Proskauer

ERISA Newsletter

First Quarter 2020

Editor's Overview

Of course, on the top of everyone's minds these days is COVID-19. In this edition of Proskauer's ERISA Newsletter, our colleagues discuss some of the legislation and guidance that has been issued over the past several weeks related to employee benefits. In the meantime, the U.S. Supreme Court has been quite busy this term addressing complex ERISA issues. We take a look at the Court's decision in the IBM ERISA stock-drop case where, for the third time in the last six years, the Court addressed the pleading standards necessary for a plaintiff to plausibly plead a breach of fiduciary duty concerning investments in company stock funds. Finally, highlights from our blog include issues pertaining to the impact of releases on future litigation, arbitration clauses, ERISA preemption, the SECURE Act, and withdrawal liability.

Coronavirus

Minimizing the Risk of ERISA Litigation in a Turbulent Economic Climate

By: Myron Rumeld, Russell Hirschhorn, Tulio Chirinos and Kyle Hansen

As recent history has shown, ERISA claims seeking recovery of investment losses tend to proliferate during times of market volatility. The Coronavirus (COVID-19) pandemic presents a unique opportunity for plaintiffs to search for and bring fiduciary-breach claims based on the underperformance of company stock funds and other available investment options in 401(k) and 403(b) plans. The pandemic has had an extraordinarily disruptive impact on the economic markets since spreading globally and into the United States. Recent swings have seen historic losses in market prices, and although all investments are feeling the hit and some slightly rebounded after Congress passed the $2.2 trillion CARES Act, some will be more adversely affected than others. This is precisely the environment in which plaintiffs can make hindsight accusations against ERISA plan fiduciaries for offering allegedly imprudent investment options.

Based on past litigation experience, we find that there are some types of investments that are considerably more likely to be the target of claims under ERISA. We review these claims below, and also offer some thoughts on preventative measures that plan sponsors and fiduciaries can consider.

Company Stock Fund Claims

For decades, the ERISA plaintiffs' bar has attempted to hold employee stock ownership plan (ESOP) fiduciaries liable for breaching their fiduciary duties when the price of a company stock declines. The claims typically allege that the ESOP fiduciaries breached their fiduciary duties by allowing plan participants to continue to invest in company stock funds at a time when (i) such funds were artificially inflated as a result of some undisclosed event, or (ii) there were some "special circumstances" that made the company stock funds too risky to be a suitable investment option in a 401(k) plan.

ESOP fiduciaries may be particularly vulnerable to employer stock fund claims during this period of the COVID-19 pandemic in light of the risk of a substantial downward movement of the stock—one that is larger than the market generally. This risk would seem to be particularly pronounced in the industries most impacted by the stay-at-home orders, such as the retail, airline, and hospitality industries. The vulnerability to claims increases if the plan fiduciaries include corporate officials with knowledge of nonpublic information that could severely affect the stock price, such as whether their company plans to implement a significant reduction-in-force or file for bankruptcy protection. The failure to protect plan participants against the anticipated drop in the price of the stock once these plans become public could give rise to a subsequent ERISA lawsuit. While there would certainly be available defenses to such claims, plan fiduciaries who are looking to avoid them altogether may wish to consider at this time implementing changes to the fiduciary decision making structure that would remove senior executives who may be privy to nonpublic information, including the possible retention of an independent fiduciary to be responsible for the ESOP.

Other Investment Vehicles That May Become Litigation Targets

The plaintiffs' bar also has brought suits challenging other investment offerings in 401(k) and 403(b) plans. Certain types of funds have proven to be particularly vulnerable to challenge, and we can expect that to be even more so the case in this volatile environment.

- *Stable Value Funds*. Stable value funds are typically offered as plan investment options to participants seeking capital preservation. Plaintiffs have brought a variety of claims challenging the offering of these funds, including claims alleging that a stable value fund was not sufficiently diversified and, as a result, underperformed other available stable value funds. In these volatile times, plan fiduciaries would be well advised to conduct a review of their capital preservation options, including their stable value funds, to determine whether they are in fact serving the objective of capital preservation, and whether more conservative options, like money market funds, should be offered as well. As with all fiduciary conduct, the review and the rationale for any resulting decisions should be well documented.

- *Alternative Investments.* Some plans offer as investment options alternative investments, such as hedge funds and private equity investments. In many cases, these investments are offered because they can function as a hedge against declining prices in the domestic equity market. Nevertheless, plaintiffs have challenged their use whenever they underperform and have contended that they are imprudent because of their high fees, volatility, or exotic nature. We can expect the same to occur if it should turn out that, during this period of market volatility, alternative investments underperform other investment alternatives. In anticipation of such claims, plan fiduciaries should pay particular attention to developing a clear record of the rationale for maintaining these investments, and that this rationale is clearly reflected in participant communications.

- *Actively Managed Funds*. Some plans continue to offer actively managed funds in lieu of index funds. Index funds are generally less expensive than actively managed funds and frequently have performed better during the steady gains of the S&P 500 during the last decade. Depending on their investment philosophy or market sectors, actively managed funds may outperform index funds in these volatile times. But those that do not may be the target of the ERISA plaintiffs' bar. If they are not already doing so, plan fiduciaries may wish to consider supplementing actively managed products with index fund alternatives in the same market sectors.

- *Proprietary Funds.* Plans in the financial sector (and less frequently in other sectors) sometimes offer proprietary (or affiliated) investment options. These funds have been particularly vulnerable to claims when they underperform, net of fees, since participants will argue that the funds were offered in order to enrich the corporate plan sponsor. This will be particularly the case if a proprietary fund underperforms in this economic climate, when relative losses could prove to be very large. Plan fiduciaries may want to consider supplementing their plan offerings with nonproprietary options as a means to reduce the risk of such challenges.

Proskauer's Perspective

It would be truly unfortunate if companies that are already struggling to survive in the face of COVID-19 have to confront costly ERISA litigation over the retirement plans they sponsor. There is no sure way to avoid such litigation. But, at a time when plan sponsors and fiduciaries may be distracted by more emergent issues, it is important to keep in mind that ERISA fiduciary breach claims are best defended by a clear record of an objective decision-making process. Whether or not a regularly scheduled meeting is coming up, plan sponsors and fiduciaries may wish to schedule one soon for the purpose of thoroughly reviewing their investment offerings and the decision-making process, and with an eye toward the potential risks outlined above.

Plan participant communications also should be reviewed to make certain that they fully inform participants of the rewards and risks presented by their investment options in a volatile market. These reviews should be done in coordination with, and with the assistance of, competent service providers who are asked to fully review the alternatives available in these challenging times. Any changes made to the plan as a result of these reviews, and the reasons why, should be clearly communicated to plan participants.

In sum, the best defense to anticipated litigation in this volatile market is a proactive approach that enhances the fiduciary decision-making process.

