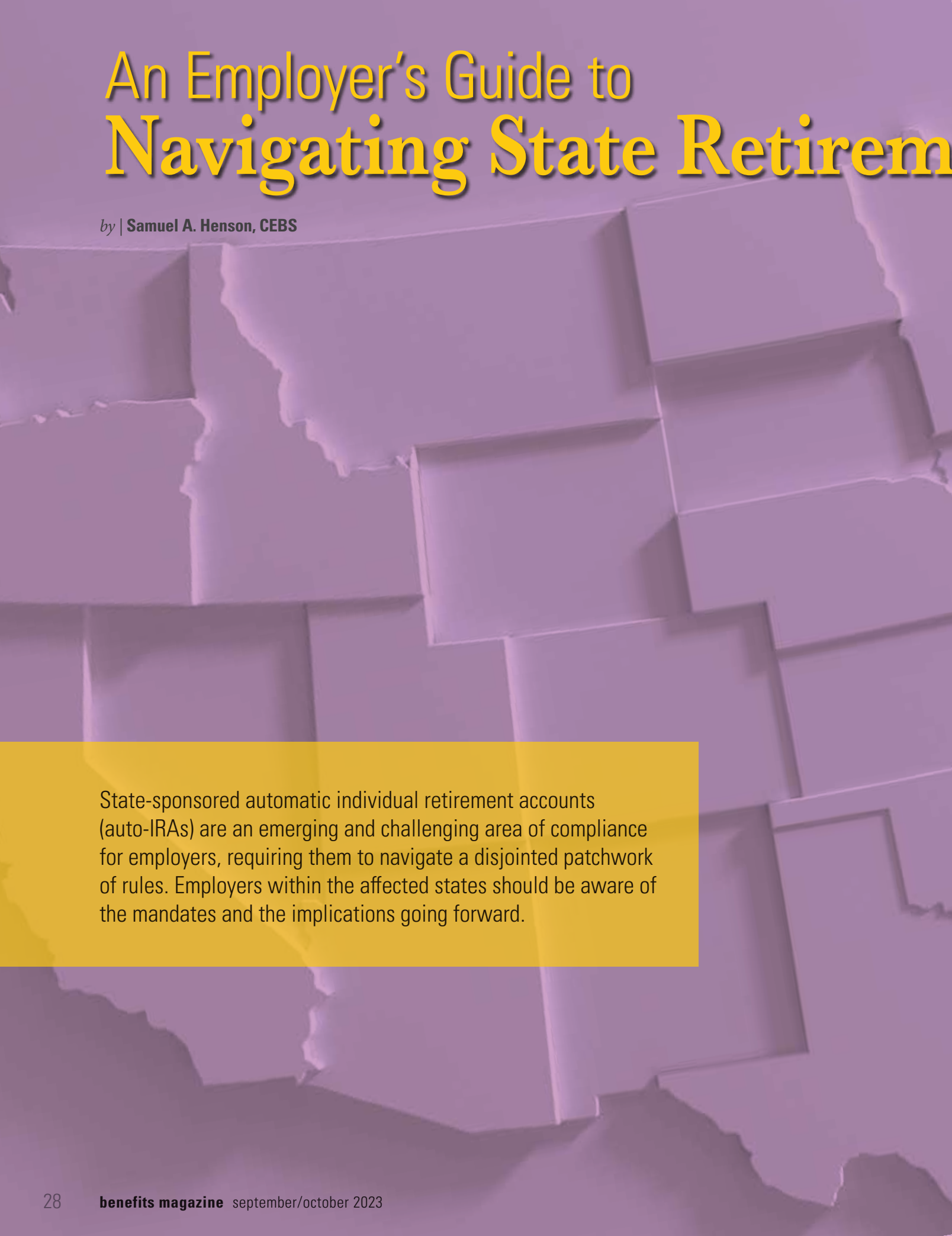
An Employer's Guide to Navigating State Retirem

by | **Samuel A. Henson, CEBS**



State-sponsored automatic individual retirement accounts (auto-IRAs) are an emerging and challenging area of compliance for employers, requiring them to navigate a disjointed patchwork of rules. Employers within the affected states should be aware of the mandates and the implications going forward.

ent Mandates

The Retirement Accessibility Problem

Retirement readiness is a real problem in the United States. A recent study found that 48% of U.S. private sector workers ages 18-64—or about 57 million people—do not have access to a workplace retirement savings plan.[1] Over the next couple of decades, it is projected that older Americans are not going to have enough money to last through retirement, and the shortfalls will be a massive burden on the government. The lack of savings could lead to a cumulative cost to federal and state governments of $1.3 trillion between 2021 and 2040 in the form of public assistance funded by taxpayers.[2] Even more concerning, the ratio of retirement-age households to working-age households will grow by 46% between now and 2040, meaning the shortfall will be borne by a smaller population of working-age taxpayers in the form of an estimated additional taxpayer liability of $13,600 per household.[3]

While individual retirement accounts (IRAs) are widely available, they require individuals to develop a long-term investment strategy and to fund them by making their own contributions. This can be an overwhelming set of decisions to navigate for many people, which often results in them doing nothing. A series of solutions to this problem has begun to emerge, and the one getting the most traction is the automatic IRA (auto-IRA).

takeaways

- State-sponsored automatic individual retirement account (auto-IRA) programs are now active in six states, and an additional seven states have enacted legislation to create such programs.
- If they do not offer their own retirement plan, employers in states that have auto-IRA programs are required to facilitate payroll deductions to Roth IRAs that are set up for employees.
- Exemptions are available for some employers, but the process and exemption criteria vary by state. Penalties for failure to comply can be as high as $500 per year for each employee not properly enrolled in an auto-IRA program.
- Compliance with state auto-IRA programs can be challenging, particularly for employers with multistate operations or with employees living in a state different from where the business operates.
- Another important concern for employers has been how or whether the federal fiduciary standard under the Employee Retirement Income Security Act (ERISA) applies to their participation.

The Auto-IRA Solution

The basic concept of the auto-IRA is rather straightforward. An IRA is set up for an employee and funded through automatic payroll deductions facilitated by their employer. On their enrollment anniversary date, the auto-IRA can also be set up to escalate the employee's deferral until it hits a targeted limit. The employer does not contribute—Its role is simply to facilitate the deposit of contributions. The program is simple and streamlined, allowing for generally low administrative costs. The investment options are typically low-cost and built on a target-date solution. The employee can opt out at any time, but most will not because of inertia. Automatic enrollment has existed in 401(k) plans for nearly two decades, and the effect is strongest in influencing participation rates, with nine in ten automatically enrolled new hires remaining in their employer plan after three years.[4] The question for auto-IRAs is, in the absence of the employer sponsoring the plan, who is best suited to provide this savings option to employees?

The Failed Federal Solution

Recent attempts to solve the real problem of retirement plan accessibility have not been successful. Under President Obama, the federal government created myRA (short for "my Retirement Account"), which was intended to be a risk-free, government-administered savings account available for all.[5] MyRA was built from the auto-IRA concept, intending to fill the gap for employees without access to an employer-sponsored retirement plan. Employers would receive a tax credit to offset their administrative expenses of using their payroll system and sending the contributions but would not make employer contributions or face fiduciary liability.

Conceptually, myRA seemed like a viable solution to fill the accessibility gap. It was a no-fee, no-minimum-balance account, backed by the U.S. Department of the Treasury. However, less than 18 months after myRAs went live, Treasury decided to cancel the program due to high costs and low participation.[6] After three years, just 30,000 employees had created a myRA, and only 20,000 put money into it.[7] Notably, the expense to taxpayers to administer the program largely resulted in its demise, since it cost nearly $2 in expenses for every $1 in deposits.[8] With the federal solution shut down, state legislatures took it upon themselves to fill the void.

TABLE

State-Sponsored Automatic Individual Retirement Account (Auto-IRA) Programs

State Program	Eligible Employees	Exempt Employers	Program Website
California CalSavers	• Age 18 • Receive W-2 with California wages • Defined as an employee under the California Unemployment Insurance Code	• Maintain a 401(a), 401(k), 403(b), SEP, SIMPLE or automatic enrollment payroll deduction IRA	www.calsavers.com
Colorado SecureSavings	• Age 18 • Employed for at least 180 days • Earn wages subject to Colorado state income tax	• Maintain a 401(a), 401(k), 403(a), 403(b), SEP, SIMPLE IRA or 457(b)	www.coloradosecuresavings.com
Connecticut MyCTSavings	• Age 19 • Employed for at least 120 days • Paid more than $5,000 in the calendar year.	• Offer a 401(a), 401(k), 403(a), 403(b), SEP, SIMPLE or governmental 457(b)	www.myctsavings.com
Illinois Secure Choice	• Age 18 • Employees with W-2 wages during all four quarters of the previous calendar year reported to the Illinois Department of Revenue (IDOR)	• Offer a 401(a), 401(k), 403(a), 403(b), SEP, SIMPLE, or multiemployer or governmental 457(b)	www.ilsecurechoice.com
MarylandSaves	• Age 18 • Earn wages subject to Maryland state income tax	• Offer an employer savings arrangement (e.g., an IRA, DB plan, 401(k), 403(a), 403(b), SEP or SIMPLE)	www.marylandsaves.com
OregonSaves	• Age 18 • Earn wages subject to Oregon state income tax	• Offer a 401(a), 401(k), 403(a), 403(b), SEP, SIMPLE, or multiemployer or governmental 457(b).	www.oregonsaves.com

State Mandates Emerge

As far back as 2012, California's state legislature began the process of implementing a state-run auto-IRA with the enactment of CalSavers. Both Illinois and Oregon soon followed, with Maryland, Connecticut and Colorado also joining in. At the time of this writing, all six of those state programs are live. An additional seven states have enacted legislation but have not yet finalized their programs, requiring employers to keep a watchful eye. Twelve other states and two municipalities are at various stages of enacting mandates as well.

Unlike myRA, employer participation in these state programs is mandatory. However, acknowledging that many employers already offer a retirement savings program, the states created mechanisms for those employers to receive an exemption from participating. The specific rules and design of each state auto-IRA varies by state, but they all maintain this basic framework:

- Participant accounts are designed as Roth IRAs
- Mandates and timing are triggered for employers based on the number of employees
- Service providers and investments are chosen by the state
- Employers are required to automatically enroll employees at a contribution of 3-5% of each employee's payroll wages and may allow for annual escalation
- Employer contributions are not permitted
- Employees may opt out of contributing via payroll deduction.

Where the specific states largely differ is the criteria by which an employer determines eligible employees for purposes of establishing whether they must comply. The table provides a summary of the six live state programs, the types of plans that qualify for an exemption and the website for filing for an exemption.

Obtaining an Exemption

All states have enacted a process by which plan sponsors can obtain an exemption to their respective programs. The process to obtain the exemption differs by state but generally requires the employer to file some sort of certification of exemption. Some states directly issue a notification from the state that the employer is required to participate and provide an access registration code. However, in many cases, the right point of contact at the employer may not receive this communication, or it is simply lost in transmission. In other cases, the state may issue a notice of presumed exemption based on Form 5500 data, but these notices have been problematic. For example, some plan names don't match the plan sponsor's name on the Form 5500, the employer identification number (EIN) listed on the plan may not match the business in the state or various other data issues have occurred, and the process has not been as seamless as hoped.

Once obtained, a certificate of exemption or notice of presumed exemption remains valid as long as the employer continues to offer a qualified plan. It is important to note that related employers or employers with multiple divisions that have individual EINs will need to seek an exemption for each EIN.

Employer Penalties

While initial implementation of each state program was intended to encourage voluntary compliance, each state has the authority to assess a penalty on noncompliant employers. The amount and process for penalty assessment also varies by state, but most are triggered when an employer fails to enroll a covered employee as required under the program. The penalty can be as high as $500 per year for each employee not properly enrolled in the program. In some states, the penalty assessment may also include costs and reasonable attorney fees when a state must take legal action. States that have now implemented all of their registration deadlines have started sending past-due notices and assessing penalties for employers that have not complied.

