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FEATURE ARTICLES

COLUMNS

All About Benefits

This issue of *Employee Benefit Plan Review* covers a range of topics, including retirement plan investments, tuition reimbursement benefits, protections for pregnant employees, pharmacy benefits, and much more!

Retirement Plan Investments

In *Meiners v. Wells Fargo & Company*, the U.S. Court of Appeals for the Eighth Circuit clarified the burden plaintiffs must meet to state a claim for breach of fiduciary duty under the Employee Retirement Income Security Act (ERISA) based on the inclusion of allegedly underperforming and expensive investment funds. Because plaintiffs often lack detailed information about the process plan fiduciaries followed to make investment choices, pleading a plausible claim that those fiduciaries have acted imprudently can pose a significant challenge. In our "Feature" article, "In Closely Watched Mutual Funds Case, Eighth Circuit Sets High Bar for Labeling Retirement Plan Investments 'Imprudent,'" David Tetrick, Jr., Darren A. Shuler, and Zheyao Li, attorneys at King & Spalding LLP, discuss the decision.

Tuition Reimbursement Benefits

The benefits of tuition reimbursement programs for employers have been self-evident to companies for decades, but sometimes it helps to go "back to school" on this topic and revisit exactly why organizations should consider this a priority program. Andrew Gertz, a senior digital marketing manager with ConnectYourCare, reminds employers of these benefits in our lead "Focus" article, "Back to School: Tuition Reimbursement Benefits for Employers Study Guide."

Protections for Pregnant Employees

Several states across the country (including most recently Connecticut and Massachusetts) have enacted legislation that provides additional protections to pregnant employees. In these laws, pregnancy is broadly defined to include not only pregnancy, but also childbirth and related conditions (such as lactation and expressing milk for a nursing child). In our next "Focus" article, "We're Pregnant: New State Law Protections for Pregnant Employees," Theresa A. Kelly and Alba V. Aviles, attorneys at Day Pitney LLP, provide an overview of the recently enacted legislation in Connecticut and Massachusetts, as well as similar requirements in New Jersey and New York.

Pharmacy Benefits

With rising prescription drug costs, there is no question that pharmacy is, and will continue to be, on the minds of those who are responsible for consulting on or administering employee benefits. We see the discussion and debate play out almost daily in the media, the trades, conferences, and board rooms across the country with significant regularity. Cory Easton, a partner at Confidio, discusses pharmacy benefits in our next "Focus" article, "Pharmacy Benefits 2020: Ready to Spend Half of Your Medical Plan Budget on Rx?"

And More...

In this issue, we have three columns, "Ask the Experts," "From the Courts," and "Retirement Plan Update," by Marjorie M. Glover, David Gallai, and Rachel M. Kurth of Norton Rose Fulbright US LLP, Ian S. Linker of Rivkin Radler LLP, and Lori Welding Jones of Thompson Coburn LLP, respectively.

Enjoy the issue!

Steven A. Meyerowitz
Editor-in-Chief

November 2018Submit questions to Employee Benefit Plan Review via e-mail to smeyerowitz@meyerowitzcommunications.com Answers by the columnists may appear in an upcoming issue.

Disclosure of Health Plan Documents to Former Employee

Q A former employee has reached out to my company asking for documents related to our company-sponsored health plan. This person has neither worked for our company, nor participated in our health plan, for over a year. We are not sure why he is asking, and we have concerns about providing some of the requested documents. Are we required to respond to his request and give him the requested documents?

A It depends. Under ERISA, your company has an obligation to provide a health plan participant with certain documents upon written request.[1] Under ERISA §104(b)(4), a plan administrator:

> shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated.

Failure to provide such information subjects the plan administrator to a penalty of up to $100 per day for each day it is late, and such other relief as a court deems proper.[2]

Under ERISA § 3(7), the term "participant" means any employee or former employee of: an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. The U.S. Supreme Court addressed the question of when a claimant is a "participant" for purposes of ERISA's document disclosure requirements in the case *Firestone Tire & Rubber v. Bruck*.