Executive Compensation Considerations for COVID-19 (Salary/Wage Reductions)

By: Andrea Rattner, Colleen Hart, Joshua Miller, Seth Safra, Kate Napalkova and Katrine Magas

COVID-19 has had significant impacts on all aspects of business. While employers are assessing how to handle immediate employee needs related to sick leave, family leave and benefits claims, employers should also consider the impact that changes in their workforce or economic conditions will have on their compensation plans and programs.

Click here to read the next post in a series addressing the impact that COVID-19 has had on executive compensation issues. In their second post, our colleagues Andrea Rattner, Colleen Hart, Josh Miller, Seth Safra, Kate Napalkova and Katrine Magas discuss certain issues that employers should take into consideration before implementing salary and wage reductions.

Coronavirus Stimulus Deal's Impact on Employee Benefit Plans

By: Paul M. Hamburger, Seth Safra and Malerie Bulot

On March 27th, Congress passed a stimulus package in response to the Coronavirus/COVID-19 pandemic. The package, which is entitled the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act" or the "Act"), contains several provisions that affect employee benefits.

Retirement Plans

- *Early "Coronavirus-Related Distributions":* The CARES Act allows plans to offer "coronavirus-related distributions" up to $100,000 (from all plans in the controlled group combined). These distributions would be taken into income over three years (unless the participant elects otherwise) and are not subject to the 10% additional tax for withdrawal before age 59 ½. To qualify, the distribution must be taken during 2020 (before December 31st), and the participant must (i) have been diagnosed or have a spouse or dependent who was diagnosed with SARS–CoV–2 or COVID-19 by a test approved by the CDC, or (ii) have experienced "adverse financial consequences" as a result of being quarantined, furloughed, laid off, unable to work due to lack of child care, experiencing a closing or reduction of hours of a business owned by the individual, or other factors determined by the Secretary of Treasury. Similar to other recent qualified disaster relief and the adoption expense provision in the SECURE Act, these distributions may be repaid within three years after the distribution.
- *Increased Loans from Qualified Plans:* The Act also increases the limit on loans from qualified employer plans from $50,000 to $100,000 if the individual is a "qualified individual" (meaning someone who meets the requirements for a coronavirus-related distribution, as described above). The qualified individual's full vested balance (rather than the usual cap of *one-half* of the balance) is available for this loan. In addition, the Act delays by one year the deadline for qualified individuals to make loan repayments that are otherwise due between the date of enactment and December 31, 2020. Unlike suspension of payments for other leaves, a suspension under the Act will extend the maximum permitted term of the loan (5 years for non-residence loans).
- *Waiver of Required Minimum Distributions ("RMDs"):* The Act allows a temporary waiver for defined contribution plan RMDs that would otherwise have to be paid for calendar year 2020. The delay is available for section 401(a), 403(a), 403(b), and governmental 457(b) plans (in each case defined contribution only) and IRAs.

- *Plan Amendments:* A plan sponsor could adopt the above changes immediately,but it will eventually need to adopt plan amendments to reflect the changes. The deadline to adopt the amendments is extended to December 31, 2022 (or, for non-calendar year plans, the end of the plan year that starts in 2022). For governmental plans, amendments reflecting the RMD change may be adopted as late as the end of the 2024 plan year.
- *Single-Employer Defined Benefit Funding Relief:* The CARES Act allows sponsors of single-employer defined benefit plans to delay payment of minimum required contributions for calendar year 2020. Delayed contributions must be made with interest by January 1, 2021. A plan sponsor also has the option under the Act to use the plan's adjusted funding target attainment percentage for the last plan year ending before January 1, 2020 as the percentage for plan years which include calendar year 2020.

Health Plans

- *Expansion of Tests Covered under Families First Act:* The CARES Act amends the recent Families First Coronavirus Response Act (the "FFCRA"), which was discussed in a previous blog, to expand the types of SARS-CoV-2 and COVID-19 tests that group health plans and health insurance issuers must cover without cost-sharing, prior authorization, and other medical management requirements. The new tests to be covered include tests for which the developer has requested "emergency use authorization" under the Federal Food, Drugs, and Cosmetics Act and tests authorized and used by a state to diagnose patients.
- *Transparency in Pricing of Tests:* The Act generally requires providers to publicize the prices of COVID-19 tests. Plans and issuers paying for the tests under the FFCRA then have to reimburse the provider in accordance with the negotiated rate that it had with the provider *before* the COVID-19 public health emergency or, if no negotiated rate, whatever is the publicized cash price.
- *Coverage of Qualifying Coronavirus Preventive Services and Vaccines:* The Act also directs the Secretaries of Health and Human Services, Labor, and Treasury to require plans and issuers to cover any coronavirus preventive services without cost-sharing. Such services include vaccines and any other services that are determined by the CDC or U.S. Preventive Services Task Force will prevent or mitigate COVID-19.
- *Telehealth under a High-Deductible Health Plan ("HDHP"):* Expanding on the IRS's Notice with respect to HDHPs' coverage of COVID-19 costs, the Act permits (but does not require) HDHPs to waive deductibles for all telehealth or remote care services in plan years beginning on or before December 31, 2021 (even if not related to COVID-19) without impacting the plan's status as an HDHP.

- *Over-the-Counter Drugs and Menstrual Care Products:* The Act eliminates the requirement to have a prescription for over-the-counter drugs to qualify for tax-favored reimbursement from health savings accounts ("HSAs"), health reimbursement accounts ("HRAs"), and health flexible spending arrangements ("FSAs"), effective as of January 1, 2020. Menstrual care products likewise will be considered qualified medical expenses payable from those accounts.

Student Loans

The Act allows employers to reimburse or pay up to $5,250 of an employee's student loan payments through a Code Section 127 education assistance plan. This expansion applies only for loan payments (whether to the employee or directly to the lender) made by the employer after enactment and before January 1, 2021. The $5,250 limit is an aggregate limit for other permitted educational assistance and loan repayments combined. Section 127 arrangements are subject to certain technical requirements, including nondiscrimination and a plan document. For employers that already have Section 127 plans, this change can be implemented by an amendment to the definition of qualifying expenses. The Act also prohibits "double-dipping" by employees: employees may not deduct amounts that are reimbursed or paid by the employer.

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

Executive Compensation Considerations for COVID-19 (Leave)

By: Andrea Rattner, Colleen Hart, Kate Napalkova and Katrine Magas

COVID-19 has had significant impacts on all aspects of business. While employers are assessing how to handle immediate employee needs related to sick leave, family leave and benefits claims, employers should also consider the impact that changes in their workforce or economic conditions will have on their compensation plans and programs.

Click here to read the first post in a series addressing the impact that COVID-19 has had on executive compensation issues. In their first post, our colleagues Andrea Rattner, Collen Hart, Kate Napalkova and Katrine Magas discuss whether a temporary leave of absence or furlough triggers forfeiture, payment, vesting, or other treatment under compensation arrangements.