Challenges for Employers

The biggest challenge for any employer is determining whether it needs to comply with a particular state's program requirements. Each state has specific criteria by which employer compliance is required. Many have phased registrations triggered by an employer's employee count. For example, California and Oregon require employers with as few as one covered employee to comply. The determination of employee eligibility varies by state, with criteria generally based on earning wages subject to the state's income tax reporting requirements. As one can imagine, navigating the specific requirements for each state can be difficult.

Compliance with a patchwork of different laws can be especially challenging for employers with multistate operations or with employees living in a state different than where the business operates. For example, an employer located in a state without a mandate still may have to comply with other states' auto-IRA programs if it has employees working and reporting income in a state with a mandate. This may be especially problematic for employers close to state lines whose employees may cross over to work or for employers with remote employees.

Another issue that has arisen is for employers whose plan doesn't cover their entire workforce either due to eligibility provisions or specific exclusions. Take, for example, a plan that excludes a division in another state or a plan that covers salaried employees only. Would this type of plan qualify for an exemption? Generally, yes, states seem to have taken the position that an employer must only offer a plan to qualify for the exemption, but a plan is not required to cover all employees. This is also a particular issue for employers that are part of a controlled group of businesses. California has issued guidance that as long as one of the controlled group members sponsors a qualified plan, then all of the employers in the controlled group are exempt from CalSavers.

Employers that fall into unconventional categories will also need to determine whether they should comply. While some states have exempted religious, tribal and government organizations, not all have. Employers in these categories should consult the rules of the state for which they may have to comply. In addition, nonprofit employers must also generally comply. However, the guidance is not entirely clear about the obligation to comply for employers with collectively bargained workforces, where the employer contributes to a

multiemployer plan on behalf of its employees. Although these employers do not technically "sponsor a plan," they do provide access to a retirement plan. Finally, special consideration should be given in the case of multiparty employment relationships, such as an employee leasing organization or a professional employer organization (PEO), since the rules vary from state to state.

Coordination With ERISA

An important concern for employers has been how or whether the federal fiduciary standard under the Employee Retirement Income Security Act (ERISA) applies to their participation. ERISA applies national standards for retirement plan reporting, disclosures, fiduciary responsibilities, claims/appeals and remedies for noncompliance. When it was created, ERISA specifically included a broad preemption of state laws that would potentially be in conflict, thus allowing employers to rely on a single consistent standard.[9] With the new state auto-IRA mandates, the question becomes, does ERISA apply to participating employers?

The Department of Labor (DOL), which enforces ERISA, has issued safe harbor guidance with respect to employer-sponsored IRAs, generally providing that if the employer's activities are kept to a ministerial (mostly nondiscretionary) level, ERISA would not apply.[10] To qualify, the plan must meet the following conditions.

1. The employer did not contribute on behalf of employees.
2. The employer did not endorse the program.
3. The employer did not receive any financial advantage.
4. Each employee's contributions to the IRA were completely voluntary.

Because the state auto-IRAs are designed so that employers do not sponsor the plan and have no discretion, decision making or control, and they only process payroll withholding, the state IRAs are not subject to ERISA. To further clarify this point, during the Obama administration, DOL issued additional safe harbor guidance specific to state automatic IRAs specifying the conditions that a program could satisfy to automatically be exempt from ERISA,[11] but this guidance was later nullified by Congress in 2017 at the request of the Trump administration.[12] Although attempts at legal challenges have been made, so far courts have found that the degree of employer involvement in facilitating auto-IRAs was minimal and that the programs were not established or maintained by an employer.[13]

Employer Action Steps

All employers, regardless of size, will need to determine their potential compliance obligation on a state-by-state basis. For employers that offer their employees a retirement plan, navigating the exemption process should be the primary focus. Following are employer best practice recommendations.

1. Designate an internal single point of contact that will take ownership of the business' compliance process.
2. Conduct an assessment to determine whether there are employees or operations in each state where the auto-IRA program is live.
3. Using the assessment, determine whether the business is required to enroll employees in the state's program or can qualify for an exemption.
4. If the business qualifies for an exemption, quickly seek to certify the business and document the certification once obtained.

bio

Samuel A. Henson, CEBS, is the chief legal officer/partner for retirement plans at Creative Planning in Overland Park, Kansas, where he oversees Employee Retirement Income Security Act (ERISA) compliance and monitors the activities of various federal agencies for clients and associates. He is also a consultative partner in the areas of regulatory and legislative compliance, investment, pension risk management and vendor management. Previously, Henson was senior vice president–director of legislative and regulatory affairs for Lockton Companies and spent almost ten years with the U.S. Department of Labor. He writes and speaks frequently on numerous fiduciary topics. Henson is a past member of the International Foundation of Employee Benefit Plans Corporate Board and currently serves as chair of the CEBS Committee. He also served as the 2019 president of the ISCEBS Governing Council. He holds a J.D. degree from the University of Missouri–Kansas City School of Law.

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Education

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5. Consider proactively filing for exemptions in all states, since employees may move into states or mergers and acquisitions may occur, triggering new compliance requirements.
6. If attempts to obtain an exemption are not successful, make sure to document the date and time of the attempt, record any reference numbers and retain copies of documentation provided by the state.
7. Implement an annual checkup to follow up on an exemption that was previously unsuccessful and monitor as new state programs are implemented.

The retirement savings accessibility problem is real, but whether state-sponsored auto-IRAs are the right solution remains to be seen. The reality is that these state mandates are not likely to go away any time soon and will likely continue to expand to new states. Eventually, the conversation will again return to whether this is preferable or if a single federal solution is the better option. Bills that would create a federally mandated program have been proposed in each of the last two sessions of the U.S. Congress. Until and unless a single federal solution comes forward, employers will be required to continuously monitor and navigate the increasingly complex patchwork of state mandatory IRAs.

Endnotes

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2. https://econsultsolutions.com/wp-content/uploads/2023/05/Impacts_of_Insufficient_Retirement_Savings_May2023.pdf.
3. Ibid.
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7. https://money.cnn.com/2017/07/28/retirement/treasury-myra-retirement-account/index.html.
8. Ibid.
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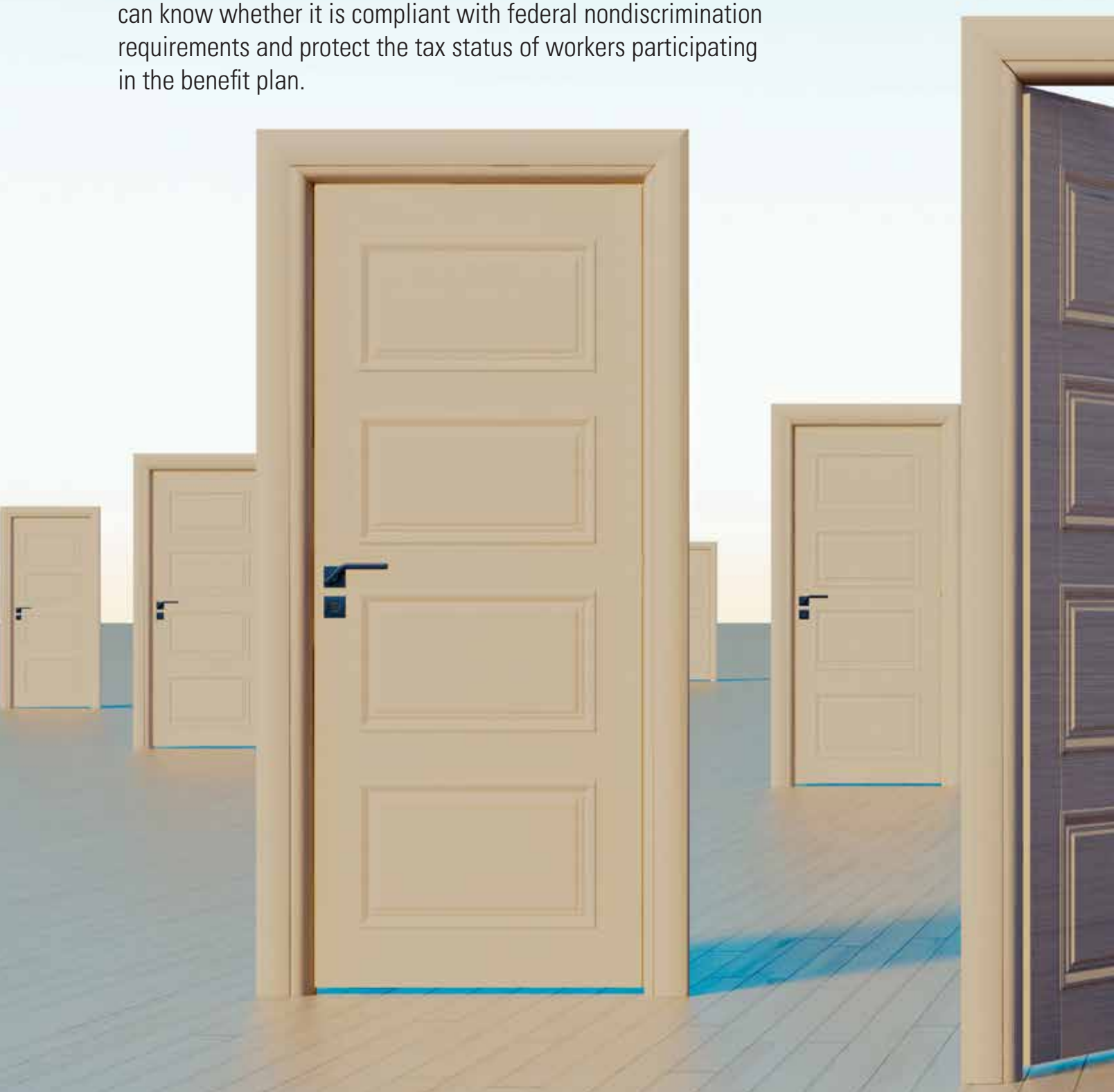
Conducting formal testing is the only way a health and welfare plan can know whether it is compliant with federal nondiscrimination requirements and protect the tax status of workers participating in the benefit plan.



The Ins and Outs of N Testing for Health Pl

Sponsoring a group health and welfare plan provides many advantages to employers and employees, not least of which are tax benefits. However, employers and plan sponsors are not supposed to provide reduced access or inferior benefits to their lower paid employees and plan members. If they do, higher paid participants may face serious tax consequences.

Unfortunately, sometimes group health plans unintentionally discriminate against their non-highly compensated participant population, putting certain employees at significant tax risk. Conducting formal nondiscrimination testing is the only way a plan can know whether it is compliant and protect the tax status of all benefit plan participants.

ONDISCRIMINATION ANS

by | **Hannah Chernov** and **Jessica Waltman**

Federal nondiscrimination requirements apply to three categories of health and welfare plans:

1. Self-funded medical plans, health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs), which fall under Internal Revenue Code Section 105(h)
2. Cafeteria plans, governed by Code Section 125
3. Dependent care assistance programs (DCAPs), governed by Code Section 129.

The Internal Revenue Service (IRS) has designed various tests to determine the equality of each plan type, with distinct rules for each, including calculating which employees are highly compensated for testing purposes and which types of employees may be excluded from the overall test population.

Which Plans Need to Test . . . and Which Do Not?

Any group plan sponsor (regardless of size) that (1) offers benefits on a pretax basis through a Section 125 cafeteria plan, (2) offers workers coverage through a self-funded medical plan or (3) offers plan participants access to an HRA, health FSA or DCAP needs to have nondiscrimination testing on its radar. The best practice for all these plans is to conduct the tests at least annually.

The good news is that if a group plan offers the same benefits to participants and has identical contribution requirements and benefits waiting periods for all eligible members across all employment classes, the group has a very high chance of passing nondiscrimination testing as long as the number of participating highly compensated employees (HCEs) doesn't exceed the number of non-HCEs. If an employer does the same thing for everyone regarding health and welfare benefits, it is tough to favor one type of employee over another. These plans may not need to test.

Testing is imperative if there are any variations in the benefits being offered to different classes of employees, such as varying the cost of benefits or benefit waiting period by type of employee, since there is a higher chance of failure. Too many higher paid employees can fall into a classification considered to have better benefits, even if the employment classification has nothing to do with factors that drive compensation.