In the *Firestone Tire* case, the U.S. Supreme Court found that the term "participant" for purposes of determining the persons entitled to information and documents under ERISA's disclosure requirements includes a former employee who has a reasonable expectation of returning to covered employment or a "colorable claim" to benefits. The U.S. Supreme Court stated in the *Firestone Tire* case that the claimant "must have a colorable claim that (1) he will prevail in a suit for benefits, or that (2) eligibility requirements will be fulfilled in the future...."[3]

The documents required to be disclosed to participants upon written request under ERISA §104(b)(4) generally would be limited to the "latest" of the covered documents, and a plan administrator generally does not violate ERISA when it provides only current documents and not historical ones.

However, there is an exception for prior versions of plan documents that might have current bearing on the requesting participant or beneficiary that might be material in evaluating a participant's or beneficiary's rights. Which documents are considered "other instruments under which the plan is established or operated" is generally a facts-and-circumstances determination, and case law in your jurisdiction may provide relevant guidance.

Your company should use care in determining what this former employee's rights are under the plan, and what documents must be provided. We recommend consulting with an experienced employee benefits attorney to assess the former employee's rights under your company's plan, whether the former employee is eligible for benefits under the plan, the extent of the former employee's interest in the plan, and your company's disclosure obligations with respect to each specific document requested by the former employee.

Your company will want to do a fact-intensive inquiry to determine what documents referenced in ERISA § 104(b)(4) must be disclosed to this former employee upon written request, and should make a document-by-document determination based on input from legal counsel.

Status of Foreign Employees for Purposes of Employer Mandate

Q I work for a large global company which sponsors a group health plan for our U.S. workforce. I understand that, to avoid penalties under the health care reform law, one of the requirements is that we are required to offer coverage under the health insurance plan to 95 percent of our full-time employees

each month. Does this requirement to offer coverage to 95 percent of our full-time employees apply only to our employees within the United States, or to our company's foreign employees as well?

A For purposes of meeting the Affordable Care Act's requirement to offer health plan coverage to 95 percent of your full-time employees to avoid penalties, compensation that is not U.S. source income is generally excluded from the determination of whether a service provider is a "full-time employee," so your company's foreign employees are unlikely to be counted for this purpose.

Under the Affordable Care Act, for purposes of the "employer mandate" pursuant to which an applicable large employer must offer qualifying health insurance coverage to its full-time employees or else be subject to a penalty, an applicable large employer is treated as offering health insurance coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers coverage to all but five percent (or, if greater, five) of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also offers coverage to that employee's dependents).

For this purpose, "full-time employee" is defined as, with respect to a calendar month, "an employee who is employed an average of at least 30 hours of service per week with an employer." The term "hour of service" means "each hour for which an employee is paid, or entitled to payment for the performance of duties for the employer; and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence...."

However, the definition of "hour of service" specifically excludes certain hours, including an exception for services outside of the United States. The definition specifies that the "term hour of service does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States" (within the meaning of Internal Revenue Code Sections 861 through 863 and the regulations thereunder). This means that "hours of service" do not include hours for which an employee receives compensation that is taxed as income from sources outside the United States (generally meaning certain work overseas).[4]

Qualified Moving Expense Reimbursements

Q We have an employee who was transferred to our Illinois office on December 31, 2017. He recently submitted requests for reimbursement of final moving expenses under our company's relocation policy. Are the amounts he is reimbursed under our relocation policy included or excluded from his income?

A This is a very timely question. The Internal Revenue Service (IRS) issued guidance in late September 2018, which clarifies that amounts received by an employee for moving expense incurred before January 1, 2018 may be excluded from income if certain requirements are met.[5]

As noted in IRS Notice 2018-75, Section 132(a)(6) of the Internal Revenue Code (IRC) generally excludes from income "qualified moving expense reimbursements." Section 132(g)(1) defines a "qualified moving expense reimbursement" as any amount directly or indirectly received by an individual from an employer as payment for (or a reimbursement of) expenses which would be deductible as moving expenses under Section 217 if such expenses were paid or incurred by the individual.

"Qualified moving expense reimbursements" do not include any payment for (or reimbursement of) expenses that were actually deducted by the individual in the prior taxable year. In addition, qualified moving expense reimbursements are excludable from wages and compensation for employment tax purposes.[6]

The Tax Cuts and Jobs Act of 2017 (TCJA) suspended the exclusion from income of qualifying moving expenses reimbursed by an employer for taxable years beginning after 2017 and ending before 2026. This suspension does not apply to members of the U.S. Armed Forces on active duty who move pursuant to a military order and incident to a permanent change of station.