Families First Coronavirus Response Act: From a Benefits Perspective

By: Robert Projansky and Malerie Bulot

On March 18, 2020, the Senate passed and the President signed into law the Families First Coronavirus Response Act (the "Families First Act" or the "Act) which was first drafted and passed by the House earlier in the week. As noted in our Law and the Workplace summary of the Act, the new Act contains many important provisions regarding expanded family and medical leave and emergency paid sick leave as they relate to COVID-19. The Families First Act, however, does not stop there. It also mandates coverage of testing for COVID-19 without cost-sharing, prior authorization, or other medical management requirements.

The Act requires that both group health plans (including grandfathered plans) and health insurance issuers in the group and individual market cover the following:

- In vitro diagnostic products for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 that are approved, cleared, or authorized under the relevant provisions of the Federal Food, Drug, and Cosmetic Act.
- The administration of such in vitro diagnostic products.

Further, plans and issuers must provide coverage for all items and services furnished to an individual during a health care provider office, urgent care center, or emergency room visit that result in the ordering of the testing, the furnishing or administration of the testing, or the evaluation of an individual to determine whether testing is needed. Other notable requirements of this coverage include the following:

- The items and services must be covered to the extent they relate to the furnishing or administration of the testing or to the evaluation of the individual to determine the need for testing.
- The coverage must be provided without cost-sharing, including deductibles, copayments and coinsurance.

- Moreover, no prior authorization or other medical management requirements can apply.
- Office visits include so-called “telehealth” visits. (This is important given the rise in telehealth utilization due, in part, to fear over the spread of the virus.)

The Act covers only testing and diagnostics, suggesting that plans can continue to impose deductibles and other cost-sharing requirements for treatment of COVID-19. Of course, plan sponsors can elect to waive cost-sharing for treatment. (See our blog regarding recent IRS guidance permitting a high deductible health plan to waive deductibles for COVID-19 testing and treatment, without affecting its status as a high deductible plan.) Also, some state legislatures have proposed laws which, if enacted, would prohibit cost-sharing under covered plans with respect to treatment.

Some uncertainty remains as to how far the Act’s coverage mandate extends, including, for example, the following:

- The scope of the provision on telemedicine, including, for example, whether telemedicine visits outside the plan’s existing telemedicine program must be covered. (As the law is drafted broadly, the answer appears to be yes.)
- Whether out-of-network claims must be covered without cost-sharing. (The law is drafted broadly without exception for out-of-network services.)
- Whether retiree only plans are exempt from the requirements. (As we saw in connection with the passage of the Affordable Care Act, there was a fairly drawn out history related to the application of this exception.)

* * *

For more information about the paid sick and family leave requirements of the Act, see our Proskauer Law and the Workplace blog. For more information about tax credits available to employers providing this leave, see our Proskauer Tax Talks blog.

Proskauer’s cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

IRS Loosens HSA Rules for Coronavirus

By: Seth Safra

On March 11, 2020, the IRS issued Notice 2020-15, to address an important coronavirus issue for high-deductible health plans that are coordinated with health savings accounts ("HSAs"). The guidance paves the way for health plans to waive or reduce deductibles for any "medical care services and items purchased relating to testing for and treatment of COVID-19," without affecting eligibility to make HSA contributions.

In general, employees may make and receive contributions to HSAs only if they are enrolled in a "high deductible" health plan. With limited exceptions, covering medical expenses before the minimum deductible is reached would make employees ineligible to make or receive HSA contributions, and would subject employees who have made HSA contributions to an excise tax. The HSA rules generally have an exception for "preventive" care, but not for services and items purchased to treat a disease.

The new guidance expands the scope of the "preventive" care exception, but is limited to testing and treatment of COVID-19. Treatments for other conditions and diseases remain subject to the minimum deductible rules.

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. Visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take and resources to help manage ongoing operations.

U.S. Supreme Court Sends ERISA Stock-Drop Case Back For Further Evaluation

By: Russell L. Hirschhorn

In a closely-watched case among ERISA plan sponsors, fiduciaries, and practitioners, the U.S. Supreme Court vacated the Second Circuit's decision in *Jander v. Retirement Plans Committee of IBM*, 2018 WL 6441116 (2d Cir. Dec. 10, 2018)—a case alleging that the IBM 401(k) plan fiduciaries breached their fiduciary duties in connection with the plan's investment in the IBM company stock fund—and remanded the case for further consideration. As discussed below, the case is notable for several reasons, notwithstanding the Supreme Court's decision to defer ruling on the question presented. But first a brief background on how we got to where we are now.

The Supreme Court's Decisions in Dudenhoeffer and Amgen

In *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459 (2014), a unanimous Supreme Court held that there are no unique pleading standards for employer stock claims under ERISA, but nevertheless provided more rigid criteria for satisfying these standards, particularly in claims alleging that insider fiduciaries breached their fiduciary duties by failing to act on non-public information to prevent losses from investments in allegedly overvalued employer stock. The Supreme Court held that, to satisfy the pleading requirements, the plaintiff must allege an alternative action that the plan fiduciary could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances could not have viewed as more likely to harm the fund than to help it. Three considerations informed the Court's development of this standard: (1) fiduciaries are not required to break the law, (2) disclosures under ERISA could conflict with the letter and objectives of insider trading and other securities laws, and (3) acting on inside information could cause a drop in the stock price and do more harm than good to the stock already held by the plan.

The Court subsequently confirmed that the *Dudenhoeffer* standard sets a high bar. In *Amgen Inc. v. Harris*, 136 S. Ct. 758 (2016), the Court ruled that the Ninth Circuit erred by permitting a breach of fiduciary duty claim to proceed without first determining whether the complaint contained facts and allegations supporting a claim that removal of the Amgen stock fund was an alternative action that no prudent fiduciary could have concluded would cause more harm than good.