Other critical reasons a group should conduct nondiscrimination testing include but are not limited to the following.

- The introduction of a new plan for a specific class of employees
- Participation in an acquisition or merger that will affect the benefit plan(s)
- Having different contributions, waiting periods and/or specific benefits based on employee classifications
- Having a large population of HCEs in any given class of employees, since this can skew test results
- Having a large population of noneligible employees, including part-time employees

Any of these situations frequently cause groups to fail nondiscrimination testing and could result in the need for a plan to make corrections for their HCEs.

How Does Testing Work?

Each type of test within the nondiscrimination testing requirements has its own set of standards. These rules allow for the exclusion of certain types of employees from the test population and set the parameters for what is an HCE.

Section 105(h) Plans

Testing for these plans looks at which employees are eligible to participate in the plan to determine whether the rules favor highly compensated individuals (HCIs), who are the plan's top five highest paid officers, any shareholders with more than 10% ownership status, and the top 25% highest paid individuals who are within the test population. There are three eligibility rule measures: (1) the 70% test, (2) the 70%/80% test and (3) the nondiscriminatory classification test. A plan needs to pass only one to pass eligibility as a whole. Self-funded plans must also pass a test that examines the types of benefits available to all employees, the richness of the benefits available to HCIs and non-HCIs, and the conditions (waiting periods, etc.) upon which benefits may depend. This test is designed to review the benefits available to individuals who elect coverage under the plan, both in plan design and operationally.

Section 125 Plans

The test for Section 125 plans focuses on HCEs, highly compensated participants (HCPs) and key employees, defined below.

- *HCEs* are officers, shareholders owning more than 5% of the employer, employees with an annual compensation of more than $150,000 in the previous year, and any of these individuals' spouses and dependents (who are employees at the same company).
- *HCPs* are HCEs who participate in the plan.
- *Key employees* are officers who received more than $215,000 in annual compensation in 2023, shareholders who own more than 5%, and shareholders who own more than 1% of the entity and have an annual compensation that exceeds $150,000.

The test examines three factors:

1. An employee's eligibility to participate in the plan
2. Whether the employer's premium contributions and plan benefits offered to HCPs are similar to benefits being offered to other employees and if HCPs are not disproportionately participating in the plan
3. The concentration of key employees utilizing pretax benefits, which cannot exceed 25% of the total nontaxable benefits provided under the plan.

DCAPs

The Section 129 DCAP test includes four different components to see whether there is discrimination in favor of HCEs. For the purpose of DCAP testing, HCEs are:

- People who owned more than 5% of the company at any time during the current plan year or the prior year
- Employees with annual compensation of more than $150,000 during the prior year who are part of the top 20% of eligible employees when all are ranked by compensation
- Any of these individuals' spouses or dependents.

The test reviews the following four components.

1. The fairness of employee classifications used to determine eligibility for the plan
2. Whether HCEs and their dependents are eligible for better benefits than non-HCEs and if they need to pay less for those benefits
3. The concentration of shareholders and their spouses and dependents on the plan, which cannot exceed 25%
4. The average benefits received by HCEs versus non-HCEs

takeaways

- By law, employers cannot provide reduced access or inferior health and welfare benefits to lower paid employees. Higher paid employees may face tax consequences if their employer fails to comply.
- Federal nondiscrimination requirements apply to (1) self-funded medical plans, health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs); (2) cafeteria plans; and (3) dependent care assistance programs (DCAPs).
- Nondiscrimination testing should be conducted if there are any variations in the benefit being offered to separate groups of workers. Having a large population of highly compensated employees (HCEs) or a large population of noneligible employees also are reasons to conduct testing, among others.
- The type of test that should be conducted and the consequences of failing vary by plan type.
- It's a good idea to conduct testing annually, although testing more than once in a year may be advisable if a group experiences many changes throughout the year, such as high turnover or an influx of new hires.

The Consequences of Failure

The short answer to the question, "What happens if a group fails nondiscrimination testing?" is tax consequences for higher paid participants. It is important to note that non-HCEs are not affected in any way when a benefit plan fails nondiscrimination testing. HCEs may see their benefit plan payments or salary reductions become part of their taxable income. In the case of a health FSA or DCAP, HCEs may be able to limit their contributions if the plan's failure was identified early enough during the plan year.

The tax consequences for affected employees vary based on the type of health and welfare plan that fails nondiscrimination testing.

- **Section 125 plans:** Pretax benefit contributions flowing through the cafeteria plan may become taxable. However, the cafeteria plan will continue to be a valid Section 125 plan even if it is discriminatory. A qualified benefit does not stop being a qualified benefit solely because it is taxable for failing a nondiscrimination rule.
- **Health FSAs and DCAPs:** The affected benefits that could be taxed are merely what the employee contributes to their own health FSA or DCAP account.
- **Section 105(h), self-funded medical plans:** HCIs would have to pay taxes not only on the money they

contributed toward their plan premiums but also on the value of any benefits received under the plan, including the value of any medical benefit claims paid on their behalf. Put another way, if an HCI in a self-funded medical plan that fails nondiscrimination testing has surgery, and the plan's network pays a provider $25,000 for that surgery, then the HCI could pay taxes on that $25,000 surgical benefit.

While there is no direct penalty linked to plan sponsors if a group fails nondiscrimination testing, there are still risks. As the plan fiduciary, a sponsor assumes risk under the Employee Retirement Income Security Act (ERISA) if the plan fails to maintain a legal plan structure. If a plan sponsor is ever audited, nondiscrimination testing results can be included in the documentation requested. If a plan sponsor cannot provide nondiscrimination testing results while under audit, the plan could be disqualified. Furthermore, employers have annual wage and employment tax reporting obligations. If nondiscrimination testing fails, employers may need to make retroactive tax record corrections, and potential penalty obligations can increase over time.

When to Test

Testing annually is a good habit to establish to ensure that the group is compliant and there are no adverse tax consequences for participants. A plan's assessment needs to be done during the current plan year, ideally earlier on in the year, so contribution amounts may be adjusted as needed before year-end. Employers and plan sponsors may conduct testing themselves or contract through an outside vendor.

Many groups need to conduct testing only once annually, but if a group experiences many changes throughout the year, such as high turnover or an influx of new hires, testing more than once may be advisable. It's also sensible to conduct a second round of nondiscrimination testing if a group makes any midyear changes—such as changes in contribution amounts or waiting periods—to its benefit structure.

Sometimes plan sponsors wonder whether they can get away with skipping a year of nondiscrimination testing. If a group offers different benefits to varying classes of employees or requires different contribution amounts by class, then not testing regularly is a risk, notably if the group's population or benefit structure changes during the year. However, groups with stable populations that routinely pass annual testing with flying colors may feel comfortable missing a year now and then. An audit may flag a failure to test annually, but the risk is generally low for such plans.

Conclusion

Employers should consider conducting nondiscrimination testing on all health and welfare plans annually to avoid discrimination issues, remain compliant and mitigate risk to both employees and the group overall. The best way to prevent any test failure is to offer the same benefit plans to all eligible plan members with the same variables, such as employee contribution levels, waiting periods and maximum contributions. Doing so will allow all participants to benefit in the same ways at the same cost, and it will also save the plan sponsor and HCEs from unwanted costs, penalties and aggravation.

bios

Hannah Chernov is a compliance specialist at MZQ Consulting, LLC, in Pikesville, Maryland, where she specializes in nondiscrimination testing and wrap plan documents. She has five years of experience in employee benefits compliance. Chernov holds a bachelor's degree in law and American civilization from Towson University and a Certificate in ERISA Compliance from the International Foundation of Employee Benefit Plans.

Jessica Waltman is vice president of compliance at MZQ Consulting, LLC, in Pikesville, Maryland, where she leads the compliance consulting and services team. She has more than 20 years of experience in health insurance markets and is considered an industry-wide expert on the complex laws and regulations essential to maintaining a compliant employee benefits arrangement. Waltman holds a bachelor's degree in political science and nonfiction writing from Drew University.

member profile

Member of the Moment
Iris Urquidi

Position

Training coordinator for the International Association of Sheet Metal, Air, Rail and Transportation Workers (SMART) Local Union No. 49 Joint Apprenticeship and Training Committee (JATC) in Albuquerque, New Mexico.

How I Got Started in My Career

"I began my career with the SMART Local Union No. 49 in November 2013 as a bookkeeper. In May 2022, I graduated from the University of New Mexico with an M.B.A. degree and transitioned to the SMART Local Union No. 49 JATC (the training center). I've been here since then, working with my team to provide the best level of training to our apprentices."

Biggest Reward

"Seeing our apprentices advance throughout their career in the trade and seeing them gain financial stability."

Biggest Challenge

"Meeting the demand for workers from our contractors. With the amount of work our industry has, it can be a little difficult at times to provide the adequate workforce."

What the JATC Is Working on Now

"Our training center is currently building a pharmacy mock-up. With this new project, we will be able to provide additional training in testing, adjusting and balancing (TAB), and indoor air quality (IAQ)."

In My Spare Time

"I enjoy camping and fishing and doing anything outdoors. I also like watching *Cold Case Files* and reading. The last book I read was *It Starts With Us* by Colleen Hoover."

First Job

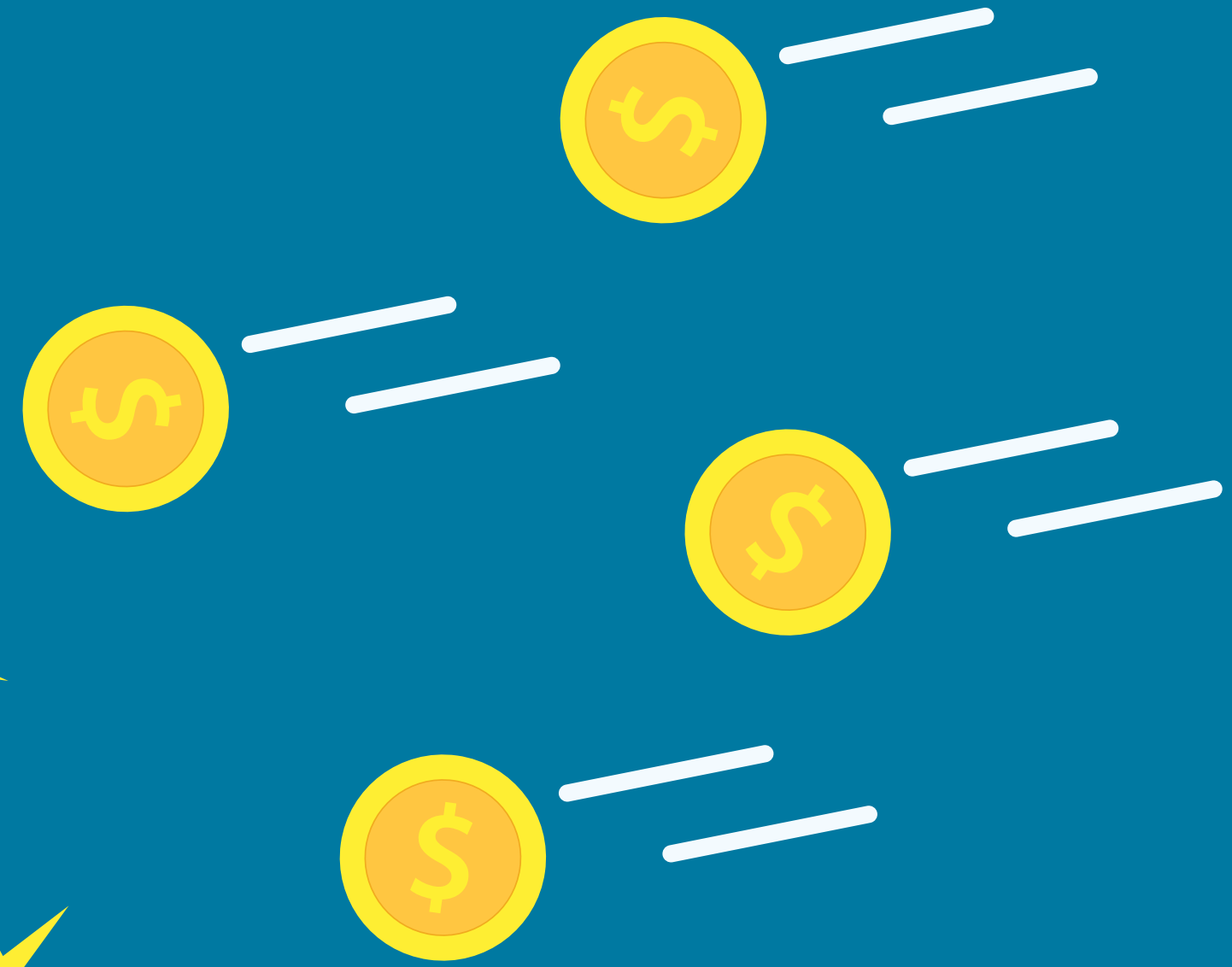
"I started working at 16 as a cashier at a Mexican restaurant. I've been working ever since."