The Aftermath of Amgen

Following *Amgen*, four circuit courts—the Second (unpublished), Fifth, Sixth, and Ninth Circuits—had occasion to consider whether a 401(k) plan participant satisfied the *Dudenhoeffer* standard by alleging an alternative action that a plan fiduciary could have taken that would have been consistent with the securities laws and that a prudent fiduciary in the same circumstances could not have viewed as more likely to harm the fund than to help it. All four circuits concluded that the participants had failed to satisfy this standard and affirmed the dismissal of the claims. In each case, the court held that a prudent fiduciary could have concluded that a premature disclosure of negative company information outside normal corporate channels of communication would do more harm than good to a plan. *See Laffen v. Hewlett-Packard Co.*, 721 F. App'x 642, 644–45 (9th Cir. 2018); *Martone v. Robb*, 902 F.3d 519, 526–27 (5th Cir. 2018); *Graham v. Fearon*, 721 F. App'x 429, 437 (6th Cir. 2018); *Saumer v. Cliffs Nat'l Res. Inc.*, 853 F.3d 855, 861 (6th Cir. 2017); *Loeza v. John Does 1-10*, 659 F. App'x 44, 45–46 (2d Cir. 2016); *Whitley v. BP, P.L.C.*, 838 F.3d 523, 529 (5th Cir. 2016); *Rinehart v. Lehman Bros. Holdings Inc.*, 817 F.3d 56, 68 (2d Cir. 2016). The courts reasoned that a prudent fiduciary could have concluded that an unusual disclosure of negative news by a plan fiduciary before the issues had been fully investigated would spook the market into believing that problems at the company were worse than they actually were and thus harm plan participants already invested in the company stock fund. The Ninth Circuit also concluded that public disclosure of allegations that are not yet fully investigated would be inconsistent with the objectives of the securities laws. *In re HP*, 2015 WL 3749565, at *7 (N.D. Cal. June 15, 2015), *aff'd sub. nom Laffen*, 721 F. App'x 642.

The Second Circuit's IBM Decision

In 2018, the Second Circuit had occasion to revisit the pleading standards for ERISA stock-drop cases in a case against the IBM 401(k) plan fiduciaries. In this case, the plaintiff alleged that the defendants knew of, and should have disclosed to plan participants, certain accounting irregularities—for which the defendants themselves were allegedly responsible. According to the complaint, the failure to disclose left IBM's stock price artificially inflated and harmed participants when the irregularities were eventually disclosed and the price of the stock declined by more than $12 per share.

The district court twice dismissed the complaint based on its finding that the complaint lacked context-specific allegations as to why a prudent fiduciary could not have concluded that plaintiff's proposed alternatives were more likely to do harm than good and therefore failed to satisfy the *Dudenhoeffer* pleading standard.

On appeal, the Second Circuit reversed and concluded that the plaintiff had pled a plausible claim. The court first explained that, in its view, the *Dudenhoeffer* test was not clear because it initially asked whether a prudent fiduciary in the same circumstances would not have viewed an alternative action as more likely to harm the fund than to help it, and then reframed the question as whether a prudent fiduciary could not have concluded that the action would do more harm than good by dropping the stock price. According to the court, the use of the "would not have" phrase considers the conclusions that an "average prudent fiduciary" may reach, and the use of the "could not have" phrase suggests a more restrictive standard requiring consideration of whether "any prudent fiduciary" could conclude that the alleged alternative actions would do more harm than good.

The court found it unnecessary to decide which formulation applies because, in its view, the complaint's allegations satisfied either standard. According to the court, the plaintiff pled a plausible fiduciary breach claim because: (i) the plan fiduciaries allegedly knew that company stock was artificially inflated; (ii) the defendants were "uniquely situated to fix [the accounting irregularities] inasmuch as they had primary responsibility for the public disclosures that had artificially inflated the stock price to begin with" and disclosure could have been made within IBM's quarterly SEC filings; (iii) the failure to promptly disclose the truth allegedly caused reputational harm to the company that exacerbated the harm to the stock price; (iv) the stock traded on an efficient market and there was thus no need to fear that disclosure would result in an overreaction by the market; and (v) disclosure of the truth was inevitable. Accordingly, the court reversed the district court's judgment dismissing the complaint and remanded the case for further proceedings.

The Supreme Court's IBM Decision

At IBM's request, the Supreme Court agreed to accept the case for review and, more specifically, to address what it takes to plausibly allege an alternative action "that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it." Stated another way, the question presented asked whether *Dudenhoeffer*'s "'more harm than good' pleading standard can be satisfied by generalized allegations that the harm of an inevitable disclosure of an alleged fraud generally increases over time."

On January 14, 2020, the Supreme Court, in a *per curiam* decision, vacated the Second Circuit's decision and remanded the case for further consideration. In so ruling, the Court determined that briefing by the IBM petitioners and the Government focused on issues other than the question presented. The Court observed that the IBM petitioners argued that ERISA imposes no duty on an ESOP fiduciary to act on inside information, and the Government argued that an ERISA-based duty to disclose inside information that is not otherwise required to be disclosed by the securities laws would conflict with the objectives of the insider trading and corporate disclosure requirements imposed by the federal securities laws. Because the Second Circuit had not addressed these arguments, the Court declined to do so and left it to the Second Circuit to decide whether to address them in the first instance.

There also were two competing concurring opinions, which may provide some insight on how some of the Justices are thinking should the case wind its way back to the Supreme Court. In the first opinion, Justice Kagan, with whom Justice Ginsburg joined, suggested that if the arguments advanced by the IBM petitioners and the Government were not properly preserved, "sound judicial practice" pointed toward declining to address them. Furthermore, Justice Kagan expressed skepticism as to whether the merits of either argument would be consistent with *Dudenhoeffer* because (i) *Dudenhoeffer* made it clear that an ESOP fiduciary has a duty to act on insider information; and (ii) when an action does not conflict with securities laws, it might fall within an ESOP fiduciary's duty even if the securities laws do not require it.

In the second concurring opinion, Justice Gorsuch expressed his view that if the arguments advanced by the IBM petitioners and Government are not addressed immediately on remand, they will only prove "unavoidable later." Justice Gorsuch also disagreed with Justice Kagan's assertion that the parties' arguments were foreclosed by *Dudenhoeffer* because *Dudenhoeffer* did not address them—as no party in that case asked the Court to decide whether ERISA plaintiffs may hold fiduciaries liable for alternative actions they could have taken only in a non-fiduciary capacity.

Proskauer's Perspective

While the Supreme Court's decision may not have provided any concrete rules on what it takes to plausibly allege an alternative action "that a prudent fiduciary in the same circumstances would not have viewed as more likely to harm the fund than to help it," there are some notable take-aways from the *per curiam* opinion and the concurring opinions. To begin with, the Court vacated the only decision ever sustaining a claim under the pleading standard articulated in *Dudenhoeffer* and *Amgen*. Second, that the Court left to the Second Circuit to decide whether ERISA imposes no duty on an ESOP fiduciary to act on inside information suggests, at a minimum, some of the Justices believe that public disclosure of inside information may never be an alternative action that could satisfy *Dudenhoeffer*'s "more harm than good" pleading standard. In fact, Justice Gorsuch's concurring opinion seems to confirm that very view.

Stay tuned for additional developments.

Highlights from the Employee Benefits & Executive Compensation Blog

Arbitration

No Class Arbitration Available in PBM Case

By: James W. Barnett

A federal district court in Texas referred to arbitration a 401(k) plan participant's ERISA breach of fiduciary duty action based on allegations that certain plan investment options charged excessive fees. In a two-page order, the court instructed the arbitrator to determine whether the arbitrator or a court should determine whether the class action waiver provision in the participant's arbitration agreement waived her right to bring a representative action under ERISA § 502(a)(2). The case is *Torres v. Greystar Mgmt. Servs., L.P.*, No. 5:19-cv-00510 (W.D. Tex. Oct. 25, 2019).

Mental Health Parity

EBSA FY 2019 MHPAEA Enforcement

By: Russell Hirschhorn and Kyle Hansen

The Employee Benefits Security Administration (EBSA) is charged with ensuring that plans comply with ERISA, including the Mental Health Parity and Addiction Equity Act (MHPAEA). EBSA recently released its MHPAEA report for Fiscal Year (FY) 2019. We provide below highlights from EBSA's report and also note some comparisons to FY 2018.

In FY 2019, EBSA investigated and closed 186 health plan investigations (nearly all of the plans were subject to the MHPAEA) and cited 12 MHPAEA violations. By comparison, in FY 2018, EBSA investigated and closed 285 health plan investigations (less than half of the plans were subject to the MHPAEA) and cited 21 MHPAEA violations.

EBSA reported that it in FY 2019 it investigated MHPAEA violations in the following six categories:

(1) Annual dollar limits on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit (such as self-only or family coverage);

(2) Aggregate lifetime dollar limits on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit;

(3) The requirement that if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the regulations, then such benefits must be provided in every classification in which medical/surgical benefits are provided;

(4) Financial requirements relating to deductibles, copayments, coinsurance, and/or out-of-pocket maximums;

(5) Quantitative and nonquantitative treatment limitations; and

(6) Cumulative financial requirements and quantitative treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, including deductibles, out-of-pocket maximums, and annual or lifetime day or visit limits.

The cited violations included: 5 non-quantitative treatment limitations, 5 quantitative treatment limitations, 1 benefits in all classifications, and 1 in cumulative financial requirements and quantitative treatment limitations.

A copy of EBSA's report is available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-enforcement-2019.pdf.

* * *

The uptick in EBSA investigations of plans subject to MHPAEA appears to be consistent with the uptick in litigation activity we have seen challenging plan rules as not being in compliance with MHPAEA. As such, plan sponsors and fiduciaries are well advised to review their plan terms to ensure compliance with MHPAEA.

Preemption

ERISA Preemption Makes A Return To The Supreme Court

By: Kyle Hansen

The U.S. Supreme Court recently agreed to hear *Rutledge v. Pharmaceutical Care Management Association*, No. 18-540, a case that asks the Court to decide whether ERISA preempts an Arkansas state law that regulates rates at which pharmacy benefits managers (PBMs) reimburse pharmacies.

PBMs are entities that verify benefits and manage financial transactions among pharmacies, healthcare payors, and patients. Contracts between PBMs and pharmacies create "pharmacy networks." Some prescription drug reimbursement practices have resulted in independent rural pharmacies being reimbursed less than the cost of drugs, which, in turn, has driven them from the marketplace. Some states, including Arkansas, have enacted legislation to curb these practices by regulating the rates at which PBMs reimburse pharmacies for drugs.

The Pharmaceutical Care Management Association (PCMA) commenced litigation on behalf of its members against Leslie Rutledge, in her official capacity as Attorney General of the State of Arkansas, arguing that the Arkansas statute was preempted by ERISA because it contained a prohibited "reference to" ERISA. The Eighth Circuit (and the district court) concluded that ERISA preempted the Arkansas statute because it both related to, and had a connection with, employee benefits plans governed by ERISA. In so ruling, the Eighth Circuit explained that the Arkansas statute made implicit reference to ERISA through regulation of PBMs, which administer benefits for plans, employers, labor unions, and other groups that provide health coverage, and which are necessarily subject to ERISA.

Rutledge petitioned the Supreme Court for review on the question of whether the Arkansas statute regulating pharmacy benefits managers' drug-reimbursement rates is preempted by ERISA. Rutledge argued that review was warranted because the Eighth Circuit's decision conflicts with Supreme Court precedent, which, in Rutledge's view, has held that (1) a law regulating a class of entities that may include ERISA plans does not "relate to" ERISA plans; and (2) ERISA was not meant to preempt "basic rate regulation." Rutledge also argued that review was warranted because the Eighth Circuit's decision deepened a circuit split by departing from a decision from the First Circuit that held that state statutes regulating PBMs are not preempted by ERISA because PBMs are not ERISA fiduciaries and are thus "outside the intricate web of relationships among the principal players in the ERISA scenario." The Solicitor General supported Rutledge's request for review.

A briefing and oral argument schedule has not yet been set.

Releases

D.C. Circuit Rules that ERISA Plan Participant's Release Extends to Fiduciary Breach Claims On Behalf of The Plan

By: Tulio Chirinos

On March 24, 2020, the D.C. Circuit Court upheld a district court ruling that an ERISA plan participant's broad release of claims includes breach of fiduciary duty claims against ERISA plan fiduciaries, notwithstanding the release's carve-out for any "claims for vested benefits." The ruling extinguishes a participant's class action claims under ERISA sections 502(a)(2) and (a)(3) that 403(b) plan fiduciaries breached their fiduciary duties of prudence and loyalty by paying excessive recordkeeping fees and allowing participants to invest in investment options that were more expensive and underperformed comparable options available in the market.

Two years before filing the lawsuit, plaintiff and George Washington University (GWU) agreed to resolve an unrelated suit and entered into a settlement agreement and general release wherein plaintiff agreed to release all "claims for violation of any federal statute." The release included a carve-out for any "claims for vested benefits under employee benefit plans." GWU moved to dismiss the lawsuit on the ground that the plaintiff lacked standing because she had released her claims under the terms of the settlement agreement. The district court granted the motion and concluded that the carve-out "plainly" referred to plan-based claims for benefits typically brought pursuant to ERISA section 502(a)(1)(B) and not statutory ERISA claims for breach of fiduciary duty under ERISA sections 502(a)(2) and/or (a)(3). In a brief *per curiam* order, the D.C. Circuit affirmed the district court decision ruling that plaintiff had "released her ERISA claims as part of a prior settlement."

The case is *Stanley v. George Washington University, et al.*, No. 19-7079 (D.C. Cir. March 24, 2020).

* * *

Proskauer's Perspective: By upholding the district court ruling, the D.C. Circuit ruling provides assurances to Plan sponsors that the requirement to carve-out of general releases individual claims for vested benefits will not leave open the door to representative claims for fiduciary breach. The district court decision did not directly discuss other related questions that have been addressed by other circuit courts in similar cases, including whether an employee may lawfully release claims brought on behalf of the plan under ERISA section 502(a)(2). But by implication, the decision may be viewed as authorizing such releases. The decision may likewise provide support to defendants seeking to enforce employee agreements containing class action waivers in favor of individual arbitration, in response to ERISA claims brought on behalf of the plan.