Last Vacation

"My family went to Disney World in the summer of 2019 to celebrate my son's fifth birthday."

Collecting Welfare Plan Overpayments—Continuing Challenges

by | **Sharon M. Goodman** and **Zachary Gaines**



Recovering an employee benefit plan overpayment from a participant may not be as simple as asking for the money back. In the second article of two parts, the authors review the challenges in recouping health and welfare plan overpayments. The first article discussed collecting retirement plan overpayments.

Self-funded welfare plans can experience overpayments for many of the same reasons as retirement plans. However, the collection of these overpayments has different complications. As a starting point, medical benefits are usually paid at the point of service and at the prompt of third parties (doctors, hospitals, etc.), so the fund office may not be aware until the claim has been paid to a third party and the overpayment has occurred.

Generally, under the Employee Retirement Income Security Act of 1974 (ERISA), trustees have a fiduciary obligation to take reasonable measures to avoid overpayments and to recoup overpayments that occur as part of the duty to manage the plan assets and follow the plan terms. In doing so, the trustees must balance the decision to pursue or not to pursue recoupment and these fiduciary obligations with the legal and administrative costs, the amount in question and whether recovery is likely. This often leads to the plan setting a threshold amount for the collection actions to be triggered in its written procedures. Unfortunately, in balancing these interests, it is difficult to know the right action to take.

This article will review the background rules and the case law for welfare plans and focus on some practical tips to use in welfare fund administration to avoid common overpayment pitfalls. Welfare plan programs discussed include disability programs, sick pay and accident benefits in addition to health plans. It is important to note that the recent significant changes that SECURE 2.0 made to how retirement plans treat overpayments do not apply to welfare plans.[1]

Why Do Overpayments Happen for Welfare Plans?

The common reasons for welfare plan overpayments fall into four general categories:

1. **Data errors:** These might include employer or plan recordkeeping errors and manual data or programming input mistakes.
2. **Human errors:** These include a delay in the plan updating its records for a change in a dependent's eligibility for benefits (such as the participant's divorce or legal separation from a former dependent spouse that results in loss of coverage) or a plan or employer's delay in notifying the plan/insurance carrier of the termination of the participant's employment.
3. **Intentional misrepresentation:** In some instances, someone bears some or all of the responsibility, such as when a participant intentionally withholds information that their dependent is no longer eligible for benefits under the plan's definition of dependent, or the employer or employee provides false employment information for the plan to cover a person who is not otherwise eligible (such as a relative who is not actually employed).
4. **Change in facts:** If a worker is determined to be eligible for and receives benefits from other benefit programs, including workers' compensation, employer individual disability pay, Social Security Disability Insurance or a disability retirement benefit, or even another employer group health plan through coordination of benefits, the welfare plan's short- and long-term disability and accident and sickness benefits will be reduced by those payments. When the plan pays disability benefits at the start of the disability and the participant is awarded one of these other benefits months or even years later, an overpayment can occur even when all parties are following the rules.

Of course, a multiemployer welfare plan's risk of overpayments, with different contributing employers, different employer disability pay programs and often a more complex eligibility process, can be greater than a single employer plan.

A Word (or Two) on Subrogation

This article will focus on general types of overpayments of welfare plan benefits and not on the special category of exposure unique to welfare plans called "subrogation." However, understanding how subrogation works can be helpful in understanding how overpayment collections work more broadly. While it can be a complex legal concept under the law, basically, the plan has a right of subrogation when a participant is injured in an accident or in any other manner involving another party, like a car accident or a fall in a business, and that other party (or their insurance) is responsible

for paying the participant's medical and disability expenses as part of the ultimate legal settlement.

Most plans will "advance" benefit payments on claims related to the injury based on the participant's agreement to reimburse the plan in full from any future recovery received from the other responsible party. Welfare plans typically use subrogation agreements with both the participant and the participant's attorney as a means of increasing the likelihood that the plan receives its share of the proceeds from the accident settlement. Well-written plan documents will contain reimbursement language requiring the participant to repay to the plan from any amounts received from third parties intended as compensation for medical expenses. The exact language requiring reimbursement can vary, but it will typically condition a participant's receipt of benefits upon an agreement for subrogation and reimbursement and allow for the offset of future benefits if the participant fails to honor the subrogation agreement.[2]

Court Cases on Welfare Plan Overpayments

Most of the U.S. Supreme Court decisions on how plans can recoup overpayments has occurred in the welfare plan context. In *US Airways v. McCutchen,* a welfare plan sued a participant for the full cost of medical expenses paid on his behalf as the result of a car accident (a subrogation case). The participant, who recovered more than the amount of the medical benefits from third parties, refused to pay the plan the full amount and argued that the payment to the plan should be reduced for his legal fees, which reduced his recovery amount from third parties to less than the amount demanded.[3] In a close 5-4 majority, the Supreme Court held that the benefit plan language allowing the plan to recover the full benefit claims paid is a valid contract that the participant agreed to comply with and that the language allowed the plan to pursue the overpayment as a contractual right.

After *McCutchen,* courts continued to find that the rights of an ERISA welfare plan to recover health care benefits when the participant recovered payments from a third party or the plan overpaid the benefit depended on the plan language and are not common law rights or statutory rights (rights that exist under federal or state law independently). Thus, the language in the plan addressing these situations becomes paramount and can determine whether the plan is likely to be successful in bringing a claim to recover health care benefits it paid from the participant by enforcing the terms of a plan under ERISA §502(a)(3).

However, the Supreme Court's message to plans seeking to collect overpayments has been mixed. In *Montanile v. Board of Trustees of the National Elevator Industrial Health Benefit Plan,* a welfare plan sued a participant for recovery of more than $120,000 in medical expenses after the participant was in a car accident and obtained a $500,000 settlement but refused to repay the plan in accordance with the terms of the plan.[4] The Supreme Court limited the plan's ability to recoupment to traceable assets—meaning that if the funds have been spent on "untraceable items" (i.e., food, services or travel), the lien is unrecoverable by lawsuit under ERISA. If the funds have been spent on traceable items (e.g., a house or a Jackson Pollock painting), the lien could be recoverable in a lawsuit under ERISA. This traceability requirement creates a significant barrier to a plan filing a lawsuit for lien

takeaways

- Common reasons for welfare plan overpayments include data and human errors as well as intentional misrepresentation or a change in facts.
- Subrogation is one category of exposure for welfare plan overpayments. Plans often have subrogation provisions requiring the participant to repay to the plan from any amounts received from third parties intended as compensation for medical expenses resulting from an accident.
- Key issues that have emerged following recent Supreme Court rulings include the importance of plan language addressing overpayments as well as whether the assets are traceable.
- To limit or prevent overpayments, plans should focus on having strong and expansive (1) plan/summary plan description language on the plan's right to collect, (2) written policies or procedures on collecting overpayments, and (3) an administrative process following the procedures that is documented.
- Many plans use the remedy of refusing to pay future benefit claims for the participant who received an overpayment.
- Plans may consider filing a lawsuit as a last resort, but trustees should balance the cost of litigation with the amount owed and whether recovery is likely before pursuing litigation.

amounts—unless it can establish how the proceeds were spent—and weakens a plan's ability to recover what it is owed.

Although both of these cases involve subrogation, the lessons apply broadly to welfare plan overpayments and the right to enforce the plan's terms under ERISA.

The *Montanile* limitations continue to apply more broadly, most recently in *Zirbel v. Ford Motor Co.,* where the Sixth Circuit held that Ford retained an equitable lien on the overpaid funds (that happened to be pension benefits), even if they were commingled with other assets, because they were all traceable.[5]

Key Takeaways and Best Practices for ERISA Welfare Plans

The best way for plans to prepare for overpayments is by taking the appropriate steps to limit or prevent them. This should focus on two elements—the plan language and the plan operational procedures. By instituting review processes for the benefit claim administrative practices followed by the fund office or third-party administrator, as applicable, plans may be able to avoid or discover overpayments early enough that the plan will save both time and money.

Plan Language

The lessons from the courts make clear that an ERISA plan's ability to enforce its recoupment rights likely is dependent on the plan terms. Welfare plans should have strong and expansive (1) plan/summary plan description language on the plan's right to collect, (2) written policies or procedures on collecting overpayments, and (3) an administrative process following the procedures that is documented. This will help the trustees show that the plan is taking the appropriate steps to protect the assets of the plan and fulfill their fiduciary duties (even if the overpayment is not collected). Plans should consider including language in the policy that:

- Creates a constructive trust, lien and/or equitable lien (by agreement) in favor of the plan on any overpaid or advanced benefits that a participant or dependent may receive. This can be useful if the plan reaches litigation regarding the overpayment.
- Requires the participant to affirmatively waive any defenses they may have in any action by the plan to recover overpaid amounts or amounts due under any other rule of the plan by virtue of accepting benefits from the plan. Thus, any refusal to reimburse the overpaid amount can be considered a breach of the participant's obligations to comply with the rules of the plan in order to receive benefits.
- Creates the right to offset future benefits payable to or on behalf of any participant or beneficiary

bios

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who is or becomes entitled to receive payments from the plan derived from the rights of the participant or any other beneficiary of the participant who received an overpayment. For example, if the participant was injured in a car accident but does not repay the plan from their settlement proceeds, the plan could offset a dependent spouse's claims for unrelated treatment.

- Creates the right to initiate legal action against any person, estate or entity that received any part of the overpayment (which can be complicated by the traceability concepts above).
- Provides that the board of trustees has full authority to assess interest, costs and attorney fees incurred by the plan in the collection process, to the maximum extent permitted by law.
- Holds that when an individual's attorney fails to comply with an ethical obligation imposed under applicable law with respect to the plan's rights to collect, the plan may notify the appropriate state bar organization of such failure.

Plan Procedures

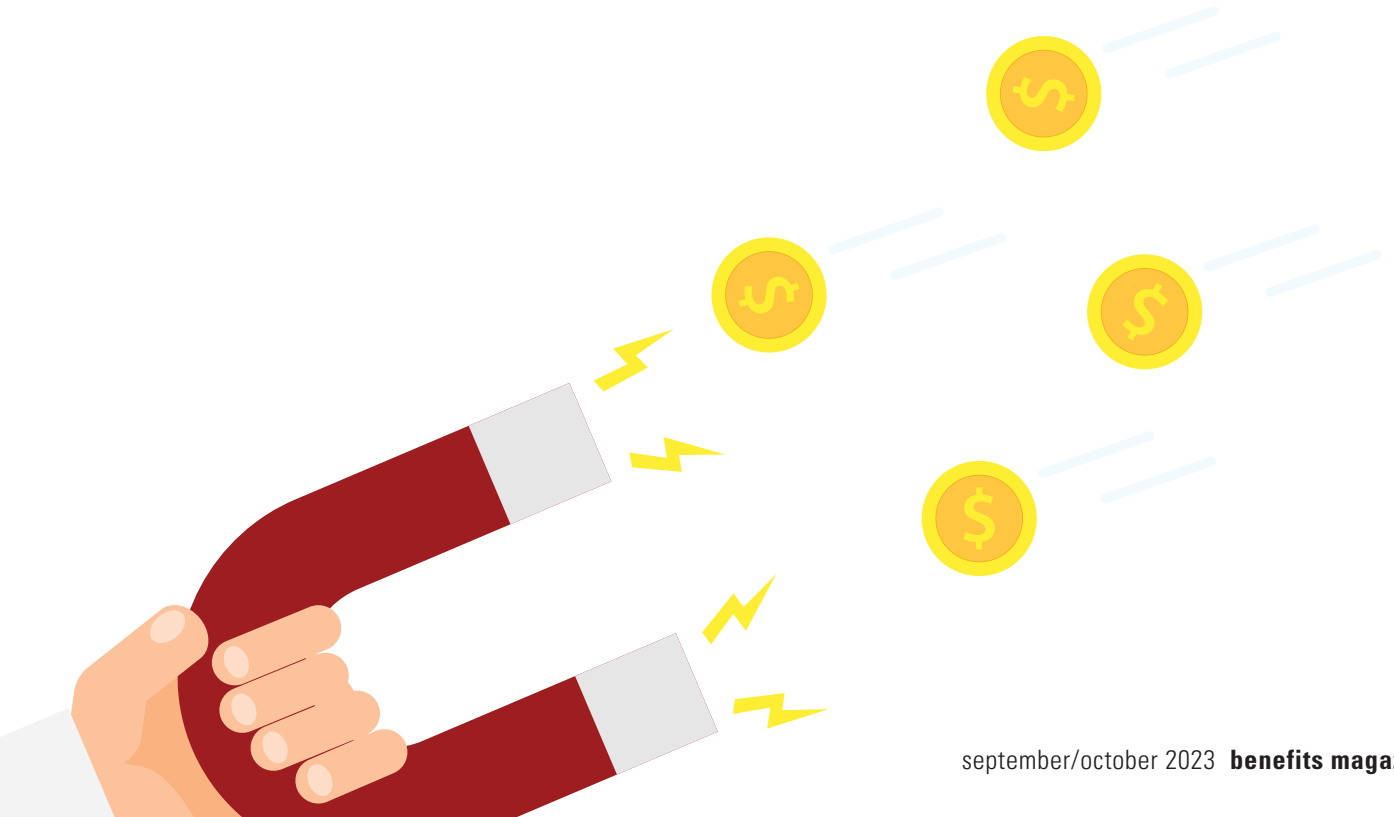
Many plans continue to use the remedy of refusing to pay future benefit claims on behalf of the participant who received the overpayment (if the plan language supports this right). That is, the plan would apply the amounts that would have been paid toward the amount of the overpayment the participant refuses to repay. While there is a chance that the participant will seek some remedy, including filing suit against the plan, many plans use this approach as a nonlitigation, low-cost way to recover overpayments.

The Last Resort

If the amount of the overpayment is large enough, the plan may consider litigation as a final resort, but such litigation comes with its own costs that may not be recoverable. Trustees will need to balance these costs with the amount owed and whether recovery is likely given the law in the plan's jurisdiction and the payee's finances. Often, the amounts are not enough to justify the usually expensive and often lengthy litigation process.

Endnotes

1. Pub. L. 117-328, Division T, §301 ("In the case of an inadvertent benefit overpayment by any pension plan . . . ").
2. The International Foundation of Employee Benefit plans has published several articles focused on collecting overpayments due to subrogation. See "Follow the Money: Challenges for Trustees After Montanile," by Philip R. O'Brien, *Benefits Magazine,* March 2017, and "Follow the Money: ERISA Reimbursement Tactics One Year After Montanile," by Philip R. O'Brien, *Benefits Magazine,* March 2017.
3. *US Airways v. McCutchen,* 569 US 88 (2013).
4. *Montanile v. Board of Trustees of the National Elevator Industrial Health Benefit Plan,* 577 US _ (2016).
5. *Zirbel v. Ford Motor Co.,* 930 F.3d. 520, 2020 U.S. App. LEXIS 36081 (6th Cir. 2020).



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Direct Benefits Communication With Beneficiary Constitutes Fiduciary Conduct

The Court of Appeals for the Ninth Circuit reverses and remands the district court's decision denying the plaintiff's claim for breach of fiduciary duties after concluding that the defendant's conduct falls squarely in line with the fiduciary duties provided under the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff is a beneficiary of a life insurance policy. The defendant is an insurance company that insures and administers the policy. The policy is governed by ERISA.

In connection with its role as the insurer and administrator of the policy, the defendant provided the plaintiff with individualized consultations with benefit counselors. The plaintiff appeals the district court's denial of her claim that the defendant breached its fiduciary duty under ERISA.

To bring a successful claim for breach of fiduciary duty under ERISA, a plaintiff must establish the following elements: (1) the defendant was a fiduciary, (2) the defendant breached a fiduciary duty and (3) the plaintiff suffered damages. The plaintiff must also show that the alleged wrong occurred in connection with the defendant's performance of a fiduciary function to make a cognizable claim for breach of fiduciary duties. Accordingly, the court finds that the threshold question of a fiduciary breach claim is whether the defendant was performing a fiduciary function when taking the action subject to the complaint.

The court finds that the defendant's actions are fiduciary functions—The defendant consulted with the plaintiff in various capacities about her benefit amount on multiple occasions. The defendant also sent letters to the plaintiff that it knew she would share with lenders as proof of her benefits, and the defendant communicated with the plaintiff's financial institutions to verify her benefit amounts. The court finds that these types of communications, where the defendant conveys information about the likely future of plan benefits, are squarely fiduciary functions.

The court also finds that the defendant exercised discretion under ERISA when it gathered information about the plaintiff's earnings and interpreted the terms of the policy to determine which benefits and deductions applied. In addition, the court finds that the defendant exercised discretion when it decided, despite knowing that the plaintiff relied on the stated benefit amount to make important financial decisions, to aggressively collect the overpayment on the plaintiff's accounts. The terms of the policy permit, but do not require, that the defendant collect any overpayment. The defendant even went as far as to entirely suspend the plaintiff's benefits. The court notes that any control over the disposition of plan money makes the person who has the control a fiduciary. Therefore, the court finds that the defendant acted with discretion, constituting a fiduciary act under ERISA. The court finds that this conduct, in connection with the defendant's failure to verify the benefit amounts when it communicated with the plaintiff, constituted fiduciary conduct.

Accordingly, the court reverses and remands the district court's decision, finding that the plaintiff is entitled to bring a claim for breach of fiduciary duty under ERISA.

Morris v. Aetna Life Insurance Company, No. 21-56169 (9th Cir., June 2, 2023).

FIDUCIARY DUTIES

legal & legislative reporter

For members of the International Foundation of Employee Benefit Plans

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Social Security Disability Determination Does Not Automatically Grant ERISA Plan Disability Benefits

BENEFIT DENIAL

The U.S. Court of Appeals for the Sixth Circuit affirms the district court's holding that the plaintiff failed to provide sufficient evidence to demonstrate her total disability under a long-term disability benefits (LTD) plan and denies her claim for benefits under the plan.

The plaintiff is a participant in the plan through her employer. The defendant is the insurance company that insures and administers the LTD benefits under the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff was enrolled in the plan through her employer. She underwent surgery, after which she left her job and filed a claim for benefits under the plan. Pursuant to the terms of the plan, the plaintiff was entitled to benefits if she could demonstrate total disability, meaning that she was unable to perform each of the main duties of her occupation during a six-month elimination period following her resignation. The plaintiff presented various forms of evidence, including a Social Security ruling in her favor, doctors' notes and statements from others explaining her condition. Following its review of these materials, the defendant denied the plaintiff's claim. In response, the plaintiff brought suit in federal district court to challenge this decision. The district court found in favor of the defendant on the basis that the plaintiff failed to prove that she was completely and continuously disabled during the six-month period following her resignation. The question before the Sixth Circuit is whether the plaintiff sufficiently demonstrated her complete and continuous disability during the six months following her resignation.

The court finds that over the course of six months, although the plaintiff's medical history shows that she had some symptoms, she failed to show proof of continuous inability to perform the main duties of her former position at work. The court finds that the total disability standard under the plan is a rigorous standard. Simply because the plaintiff has been found totally disabled for Social Security benefits purposes does not automatically mean that she meets the standard under the plan and ERISA. Therefore, the court finds that the plaintiff failed to demonstrate her total disability.

Accordingly, it affirms district court's denial of benefits under the plan because the plaintiff failed to show that she was continuously unable to perform the main duties of her position during the six-month period following her resignation.

Tranbarger v. Lincoln Life & Annuity Company of New York, No. 22-3369 (Sixth Cir., May 18, 2023).

Plan Terms Control in Severance Entitlement Dispute

The U.S. Court of Appeals for the Seventh Circuit affirms the district court's ruling finding that the defendants did not violate the Employee Retirement Income Security Act of 1974 (ERISA) in deciding not to provide severance pay to certain laid-off employees.

The plaintiffs are a group of terminated employees who were laid off by their employer. The defendants include the former employer and a severance plan sponsored by the employer. The plan is governed by ERISA.

The plan provides severance benefits to laid-off employees who were regularly scheduled to work at least 20 hours a week. The plan also provides that to receive the severance benefits, an employee must have received a cover memo signed by the vice president of human resources, with the document addressed to the participant by name (HR memo). The plan further provides that the vice president of human resources must designate an employee as eligible to receive the severance benefits under the plan in the HR memo. The plaintiffs did not receive notification of their eligibility under the plan and did not receive severance benefits after their termination from employment. The plaintiffs filed suit under ERISA, contending that they are entitled to severance benefits under the plan.

The plaintiffs argue that their eligibility under the plan was established by their working more than the 20-hour per week standard. Conversely, the defendants argue that the HR memo is a document that describes the manner in which the defendants decide which employees may receive severance benefits under the plan. The district court found that the plan's language granted the defendants discretion to determine who, if anyone, was eligible to receive severance benefits after being laid off. The district court further determined that ERISA does not prevent severance plans, generally, from processing and exercising discretion to determine recipients.

The plaintiffs and defendants originally agreed to have a magistrate judge resolve the case. Assignment of a case to a magistrate judge depends on the district judge's consent, which may be rescinded if the district court judge shows good cause or extraordinary circumstances. Once the suit was certified as a class action on behalf of all laid-off employees who did not receive an HR memo, the stakes increased, and the defendants asked the court to take over from the magistrate judge. The district judge found that the increased stakes constituted good cause. The plaintiffs argued that the increased stakes do not constitute good cause and that a magistrate can preside over the case if the representative plaintiffs provide their consent. The plaintiffs further argue that precedent supports the proposition that the amendment of a complaint to add a demand for substantial punitive damages does not allow the defendants to withdraw consent to a decision made by a magistrate judge.

The court finds that precedent does not support the plaintiffs' arguments because the applicable precedent cases do not address the meaning of good cause. Therefore, rather than rely on the plaintiffs' cited cases, the court finds that the good cause standard is not a bright line test—It implies deferential appellate review, and the court finds no abuse of discretion by the district court to rescind reference to the magistrate judge because of the increased stakes. According to the court, the plaintiffs' claim does not require extended discussion, because under the terms of the plan, receipt of benefits is contingent on the HR memo, which the plaintiffs did not receive.

Next, the court reviews the plan's terms. The court finds that a plan may include a discretionary component, and that a plan administrator acts as a fiduciary when acting with discretion. The discretionary component here is the distribution

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BENEFIT DENIAL

Joint Trade Board Confirms Arbitration Award Where Defendant Fails to Respond to Claim

ARBITRATION

The U.S. District Court for the Southern District of New York grants the plaintiffs' motion for summary judgment because the joint trade board acted with authority to render the arbitration award, which the defendant never contested.

The plaintiffs include a labor organization and the trustees of jointly administered multiemployer labor management trust funds. The defendant is an employer that is a party to a collective bargaining agreement (CBA) with the labor organization. The funds are governed by the Employee Retirement Income Security Act of 1974 (ERISA). The CBA provides that disputes must be decided by arbitration.

The instant dispute began after the defendant failed to submit wages and benefits on behalf of members of the plaintiff labor organization. The members of the labor organization submitted the dispute to the joint trade board for arbitration pursuant to the CBA. The joint trade board rendered an award in favor of the plaintiffs, directing the defendant to pay damages and benefit contributions on behalf of the plaintiff labor organization members. The award was delivered to the defendant; however, the defendant refused to comply with the award and has not begun an action to modify or vacate the award. Consequently, the plaintiffs filed the instant action to confirm the arbitration award. The court then ordered the defendant to show cause as to why the court should not consider the plaintiffs' motion unopposed. The defendant again did not respond.