Secure Act

New Year, New World: A Short Guide to the SECURE Act for Retirement Plan Sponsors and Administrators

By: Paul M. Hamburger, Steven Weinstein and Jennifer Rigterink

The SECURE Act, included as part of the Further Consolidated Appropriations Act, 2020, was signed into law on December 20, 2019. This new law contains many significant changes that may impact employer-sponsored benefit plans.

Given the scope of the law and the number of changes, we will release a series of blog posts exploring the new rules affecting employer-sponsored benefit plans and outlining best practices for implementation. For a short summary of the SECURE Act changes to health plans, please click here. Below is a chronological guide to the key retirement plan issues raised by the new law, most of which we will address in more detail in upcoming blog posts in this series.

SECURE Act Changes Effective Upon Enactment

- Extends nondiscrimination testing relief for certain closed or "soft-frozen" defined benefit plans, with an option to apply the rules to plan years beginning after December 31, 2013.
- Adds a new safe harbor for a defined contribution plan fiduciary's selection of a lifetime income provider.
- Provides that "qualified disaster distributions" up to $100,000 are exempt from the early distribution penalty tax, if the distribution is taken in connection with federal

disasters declared during the period between January 1, 2018 and 60 days after enactment.

- Prohibits making defined contribution plan loans through prepaid credit cards and other similar arrangements.

SECURE Act Changes Effective for Distributions Made After December 31, 2019

- Adds an option for penalty-free withdrawals from defined contribution plan accounts of up to $5,000 (per individual) within one year after birth or adoption of a qualifying child, with an option to "repay" qualified birth or adoption distributions under certain circumstances.
- Delays the "required beginning age" for minimum required distributions from qualified retirement plans from age 70½ to age 72 with respect to individuals who attain age 70½ after December 31, 2019.
- Caps the period to "stretch" post-death defined contribution plan distributions to 10 years (with exceptions for surviving spouses, minor children, disabled or chronically ill persons, or any person not more than 10 years younger than the employee). Effective for distributions with respect to employees who die after December 31, 2019 (with a delayed effective date for certain collectively bargained plans).

SECURE Act Changes Effective for Plan Years Beginning After December 31, 2019

- Reduces the earliest age that an employee can receive in-service retirement benefits from a pension plan from age 62 to age 59½.
- Increases the cap on the default contribution rate for qualified automatic contribution arrangements from 10% to 15% (but retains the 10% cap for the first year of participation).
- Eliminates the annual safe harbor notice requirement for nonelective 401(k) safe harbor plans.
- Adds an option to retroactively amend a 401(k) plan to become a nonelective safe harbor plan. If the nonelective contribution is at least 4% of compensation, the amendment could be made up until the end of the next following plan year.
- Allows plan participants invested in lifetime income investment options to take a distribution of the investment without regard to plan distribution restrictions—provided that the investment is no longer authorized to be held under the plan and the distribution is made by a direct transfer to another retirement plan or IRA or by distribution of the annuity contract.

SECURE Act Changes Effective for Plan Years Beginning After December 31, 2020

- Requires 401(k) plan sponsors to permit long-term, part-time employees who have at least 500 hours of service (but less than 1,000 hours) in each of the immediately preceding three consecutive 12-month periods to participate in the 401(k) plan for the sole purpose of making elective deferrals. Hours of service during 12-month periods beginning before January 1, 2021, are not taken into account for this rule.
- Permits unrelated employers to participate in an "open" multiple employer retirement plan (eliminating the current employment "nexus" rule) and generally eliminates the "one bad apple" rule under which a tax-qualification violation by one participating employer could potentially disqualify the entire multiple employer plan.

SECURE Act Changes Effective for Plan Years Beginning After December 31, 2021

- Directs the Department of Treasury and the Department of Labor to modify annual reporting rules to permit certain related individual account or defined contribution plans (*e.*, plans with the same trustee, fiduciary, administrator, plan year, and investment selections) to file a consolidated Form 5500. Applies to returns and reports for plan years beginning after December 31, 2021.

SECURE Act Changes – Special Effective Dates

- Requires that the Department of Treasury issue guidance within six months of enactment providing that individual 403(b) custodial accounts may be distributed in-kind to a participant or beneficiary in the event of a 403(b) plan termination, with the guidance retroactively effective for taxable years beginning after December 31, 2008.
- Requires defined contribution plan sponsors to provide participants with an annual estimate of monthly income that a participant could receive in retirement if an annuity were purchased with his or her plan account balance—regardless of whether an annuity distribution option is available under the plan. Effective twelve months after the release of DOL guidance.

* * *

Almost all tax-qualified retirement plans will need to be reviewed for possible amendments to reflect the SECURE Act, which provides for a remedial amendment period for making these amendments until the last day of the first plan year beginning on or after January 1, 2022 (with a delayed deadline for certain collectively bargained plans).

Check back here for more detailed analysis of these topics, as our next post will cover key points in the SECURE Act for defined benefit plans. For a more comprehensive list of SECURE Act changes for employer-sponsored retirement and health plans, please click here.

SECURE Act: Considering Implications of Changes to Required Minimum Distribution Rules

By: Paul M. Hamburger and James Huffman

As previewed in our prior blog post, the recently enacted SECURE Act includes many changes that affect employer-sponsored benefit plans and require the attention of plan administrators. Among these changes, effective for distributions made after December 31, 2019 (for individuals who reach age 70½ after that date), is the delay of the "required beginning date" for required minimum distributions from qualified retirement plans.

Under pre-2020 rules, distributions from a qualified retirement plan (including 401(k) plans) must generally begin to be made by April 1 of the calendar year after the later of the year in which an employee turns 70½ or retires (terminates employment). If someone is a 5% owner, distributions must begin to be made by April 1 of the year after the year in which the person turns age 70½, regardless of when the individual terminates employment.

The SECURE Act changes the required beginning date age from age 70½ to age 72. This change is effective for distributions made after December 31, 2019 for employees who reach age 70½ after that date. The old rule stays in place for people who reached age 70½ *before* 2020.

Example. Mary is an employee at ABC Company and reached age 70½ on August 1, 2019 (she turned age 70 on February 1, 2019). Mary is not a 5% owner at her company and she will terminate employment on September 1, 2020. The new SECURE Act rule does not apply to Mary. Mary's required beginning date is **April 1, 2021** (April 1 of the year after she terminates employment).

Example. John is an employee at ABC Company and will reach age 70½ on February 1, 2020 (he turned age 70 on August 1, 2019). John is not a 5% owner at his company and he will terminate employment on September 1, 2020. The new SECURE Act rule applies to John. John's required beginning date is **April 1, 2022** (April 1 of the year following the later of his attainment of age 72 (which will happen August 1, 2021) or termination of employment (which will happen September 1, 2020)). Before the SECURE Act change, John's required beginning date would have been April 1, 2021.