Under the Labor Management Relations Act (LMRA), federal courts have jurisdiction to enforce labor arbitration awards. Because judicial review of arbitration under LMRA is very limited, a reviewing court is bound by the arbitrator's factual findings, interpretation of the contract and suggested remedies, unless the award is procured through fraud or dishonesty. A district court is not authorized to review the arbitrator's decision on the merits, but instead may inquire only as to whether the arbitrator acted within the scope of his authority as defined by the CBA. The court's task here is to simply ensure that the arbitrator was even arguably construing or applying the contract and acting within the scope of his authority and did not ignore the plain language of the contract.

The court finds that the arbitrator acted within the scope of its authority in issuing the award. The CBA provides the joint trade committee with the power to decide grievances and disputes that arise between the parties related to the interpretation of the CBA and to make awards for violations of the CBA. The court finds that this was the case here—namely, that the defendant failed to pay the award and did not contest the amount of damages in the award, and that the record does not indicate that the award is incorrect or procured through fraud or dishonesty.

Accordingly, the court grants the plaintiffs' motion for summary judgment and confirms the arbitration award.

Trustees of the District Council No. 9 Painting Industry Insurance Fund et al. v. Madison Painting & Decorating Group, No. 1:22-cv-07688-ALC (S.D.N.Y., May 26, 2023).

LMRA Precludes Plaintiff's ERISA Claims

The U.S. District Court for the Northern District of California grants the defendants' motion to dismiss because the claims were precluded by the Labor Management Relations Act (LMRA).

The plaintiff is an employer that is a party to a collective bargaining agreement (CBA), pursuant to which multiemployer pension and welfare plans were created. The defendants are the plans. The plans are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff employs members of a union, with the employment relationship being governed by the CBA. The CBA contains an arbitration clause that applies to the interpretation, application and violation of the CBA. Under the CBA, the plaintiff was required to make contributions to the plans based on actual hours worked. The plaintiff alleges that certain employees did not actually work the hours reported on their time sheets and argues that it should not have paid contributions to the plans for these employees.

The plaintiff argues that the defendants should reimburse it for the contributions made to the plans for hours that the employees did not actually work and filed suit for violations of both state law and ERISA. The defendants argue that in order for the plaintiff to be reimbursed, it needs to provide proof from the CBA that shows whether certain time entries are not compensable. The defendants further argue, in part, that the case should be dismissed because the plaintiff's state law and ERISA claims are both precluded by LMRA.

To determine whether a state law claim is precluded by LMRA, the court engages in a two-step analysis: (1) whether the claim seeks purely to vindicate a right or duty created by the CBA itself and, if so, then the claim is preempted, and the analysis ends there; or (2) if not, the court considers whether the plaintiff's state law right is substantially dependent on analysis of the CBA, which turns on whether the claim cannot be resolved by simply looking at and interpreting the CBA.

Here, the court finds that the plaintiff's claim is not created by the CBA and, therefore, unless it can only be resolved by interpreting the CBA, it is not preempted by LMRA. The plaintiff argues that the employees overinflated their hours and knowingly overbilled for time not worked; however, the court finds that the CBA contains specific provisions that allow the employees to bill for hours not worked under certain conditions.

In addition, the court finds that the plaintiff did not meaningfully analyze the terms of the plans when making the claims. The facts underlying the present case brought under ERISA are substantially dependent on an interpretation of the CBA. Therefore, the court finds that, although the plaintiff filed suit seeking to enforce its rights under ERISA, the claim is precluded by LMRA to the extent that it requires the interpretation of the CBA.

Accordingly, the court grants the defendants' motion to dismiss because state law and ERISA claims are precluded by LMRA.

Columbia Export Terminal, LLC v. ILWU-PMA Pension Fund et al., No. 4:20-cv-08202-JSW (N.D.Cal., May 16, 2023).

ARBITRATION

Health Plans Maintained by Partnerships Are ERISA Plans With Respect to Bona Fide Partners

BENEFIT LITIGATION

The U.S. District Court for the Eastern District of Louisiana denies the plaintiffs' motion to remand, holding that the defendant properly removed the case to federal court because the health benefit polices are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiffs include a business owner and his wife, who were insured by health benefit policies. The defendant is the insurance company that insures the health benefits under the policies. At issue is whether the policies are governed by ERISA.

The plaintiff owner owned a small business with one other individual, and the company had no other employees. The plaintiff owner covered his wife as a dependent under the policies. The plaintiff wife tried to obtain precertification and receive coverage for gastric surgeries; however, the defendant refused to precertify or cover the surgeries. The plaintiffs previously filed a suit challenging the defendant's refusal to precertify and cover the surgeries in state court. The defendant removed the action to the District Court for the Eastern District of Louisiana, arguing that the policies were governed by ERISA and, therefore, the federal courts had federal question jurisdiction. In the instant motion, the plaintiffs argue that the policies are not governed by ERISA because they cover the two owners of the business and not any employees. The defendant contends that the company is a partnership and, under ERISA, bona fide partners are employees and the policies are governed by ERISA.

The Fifth Circuit, the circuit in which the Eastern District of Louisiana is located, provides a test to determine whether a benefit arrangement is an ERISA plan, including whether (1) the plan exists, (2) the plan falls within the safe harbor provision established by the Department of Labor (DOL), and (3) the employer established or maintained the plan with the intent to benefit employees.

The court finds that there is no question that a plan exists or that the plan falls within the safe harbor provision established by DOL. Therefore, at issue is whether the plaintiff owner and his business partner are employees as defined by ERISA and whether the company is an employer that established or maintained the policies.

Under ERISA, any plan, fund or program that would not be an employee welfare benefit plan and that is established or maintained by a partnership—to the extent that the plan, fund or program provides medical care to current or former partners or their dependents, directly or through insurance, reimbursement or otherwise—is treated as an employee welfare benefit plan that is a group health plan. The court finds that in the case of a group health plan maintained by a partnership, the participants include individuals receiving benefits under the plan if the individuals are partners in the partnership. Therefore, where a group health plan is maintained by the partnership and provides medical care to the bona fide partners in the partnership, ERISA governs the group health plan.

The court finds that the policies were established and maintained by the company. Under Louisiana law, a partnership is a juridical person, distinct from its partners, created by a contract between two or more persons to combine their efforts or resources and collaborate at mutual risk for their common profit or commercial benefit. The plaintiff owner and his business partner are each 50% owners in the company, and the company is distinct from each of the owners, created through the combined efforts of the owners to collaborate for common profit. The court finds that although the company is registered as an LLC, this label is not determinative as to whether the company will be legally deemed a partnership. Because the plaintiff owner and his business partner mutually consented to form

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Court Will Not Change Venue Unless Proposed District Has Sufficient Connection to the Claim

SUBROGATION

The U.S. District Court for the Western District of Washington denies the defendant's motion to transfer because the action could not have been brought in the proposed venue, nor should the venue be changed based on convenience to the parties and the interest of justice.

The plaintiff is a company that self-funds and administers a health benefits plan. The defendant is a former employee of the plaintiff and a covered person and beneficiary of the plan. The plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The defendant received medical benefits from the plan because she was injured in a car accident. The defendant later settled a personal injury claim related to the accident, and she received a sum of money. The plaintiff now brings the instant case to enforce the plan's subrogation and right of recovery provision, which allows it to recover the medical benefits paid from the settlement funds received as part of the personal injury lawsuit.

The defendant moves for a change of venue to the Northern District of New York. She argues that the facts of the case occurred in New York rather than Washington, so it is in the interest of judicial economy for the case to be in New York. A court may transfer a civil action to another district in which the case may have been brought or to which all parties have consented in the interest of justice and convenience to the parties. To transfer venue, the movant must show that the transferee district is one in which the suit could have been brought in the first instance—a district where venue would have been proper, and the defendant would have been subject to personal jurisdiction. In considering a motion to change venue, the court also exercises its discretion according to a case-by-case consideration of convenience and fairness, with a strong presumption in favor of the plaintiff's choice of forum.

An ERISA matter can be brought in the district where the plan is administered, where the breach occurred, or where the defendant resides or may be found. A defendant may be found wherever personal jurisdiction can be asserted over the defendant based on minimum contacts in the forum. The plaintiff argues that this action could not have been brought in New York in the first instance, so there is no basis for the venue to be in New York. The court similarly finds that the case cannot be transferred because the defendant did not show that the venue could have been in New York originally since the plan is administered in Washington state, the alleged breach took place in Washington state, and when the action began, the plaintiff was a resident of Washington.

The court also finds that the defendant did not have minimum contact with the proposed district in New York, meaning that there could be no personal jurisdiction in that district. To find minimum contacts, the court first considers whether the defendant purposefully avails themselves of the forum to conduct activities there. First, the court finds that the plaintiff is a Washington company. Second, although the defendant's injury occurred while the defendant was visiting upstate New York, no activity or occurrence related to the plan occurred in New York. In addition, because this action is a contractual dispute over the terms of the plan, none of the defendant's arguments relate to the car accident in New York. Therefore, because the court finds that the defendant cannot be found in New York, the court denies the defendant's motion to change the venue to New York.

The court further finds that convenience to the parties and the interest of justice weigh against the change of venue. The court considers a number of factors when reviewing a motion to transfer venue, such as the location of where the relevant agreements were negotiated, the state that is most familiar with the governing law, and the plaintiff's forum choice, among other factors. The court

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Court Will Not Change Venue

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finds that the plaintiff's choice of forum is entitled to deference and requires a strong showing of inconvenience to be overcome. The court finds that the defendant does not sufficiently show inconvenience of the forum since the plan is administered in Washington, the plaintiff chose the Western District of Washington, and the plaintiff resides in Washington. The court further finds that the plan is a contract executed in Washington state for Washington employees, both parties are citizens of Washington, and Washington has a special interest in the resolution of the matter since the plan is administered there. Consequently, the court finds that neither convenience nor the interest of justice call for the venue to be changed to New York.

Accordingly, the court denies the defendant's motion to change venue.

Protingent, Inc. v. Gustafson-Feis, No. 2:20-cv-01551-TL (W.D. Wash., May 2, 2023).

Plan Terms Control in Severance Entitlement Dispute

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of the HR memo. The court finds that because the plaintiffs did not receive the HR memo, there is no entitlement to the severance benefits. The court finds it unpersuasive that the defendant employer had a practice of distributing the HR memo to all laid-off employees, and that the plaintiffs' failure to receive such a memo (and subsequently the severance benefits) may have been a mistake. The defendant employer had the discretion to make changes to its approach to severance benefits at any time. Ultimately, the terms of welfare benefit plans are entirely in the control of the entities that establish them. Therefore, because the defendants determined that the plaintiffs were not eligible to receive benefits under the plan, the court finds that the defendants did not violate ERISA when deciding not to pay severance to the plaintiffs.

Accordingly, the court affirms the district court's holding.

Carlson et al. v. Northrop Grumman Severance Plan et al., No. 22-1764 (7th Cir., May 8, 2023).

Medical Provider May Not Bring Claim on Behalf of Participants and Beneficiaries

BENEFIT LITIGATION

The U.S. District Court for the Northern District of Illinois grants the defendants' motion to dismiss because the plaintiff lacks standing to sue under the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff is an out-of-network medical provider, acting as an authorized representative on behalf of a patient who was covered by a group health care plan. The defendants include the plan and its board of trustees. The plan is governed by ERISA.

The plaintiff brought suit on behalf of a patient to enforce her rights under ERISA. The patient originally sought medical attention from an in-network provider under the plan; however, the provider did not offer the treatment that she needed. As a result, it referred her to the plaintiff, an out-of-network provider. The plaintiff treated the patient and submitted a claim for the cost of the treatment. The plan refused to cover the entirety of the claim, and the patient filed an appeal with the plan, which was denied.

Because the patient could not allegedly afford an attorney, she appointed the plaintiff as her personal representative so that it could sue the plan for the remaining balance of the bill on her behalf. The plaintiff requested copies of the administrative record for the patient's claim but did not receive the information until over a year later, after a court ordered the defendants to comply. The plaintiff brought suit, alleging violations of ERISA for benefits owed and seeking statutory penalties for the delay in producing the patient's administrative record. In response, the defendants brought this motion to dismiss, arguing that the plaintiff does not have standing to sue under ERISA because it is neither a participant nor a beneficiary under the plan.

The plaintiff seeks to recover benefits from the plan for services it rendered to the patient. The plaintiff also alleges a violation of the ERISA provision requiring the plan administrator to provide a participant or beneficiary with a copy of plan documents within 30 days of a request. The defendants argue that because the plaintiff is an authorized representative, it does not have standing to sue under ERISA to recover plan benefits or seek statutory penalties. This is because the plaintiff is not a participant or beneficiary as defined under ERISA. Accordingly, the defendants argue that the plaintiff cannot sue on the patient's behalf because ERISA cannot confer standing to a third party. Further, the defendants argue that the plan contains antiassignment provisions that prohibit lawsuits from third parties trying to enforce a participant's rights under the plan.

ERISA limits the parties who can bring a civil action to participants, beneficiaries and fiduciaries. The defendants argue that because the plaintiff does not fall into one of these categories, it cannot sue under the plan. The plaintiff argues that because it is merely standing in the shoes of the patient, and the patient's standing to sue as a participant under the plan and ERISA is undisputed, the plaintiff is entitled to invoke her standing as her representative.

The Seventh Circuit, the circuit in which the Northern District of Illinois is located, has found that if Congress intended for representatives to bring suit under ERISA, it would have included this in the plain language of the statute. The court finds that in the ERISA regulations, authorized representatives are expressly permitted to file internal claims and appeals, but no standing is conferred to bring a civil action. The court further finds that Congress limited civil actions to participants and beneficiaries—Simply representing an ERISA beneficiary does not make a provider an ERISA beneficiary itself. The court finds that the plaintiff cites no authority under ERISA that allows authorized representatives to file suit on behalf of a participant or beneficiary and, therefore, fails to meet its burden to show that the court has jurisdiction over this claim.

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Medical Provider May Not Bring Claim

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In addition, the court finds that even if the plaintiff has standing under ERISA, it has not plausibly alleged that it was permitted to bring a civil action under the language of the plan. The plan's antiassignment language states that a participant cannot assign their rights as a participant to a provider or third party, or in any way alienate their claim for benefits. The plaintiff argues that the antiassignment language is inapplicable here because the patient appointed the plaintiff as her authorized representative and did not assign her rights to it.

The court finds that the plan language is clear as to what actions an authorized representative may take under the plan. The defendants argue that the plaintiff's interpretation of this provision renders the antiassignment language meaningless because it is not read in the context of the full plan. The court finds that permitting the plaintiff to contract around this provision would render the clause meaningless and would contravene ERISA's directive for courts to enforce the terms of an ERISA plan strictly.

Accordingly, the court grants the defendant's motion to dismiss because the plaintiff had the opportunity to plead a plausible claim but failed to do so. Instead, the plaintiff brought suit under ERISA, pursuant to which it expressly did not have standing.

OSF HealthCare System et al. v. SEIU HealthCare IL Personal Assistants Health Plan et al., No. 3:21-cv-50029 (N.D.Ill., May 2, 2023).

Health Plans Maintained by Partnerships Are ERISA Plans

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a partnership and share in the profits and losses, and the company's property forms a community of goods in which each owner has a proprietary interest, the company is legally a partnership (not a corporation). Consequently, the court finds that a partnership established and maintained the policies.

Next, the court finds that the plaintiff owner and his business partner are bona fide partners in the company. The Fifth Circuit determines whether an individual is a bona fide partner using a totality-of-the-circumstances analysis. Here, the plaintiff owner and his business partner perform services on behalf of the company and are the only partners in the company. Therefore, the court finds that because the company is a legal partnership and the owners are bona fide partners, the policies qualify as ERISA plans that provided medical care to the bona fide partners.

Accordingly, the court denies the plaintiffs' motion to remand because the policies are governed by ERISA, so the defendant's removal to federal court was proper.

Anderson v. HMO Louisiana, Inc., No. 23-971 (E.D.La., May 16, 2023).

ERISA Preempts Beneficiary's State Law Claims

PREEMPTION

The U.S. District Court for the Southern District of West Virginia grants the defendants' motion to dismiss because the plaintiff's claim is preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff is a beneficiary of two employer-sponsored retirement plans. The defendants include the employer and the third-party administrator of the plans. The plans are governed by ERISA.

While working for the defendant employer, a participant designated the plaintiff, his then-spouse, as a beneficiary under the plans. The plaintiff and participant later divorced, and the participant died shortly thereafter. The plaintiff alleges that the participant never removed her as the beneficiary of the plans, and she now claims entitlement to benefits under the plans. The plaintiff alleges that she has contacted the defendants to inquire about the process of claiming benefits under the plans, but they have refused to honor her designation as beneficiary. The plaintiff claims that the defendants intend to release the funds to the participant's estate instead.

The plaintiff filed suit at the state level, making state law claims related to the defendants' refusal to distribute the funds under the plans to the plaintiff. The defendants removed the action to federal district court and filed a motion to dismiss. The defendants argue that the plaintiff's state-level claims are preempted under ERISA and therefore should be dismissed for failure to state a claim.

ERISA's preemption provision provides that ERISA supersedes any and all state laws insofar as they relate to any employee benefit plan. A state law relates to an employee benefit plan if it has a connection with or reference to such a plan, even if the law is not specifically designed to affect employee benefit plans or if the effect is indirect. The court finds that the plaintiff's state law claims relate to an employee benefit plan and are therefore preempted. First, the court finds that the plans are employee benefit plans within the meaning of ERISA. Second, the court finds that the state law claims relate to the plans because the complaint particularizes the wrongs the defendants committed by refusing to honor the participant's beneficiary designation and release the funds to the plaintiff. Consequently, the court finds that the plaintiff's complaints relate to the defendants' failure to distribute the funds under the plans, which places the plaintiff's claim within ERISA's preemptive scope.

Accordingly, the court grants the defendants' motion to dismiss because the plaintiff's claim is preempted by ERISA.

Riley v. Am. Elec. Power Serv. Corp., No. 2:22-cv-00577 (S.D.W.Va., May 1, 2023).

Plaintiff Failed to Devise a Sufficient Claim for Relief Under State Law

REIMBURSEMENT

The U.S. District Court for the District of New Jersey grants the defendant's motion to dismiss because the plaintiff failed to allege sufficient facts to state a claim, even though the claims are not preempted by the Employee Retirement Income Security Act of 1974 (ERISA).

The plaintiff is an out-of-network medical provider. The defendant is the insurance company that acts as the third-party administrator of a patient's health plan. The plan is governed by ERISA.

The plaintiff employed a board-certified orthopedic surgeon, who diagnosed and provided medically necessary services to a patient covered by the plan. At the time the services were provided, the plaintiff was a nonparticipating or out-of-network provider for the patient. The plaintiff claims that it obtained preauthorization for the services as part of its normal business practice. After providing the services, the plaintiff billed the defendant for the services performed. The defendant paid a portion of the balance based on its out-of-network payment rate. The plaintiff now seeks to recover the remaining amount. In the present actions, the plaintiff asserts three claims under state law, including breach of contract, promissory estoppel and account stated.

The defendant argues that the state law claims should be dismissed because they are preempted by ERISA. ERISA preempts all state laws insofar as they may relate to any applicable employee benefit plan. ERISA's preemption applies in two contexts—state laws that have a reference to an ERISA plan or state laws that have a connection with the ERISA plan at issue.

The Supreme Court has determined that a state law has a connection with a plan if it governs a central matter of plan administration, interferes with nationally uniform plan administration or its acute economic effects force an ERISA plan to adopt a scheme of substantive coverage or effectively restricts its choice of insurers. The defendant argues that the plaintiff's claims require an impermissible reference to the plan. The defendant relies on the authorization letter that it sent to the patient and the plaintiff's surgeon, which approves the patient for the services provided but explains that payment is not guaranteed if the services are not covered by or exceed the limits of the patient's contract. According to the defendant, the authorization letter demonstrates that the plaintiff's claims stem from the plan. Because the court will have to reference the terms of the plan to determine whether any additional payments may be due, the defendant argues that the claims relate to the plan and are preempted by ERISA. The plaintiff argues that the claim is based on a separate preauthorization that it received from the defendant and that the preauthorization, along with the prior history of dealing between the parties, creates a duty for the defendant to pay for the services that is independent from the plan.

The Third Circuit, the circuit in which the District of New Jersey is located, has held that a court may consider an undisputedly authentic document that a defendant attaches as an exhibit to a motion to dismiss if the plaintiff's claims are based on the document. The court finds that the preauthorization letter supplied by the defendant does not qualify under this standard. Instead, the plaintiff disputes the authenticity of the authorization letter and argues that its claims are not based on the letter. The court finds that none of the plaintiff's claims specifically mentions the plan nor does the authorization letter. Drawing all reasonable inferences in the plaintiff's favor, the court finds that it will not consider the authorization letter.

Based on the facts and circumstances, the court finds that the plaintiff's claims are not preempted by ERISA. This is because the plaintiff's claims neither seek benefits under the plan nor require more than a cursory examination of the plan nor make impermissible references to the plan. Instead, the complaint seeks damages arising from

an independent relationship between the parties, which the plaintiff argues was created through the parties' course of dealing. The Third Circuit has repeatedly held that where the claim is based on a duty created by state law, rather than an ERISA plan, ERISA does not preempt the claim. The court also finds that the plaintiff's claims do not have a connection with any ERISA plan because the relationship between the parties on its own does not create an impermissible connection, nor does the plaintiff's claim govern a central matter of plan administration, interfere with nationally uniform plan administration, or force the plan to adopt a scheme of substantive coverage or effectively restrict its choice of insurers.

Next, the defendant argues that the plaintiff's claims should be dismissed for failure to allege sufficient facts to state a claim for breach of contract and promissory estoppel. Under New Jersey law, to state a claim for breach of contract, the plaintiff must establish three elements: (1) the existence of a valid contract between the parties, (2) the failure of the defendant to perform its obligations under the contract, and (3) a causal relationship between the breach and the plaintiff's alleged damages. Likewise, a promissory estoppel claim requires the plaintiff to establish the following elements: (1) a clear and definite promise, (2) made with the expectation that the promisee will rely on it, (3) reasonable reliance, and (4) definite and substantial detriment.

The plaintiff argues that an implied-in-fact contract was created between the parties because of the defendant's course of conduct and the defendant's authorization of the surgery. The plaintiff also argues that the defendant made a clear and definite promise by providing presurgery authorization to the plaintiff. Nonetheless, the court finds that the plaintiff alleged no facts establishing that it had any prior interactions or course of conduct with the defendant that would lead it to expect payment in full for the services provided to the patient. Instead, the court finds that the plaintiff merely made conclusory allegations, which are insufficient to state a claim. Therefore, the court finds that the plaintiff's claims of breach of contract and promissory estoppel are dismissed for failure to state a claim.

Finally, the court finds that the plaintiff's claim for the account stated should be dismissed. To establish a claim for the account stated, the plaintiff must establish three elements: (1) previous transactions between the parties establishing the relationship of debtor and creditor; (2) an agreement between the parties, express or implied, on the amount due from the debtor to the creditor; and (3) a promise by the debtor, express or implied, to pay the amount due. A debtor's partial payment of the amount may imply an admission of indebtedness and a resulting promise to pay the balance. The plaintiff argues that because the defendant paid a portion of the bill for services, this constituted an admission of indebtedness sufficient to support a cause of action for the account stated. The court finds that these allegations are insufficient to establish an account stated claim because the plaintiff fails to provide any supporting facts about the debtor-creditor relationship. Therefore, the partial payment does not imply an agreement by the defendant to pay the remaining balance on the bill.