From a plan operation and administration perspective, this change gives rise to a number of questions and considerations:

- **Timing is everything.**Note that the effective date can impact employees differently depending specifically on when they reach age 70½. As the examples above show, two employees who terminate on the same date in 2020 will have different required beginning dates depending on when they reach age 70½. Plan administrators should look at their procedures, and work with their vendors as needed, to ensure that distributions are made in accordance with the appropriate timeline. This will require updates to plan procedures as well as system programming. The IRS indicated in Notice 2020-6 that the IRS and the Department of the Treasury are considering guidance for plan administrators, payors and distributees for a situation in which a required minimum distribution is made for a participant who reaches age 70½ in 2020, suggesting that the IRS is already anticipating foot faults in connection with the transition to the new required minimum distribution rules.
- **Actuarial increases for defined benefit plans**. When an employee continues to work beyond the calendar year in which the individual attains age 70½, the federal tax Code (Section 401(a)(9)(C)) requires that a qualified defined benefit plan provide for an actuarial increase to that employee's accrued benefit to take into account the period after age 70½ in which the employee was not receiving any benefits under the plan. Even though the required beginning date for plan distributions moved from April 1 following the later of the year in which an employee retires or reaches age 72 (up from age 70½), the age for purposes of determining actuarial increases has not changed and remains at age 70½.

- **Effect on life expectancy and distribution period tables**. The IRS issued proposed regulations on November 8, 2019 updating the life expectancy and distribution period tables that are used to calculate required minimum distributions from qualified retirement plans. These updated tables were prepared by the IRS based on a required beginning date of age 70½. It is unclear whether the IRS will update the tables to reflect a required beginning date of age 72 (for those to whom age 72 is relevant).
- **Update plan documentation.** Plan sponsors should review their plan documents, SPDs, rollover and distribution notices (so-called 402(f) notices), distribution forms, and participant communications to make sure they accurately describe the new rule and the participants to whom the new rule applies. Do not assume that existing plan language can remain in place indefinitely. The SECURE Act does provide for a delayed time for making appropriate plan amendments. However, because this change impacts participants in real time, it will be important to begin the written changes and communications as soon as possible.
- **Change applies to surviving spouses.** The required minimum distribution rules include a timing rule applicable when a participant dies before the required beginning date and a surviving spouse is the beneficiary. Under that rule, the spouse could delay distributions until the participant would have reached age 70½. The SECURE Act amended this age to conform to the new age 72 rule.

In addition to the change to the required beginning date rules, the SECURE Act changed the period over which distributions must be made following a participant's death. These rules will be covered in an upcoming blog in our SECURE Act series.

SECURE Act: Changes Exclusive to 401(k) Plans

By: Steven Weinstein and Annie (Chenxiaoyang) Zhang

The SECURE Act, included as part of the Further Consolidated Appropriations Act, 2020, was signed into law on December 20, 2019. This post highlights changes that are exclusive to 401(k) plans. For a chronological guide to key retirement plan issues raised by the new law, please click here.

Increase to Maximum Default Deferral Rate for Qualified Automatic Contribution Arrangements (QACAs)

Under a QACA, unless an eligible employee opts out of compensation deferrals or elects to contribute at a different rate, the employee is deemed to have elected to defer an amount equal to a default percentage of the employee's compensation. The default deferral rate must be at least 3% of compensation through the end of the employee's first plan year of participation, 4% for the second plan year, 5% for the third plan year, and 6% for the fourth and subsequent plan years. Before the SECURE Act, the default rate could not exceed 10% of compensation. Under the new law, the maximum permissible rate increases to 15% of compensation for the second and subsequent plan years of participation (the maximum rate through the end of the first plan year of participation remains at 10%). This change is effective for plan years beginning after December 31, 2019.

Changes to Nonelective 401(k) Safe Harbor Plans

Nonelective 401(k) safe harbor plans provide a specified level of employer contributions to all eligible employees without requiring employee contributions. The SECURE Act eliminates certain administrative burdens associated with the adoption and maintenance of these plans. The following changes are effective for plan years beginning after December 31, 2019.

Elimination of Annual Safe Harbor Notice Requirement

Prior to the SECURE Act, nonelective 401(k) safe harbor plans were required to provide eligible employees, within a reasonable period before any year, written notice of the employee's rights, obligations, and other required information. The new law eliminates this notice requirement for nonelective 401(k) safe harbor plans. However, plan administrators must continue to provide eligible employees with an opportunity to make or change a deferral election at least once per plan year.

Extension of Amendment Period

Prior to the SECURE Act, a plan could be amended to become a nonelective 401(k) safe harbor plan for a plan year no later than 30 days before the end of the plan year, subject to applicable notice requirements. The new law eliminates the notice requirements and allows a plan to be retroactively amended to become a nonelective 401(k) safe harbor plan no later than (1) 30 days before the end of the plan year, or (2) before the last day of the following plan year if the employer nonelective contribution is at least 4% of compensation (rather than 3%).

Long-Term Part-Timers Must Be Eligible for Elective Deferrals

Because employer-sponsored 401(k) plans may exclude from participation employees who have not attained age 21 and/or completed one year of service (with a minimum of 1,000 hours of service), part-time employees have limited options to save for retirement. Under the new law, 401(k) plans must allow employees with at least 500 hours of service over three consecutive 12-month periods and who have attained age 21 ("long-term part-time employees") to make elective deferrals. Long-term part-timers must be able to commence participation by the earlier of (1) the first day of the first plan year after the eligibility requirements are satisfied, or (2) six months after the eligibility requirements are satisfied. Employers may continue to exclude part-time employees from otherwise applicable nonelective and matching contributions (including 401(k) safe harbor requirements) and from all nondiscrimination and top-heavy testing. For vesting purposes, long-term part-time participants must receive a year of service if they are credited with at least 500 hours of service in an applicable 12-month period. Note that if a part-time participant becomes a full-time employee, these special rules no longer apply to the participant.

These changes are effective for plan years beginning after December 31, 2020. However, for purposes of determining the eligibility of long-term part-time employees, 12-month periods beginning prior to January 1, 2021 will not be taken into account. In addition, the new rule for long-term part-time employees will not apply to collectively bargained employees.

It is expected that further guidance will be provided to address issues such as whether long-term part-time employees must be subject to the same eligibility computation period as other eligible employees and how to treat employees who switch from part-time to full-time and vice versa.

SECURE Act: Two Key Changes for Defined Benefit Plans

By: Seth Safra and Jennifer Rigterink

As part of our ongoing series on the SECURE Act, this post discusses two key changes affecting defined benefit plans: (1) the ability to start in-service distributions at age 59½ (reduced from 62), and (2) new tools for closed defined benefit plans to pass nondiscrimination tests. Below we discuss each change and its potential impact on plan sponsors.