Accordingly, the court grants the defendant's motion to dismiss the plaintiff's claims for failure to state a claim even though the claims are not preempted by ERISA.

East Coast Spine Joint and Sports Medicine v. Anthem Blue Cross Blue Shield, No. 2:22-cv-04841-WJM-JBC (D.N.J., April 27, 2023).

Regulatory Update

Washington Passes Health Data Privacy Law, Complicating Data Privacy Landscape

On April 27, 2023, the state of Washington's governor signed the My Health My Data Act into law. The Act's broad definitions extend legal protections to data that is traditionally outside the scope of health data. The Act will also require compliance from businesses that previously would not have been considered health care providers. The intent of the Act is to close the gap between consumer knowledge and industry practice regarding the collection of health data by providing stronger privacy protections in the state of Washington. The underlying rationale for the Act is a recognition that the Health Insurance Portability and Accountability Act (HIPAA) only covers health data collected by certain types of health care entities, such as health plans, healthcare providers and health care clearinghouses. The Act is designed to cover a broader range of entities, including apps and websites, that would not otherwise be covered by the protections under HIPAA.

The Act protects *consumer health data,* which is defined to encompass the personal information linked to or reasonably linkable to a consumer and that identifies their past, present or future health status. Importantly, the Act broadly defines *consumer* to include any natural person who is a Washington resident or natural person whose consumer health data is collected in Washington. Consequently, any health data that is collected—meaning bought, rented, accessed, retained, received, acquired, inferred, derived or otherwise processed in any manner—is protected, including data collected by Washington-based cloud service providers or Washington-based online retailers.

Not only does the Act broadly protect Washington consumers, but it also broadly restricts covered businesses. The Act applies to any legal entity that conducts business in Washington or produces products or services targeted at Washington-based consumers. If a company falls under the jurisdiction of the Act, it must adhere to various limitations. These include the need for extra information to be revealed to consumers, as well as obtaining their consent regarding the gathering, sharing and utilization of their health-related information. The Act also forbids the sale of health data, mandates that consumers retain the right to request the deletion of their health information, and prevents the implementation of geofences (virtual geographic boundaries) around health care facilities.

The Washington health data privacy bill can be found at https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/House%20Passed%20Legislature/1155-S.PL.pdf.

International Foundation and WELCOA Expand Workplace Wellness Impact Through Partnership

The International Foundation of Employee Benefit Plans and the Wellness Council of America (WELCOA) have formalized a strategic alliance to amplify the collective mission of improving the health and well-being of workplaces across the United States and Canada.

"We are excited about WELCOA's mission and teaming up to bring meaningful change to millions of people through our combined services," said Terry Davidson, CEBS, International Foundation Chief Executive Officer. "We feel this is a great opportunity to reconnect with our industry's roots of benefits and wellness together, joining forces to grow it into something new," Davidson added.

"WELCOA's purpose has always been to help people and organizations thrive. Combining the resources and thought leadership of two organizations that have been at the forefront of wellness and employee benefits for decades will provide needed support to the marketplace and improve workplace culture and employee experience through benefits and wellness education. We are currently collaborating and exploring how to best serve our members with this partnership, and we're excited to bring even greater value to the dedicated and passionate professionals that we serve," said Ryan Picarella, WELCOA Executive Director.

The benefits industry and wellness industry have historically shared the same goal of improving individual and organizational well-being. The International Foundation and WELCOA both come from a community of employers and plan sponsors ready to continue their critical work.

"At the center of this partnership lies a dedication to our members. They are the lifeblood of the International Foundation, and through this strategic alliance, we're able to bridge a knowledge gap and deliver exceptional value to our members, helping them thrive in their roles as employers/plan sponsors," said Sean Madix, International Foundation President and Chair of the Board.

Improving the lives of all working people has always been central to WELCOA's mission. We serve professionals who strive to build flourishing workplaces, and with this partnership, alongside those we serve, we'll come even closer to reaching that goal. This is an exciting time for WELCOA and the International Foundation as both organizations will have a greater depth of resources and support to continue propelling serviceoriented missions forward," said John Kizer, WELCOA board member and son of WELCOA founder, Bill Kizer. Under the new arrangement, WELCOA will remain a separate 501(c)(3) nonprofit organization, which is under the control of the International Foundation.

WELCOA is one of the nation's most respected resources for building high-performing, healthy workplaces. With a 30-year history, impacting countless lives around the globe, WELCOA has an impeccable reputation for helping business and health professionals improve employee well-being and create healthier organizational cultures. Visit www.welcoa.org for additional information.

Get Involved With the International Foundation

Are you interested in becoming more involved with the International Foundation? Your input could provide value and support to the many educational offerings and services International Foundation members and the benefits community rely on.

If you'd like to share your expertise, network with members or offer leadership, opportunities include:

- **Engaging with other members:** Share best practices and find solutions on the Foundation's online forum, Foundation Community. The Community allows you to connect with colleagues and fellow members and find information on Foundation social networks. Visit www.ifebp.org/community to sign up.
- **Serving on a committee:** Take an active part in developing products and services and charting courses of action for the International Foundation by volunteering at the committee or board level. Any member of the International Foundation can be nominated, and you may submit your information or nominate a colleague. Please contact us to learn more about the nomination process or to hear more about the different governance options and their areas of expertise.
- **Presenting, speaking or authoring:** Help others in the benefits community by offering your ideas and thought leadership through authoring a magazine article or presenting a conference session or a webcast. You could also moderate a session or serve as a discussion leader during a conference.

Need more information? Visit www.ifebp.org/getinvolved for details and to let us know that you're interested.

In addition, you can view two recorded webcasts (www.ifebp.org/webcasts) for more information about volunteering:

- International Foundation Membership Overview: What You Need to Know
- Get Involved: How to Engage With the International Foundation.

The ongoing success and quality of the International Foundation's products and services are due in large part to the collective efforts of our volunteers. We encourage you to join that special group of leaders.

plan | ahead

September 2023

18-22 Certificate in Global Benefits Management
Las Vegas, Nevada
www.**ifebp.org**/globalcertificate

18-23 Certificate Series
Las Vegas, Nevada
www.**ifebp.org**/certificateseries

October 2023

16-18 Certificate in Canadian Benefit Plans
Boston, Massachusetts
www.**ifebp.org**/canadacert

18-19 Mental Health in the Workplace
Virtual Conference
www.**ifebp.org**/MHWorkplaceVC

November 2023

6-7 Collection Procedures Institute
Santa Monica, California
www.**ifebp.org**/collections

6-10 Essentials of Multiemployer Trust Fund Administration
Santa Monica, California
www.**ifebp.org**/essentialsme

[schedule subject to change]

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

69TH ANNUAL
EMPLOYEE BENEFITS CONFERENCE

October 1-4, 2023 | *Boston, Massachusetts*
In-Person Preconference: September 30-October 1
www.**ifebp.org**/usannual

New Trustees Institute—Level I: Core Concepts
September 30-October 2
www.**ifebp.org**/newtrustees

Trustees Institute—Level II: Concepts in Practice
September 30-October 1
www.**ifebp.org**/trusteeslevel2

Certificate of Achievement in Public Plan Policy (CAPPP®): Pensions and Health Part I
September 30-October 1
www.**ifebp.org**/cappp

Administrators Masters Program (AMP®)
September 30-October 1
www.**ifebp.org**/amp

Trustees Masters Program (TMP)
September 30-October 1
www.**ifebp.org**/tmp

TMP Advanced Leadership Summit
October 1
www.**ifebp.org**/tmpsummit

January 2024

21 Institute for Apprenticeship, Training and Education Programs—Preconference
Las Vegas, Nevada

22-24 Institute for Apprenticeship, Training and Education Programs
Las Vegas, Nevada
www.**ifebp.org**/apprenticeshipinstitute

25-26 Construction Industry Benefits Conference
Las Vegas, Nevada
www.**ifebp.org**/construction

29 33rd Annual Health Benefits Conference and Expo—Preconference
Clearwater Beach, Florida

30-31 33rd Annual Health Benefits Conference and Expo (HBCE)
Clearwater Beach, Florida
www.**ifebp.org**/hbce

February 2024

10-11 Trustees Institute—Level II: Concepts in Practice
Orlando, Florida

11 Trustees and Administrators Institutes—Preconference
Orlando, Florida

12-14 New Trustees Institute—Level I: Core Concepts
Orlando, Florida

12-14 Advanced Trustees and Administrators Institute
Orlando, Florida

March 2024

3 Health Care Management Conference—Preconference
Rancho Mirage, California

4-5 Health Care Management Conference
Rancho Mirage, California

6-7 Investments Institute
Rancho Mirage, California

benefit fringe | making the most of break time

You'll learn a lot during the sessions you attend at the 69th Annual Employee Benefits Conference, and you'll bring home a wealth of practical information that you can put to work for your benefit plans. But did you know that the break times between sessions also provide valuable opportunities to learn and network?

At this year's conference, break times have been extended to 30 minutes, giving you more time to connect and learn. Here are some suggestions:

- **Stop by the Hospitality Hub.** This is your spot for International Foundation information and more. You can take advantage of work tables or comfy couches to connect with colleagues and grab a snack or beverage. You can also get conference app help, register for the 2024 conference and get a new professional headshot. Drop in for short informational sessions during conference breaks on Monday and Tuesday to learn more about volunteering with the Foundation, making the most out of your Foundation membership and more. The Hospitality Hub will be open throughout the conference. Check www.ifebp.org/usannual for a full list of events.
- **Check out the exhibit hall.** With more than 280 booths, the exhibit hall is the perfect place to learn about new services for your plan. This year's exhibit hall offers extended hours to provide you with more time to meet and chat with vendors.

- **Visit Health Island.** Located in the Exhibit Hall, Health Island offers a variety of free health screenings, assessments and services ranging from cholesterol and glucose tests to blood pressure screenings and mental wellness education.
- **Network.** Stay after a presentation to ask the presenter additional questions. Make plans to chat with fellow attendees. Those new connections can serve as a resource for you and your organization long after the conference is over.

Essentials *of*

Multiemployer Trust Fund Administration

Register today at www.ifebp.org/essentialsme

November 6-10, 2023 | Hilton Santa Monica Hotel & Suites | Santa Monica, California

The Essentials of Multiemployer Trust Fund Administration course is designed for salaried and third-party administrators and staff who manage multiemployer benefit funds. The curriculum will support your success by providing the critical information you need to manage the benefit fund and the fund office. Build a supportive peer network as you get up to date on the legal requirements and the changing benefits landscape.

This course is taught by an expert faculty of plan professionals and practitioners who understand your challenges. Class size is limited to support an interactive educational environment and enhance your learning experience.

Topics being presented in this curriculum include:

- Legal and regulatory environment
- Overview of insurance for funds, trustees and administrators
- Fundamentals of pension plans
- Managing people
- Investments
- Accounting
- Fundamentals of health plans
- Communicating change and essential information.

Who Should Attend

- Recently promoted supervisors or administrators
- Individuals seeking advancement
- Lead administrative staff and managers
- Account representatives
- Staff new to benefits
- New staff providing professional support services to multiemployer clients

This course is designed for salaried and third-party administrators with less than five years of experience, although those with over five years are welcome and will also benefit from attending.

International Foundation OF EMPLOYEE BENEFIT PLANS

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18700 West Bluemound Road
Brookfield, WI 53045
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69TH ANNUAL

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BE INSPIRED by these keynote speakers.

Dr. Sanjay Gupta
Sunday Keynote

Hoan Do
Monday Keynote

Lisa Gomez
Monday Special Guest Speaker

Rana Foroohar
Tuesday Keynote

Big Daddy Tazz
Wednesday Keynote

October 1-4, 2023
Boston Convention & Exhibition Center
Boston, Massachusetts
In-Person Preconference: September 30-October 1, 2023

Be Ready When It Matters

Attend the Annual Conference to gain information on the issues impacting your work, including:

- Cybersecurity
- Diversity, equity and inclusion
- Health care cost trends
- Work-life blend
- Investing
- Mental health
- Artificial intelligence, your organization and you
- Payroll auditing
- PBGC update
- Pharmacogenetics
- Preventing fraud
- SECURE ACT 2.0
- Prohibited transactions.

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