In-Service Distributions

The tax-qualification rules generally require that a pension plan be established for the purpose of paying benefits after retirement or attainment of normal retirement age. In 2006, the Pension Protection Act opened the door for in-service distributions starting at age 62, without regard to the plan's normal retirement age. Effective for plan years starting after December 31, 2019, the minimum age is reduced to 59½ – again, without regard to the plan's normal retirement age.

This change applies for section 401(a) plans ("qualified plans") and governmental section 457(b) plans, and it aligns with existing rules for in-service distributions under section 401(k) and section 403(b) plans. For non-governmental section 457(b) plans, the minimum age for in-service distributions remains 70½.

This new rule is notable for employers that are looking to accommodate phased retirement by allowing senior employees to start receiving their retirement benefits while continuing to offer the benefit of their expertise. The change will also help employers with frozen plans that are looking to derisk.

Nondiscrimination Testing Relief for Closed Defined Benefit Plans

In recent years, many employers have shifted from defined benefit pension plans to defined contribution arrangements. In many cases, employers have frozen benefit accruals under the defined benefit plan (often called a "hard freeze"). In other cases, however, employers have closed the defined benefit plan to new employees, but allowed existing participants to continue accruing benefits under the defined benefit plan (often called a "soft freeze"). Although a "soft freeze" is generally considered to be more favorable to employees than a "hard freeze," most "soft freezes" eventually run into nondiscrimination problems because the frozen population tends to become more highly compensated over time.

The U.S. Treasury Department and the IRS have recognized this problem and provided limited testing relief on a year-by-year basis. The SECURE Act provides permanent relief. Like the temporary relief from Treasury and the IRS, the SECURE Act does not provide a free pass as certain testing is still required for closed plans. However, the SECURE Act provides significant relief in three ways, and the relief is generally broader than what Treasury and the IRS had previously provided:

- For testing coverage and the amount of benefits, the SECURE Act expands the ability to aggregate the defined benefit plan with a defined contribution plan and to take into account benefits provided under the defined contribution plan ("cross-testing").
- The SECURE Act provides relief from the "benefits, rights and features" test for features that are unique to the defined benefit plan, such as annuity forms of payment.
- The SECURE Act provides relief from the "minimum participation" requirement, which requires that a defined benefit plan provide meaningful benefits to at least 50 employees or 40% of all employees.

The changes are described in more detail below.

Eligible Closed Plans: To be eligible for the new testing relief, a plan generally must meet the following requirements:

- *Closed Before April 5, 2017 or Satisfy "Five-Year Rule"*: The plan must have either (i) been closed before April 5, 2017, or (ii) existed for at least five years before the closure, without a "substantial increase" in coverage or the value of benefits, rights, and features during that five-year period. (The statute includes technical rules for determining whether an increase was "substantial.")

- *Plan Must Pass Testing For First Three Years Without SECURE Act Relief*: The plan must have passed the nondiscrimination tests without relief for the year in which the plan was closed and the next two years.
- *Subsequent Plan Amendments Cannot Discriminate*: If the plan is amended after it is closed (for example, to change the closed class, to change benefits, or to change rights or features), the amendments must not significantly favor highly compensated employees.

Expanded Availability of Cross-Testing: When a defined benefit pension plan covers a discriminatory group of employees, the plan can still pass the nondiscrimination tests if it is combined ("cross-tested") with a defined contribution plan. To compare "apples to apples," annual contributions under the defined contribution plan generally have to be converted to an equivalent annuity benefit.

Absent relief, IRS regulations impose various conditions for cross-testing, including:

- The plans must pass "gateway" conditions, such as a minimum allocation rate under the defined contribution plan for all non-highly compensated employees; and
- Only certain profit-sharing contributions may be taken into account. Matching contributions and contributions to an ESOP generally are not available for cross-testing.

The SECURE Act makes cross-testing available for eligible closed plans (as described above), without the need to pass a gateway, and it allows matching contributions and employer contributions to an ESOP or a section 403(b) plan to be taken into account.

In addition, the SECURE Act provides special relief for "make-whole" contributions under a defined contribution plan that are provided to a closed group of participants to make up for a reduction in benefit accruals under a defined benefit plan. These make-whole contributions can be in the form of non-elective contributions or matching contributions.

Relief From "Benefits, Rights, and Features" Testing: In addition to passing nondiscrimination tests with respect to coverage and benefit amounts, plans must pass a benefits, rights, and features test. In general, this means that optional forms and other features of the closed defined benefit plan must not discriminate in favor of highly compensated employees. This requirement can be a problem for closed defined benefit plans, because certain features of defined benefit plans, such as annuity forms of payment, typically are not replicated in defined contribution plans. To rectify this issue, the SECURE Act provides that eligible closed plans (as described above) automatically pass the benefits, rights and features test.

Relief From Minimum Participation Requirement: In addition to passing the nondiscrimination tests described above, a defined benefit plan must provide meaningful benefits to at least 50 employees or 40% of all employees (referred to as the "minimum participation" requirement). Over time, closed plans can fail this requirement simply because of attrition. The SECURE Act provides an automatic pass under the minimum participation requirement for eligible closed plans (as described above).

Effective Date: The nondiscrimination testing relief under the SECURE Act is available for plan years beginning after December 31, 2013.

Withdrawal Liability

Second Circuit Prohibits Retroactive Changes to Withdrawal Liability Interest Rate Assumptions

By: Anthony Cacace, Justin Alex and Neil V. Shah

The Second Circuit Court of Appeals recently issued a withdrawal liability decision of which both multiemployer pension plans and their contributing employers should be aware. Specifically, in *National Retirement Fund v. Metz Culinary Management, Inc.*, No. 17-1211, 2020 WL 20524 (Jan. 2, 2020), the Second Circuit held that the interest rate used to calculate an employer's withdrawal liability is the rate that was in effect on the last day of the fund's plan year preceding the year of the employer's withdrawal, *i.e.*, the "measurement date." In so holding, the Court rejected the plan actuary's decision to use a lower discount rate adopted after the measurement date that had the effect of substantially increasing the amount of the employer's liability. The Court reasoned that retroactive changes to the actuarial methods and assumptions used to calculate withdrawal liability are inconsistent with the legislative history of ERISA § 4214, which requires the fund to provide advance notice to employers of any "plan rules and amendments" that affect withdrawal liability. The Court also observed that withdrawal liability estimates provided under ERISA § 101(l) would be of "no value" if such retroactive changes were permitted. Going forward, multiemployer plans may need to coordinate with their actuaries to ensure that decisions regarding the methods and assumptions used to calculate withdrawal liability are made and communicated in a timely manner consistent with this decision.

Related Professionals

- **Russell L. Hirschhorn**
  Partner
- **Myron D. Rumeld**
  Partner