IRS Notice 2018-75 clarifies that the suspension of the moving expenses exclusion under Section 132(a)(6) applies only to payments or reimbursements for expenses incurred in connection with moves that occurred after December 31, 2017.

This means that, if (1) an employee moved in 2017, (2) the employee's expenses would have been deductible by the employee under IRC Section 217 before the TCJA was enacted, and (3) the expenses were not deducted by the employee, then the amount the employee receives (either directly or indirectly) in 2018 from the employer will be qualified moving expense reimbursements. As a result, these expenses would be excludible from the employee's gross income and from wage withholding and compensation under the IRC Sections cited above.

The IRS also notes that employers that have included these amounts in the employee's wages or compensation may use the adjustment process under IRC Section 6413 or file a claim for a refund under IRC Section 6402 to correct the overpayment of federal employment taxes. Additional information on these corrections and adjustments is cited in IRS Notice 2018-75.

Notes

1. *See* ERISA § 104(b)(4).
2. *See* ERISA § 502(c)(1).

3. *See* Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989).
4. *See* 26 CFR §§ 54.5980H-4(a), 54.4980H-1.
5. *See* IRS Notice 2018-75.
6. See IRC Sections 3121(a)(20), 3231(e)(5), 3306(b)(16), and 3401(a)(19).

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Federal Court Remands Case to State Court Because ERISA Did Not Preempt Claims Against Health Insurer for Revealing Plaintiff's HIV Status

A federal district court in California held that the Employee Retirement Income Security Act of 1974 (ERISA) did not preempt a plaintiff's claims under California law against his managed health care company for revealing his HIV status.

The Case

In 2015, the plaintiff learned that he had contracted HIV and began treating it with medications. He kept his HIV status confidential.

In 2017, the plaintiff, who had employer-sponsored health insurance through Aetna, received a notice at his residence in a windowed envelope that permitted anyone who handled the plaintiff's mail to see his name and discover that he was taking "HIV Medications." The plaintiff's landlord retrieved the envelope from the mailbox, discovered the information about the plaintiff's HIV status, and evicted the plaintiff from his residence.

The plaintiff sued Aetna and a number of its affiliates in a California state court, bringing claims for violation of California's Confidentiality in Medical Information Act; violation of California's HIV disclosure laws; violation of his constitutional right to privacy under Article 1, Section 1, of the California constitution; negligence; negligence per se; intentional infliction of emotional distress; and unlawful, unfair, and fraudulent business acts and practices.

Aetna removed the action to federal court on the grounds that ERISA preempted the plaintiff's state law claims.

The plaintiff moved to remand to California state court, arguing that the district court lacked subject matter jurisdiction because ERISA did not preempt any of his state law claims.

The court granted the plaintiff's motion to remand.

The Court's Decision

In its decision, the court explained that, under the U.S. Supreme Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004), a state law cause of action is completely preempted by ERISA if:

(1) An individual, at some point in time, could have brought the claim under 29 U.S.C. § 1132(a)(1)(B), and
(2) There is no other independent legal duty that was implicated by a defendant's actions.

Applying this test, the court held that ERISA did not completely preempt the plaintiff's state law causes of action.

First, the court ruled that the plaintiff could not have brought his claims under 29 U.S.C. § 1132(a)(1)(B), which permits a plan participant or beneficiary to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

The court was not persuaded by Aetna's argument that the plaintiff could have asserted a 29 U.S.C. § 1132(a)(1)(B) claim against Aetna for its alleged failure to follow the terms of the health plan requiring Aetna to "abide by all applicable laws and regulations regarding confidentiality of individually identifiable health and other personal information" as well as a claim against Aetna for breach of its fiduciary duty under ERISA.

The court reasoned that the plaintiff's claims were based on state law, not on the terms of the plan. Moreover, the court added, all of the plaintiff's claims arose out of the notice mailed by Aetna, enclosed in a windowed envelope that resulted in the disclosure of the plaintiff's HIV status to third parties who came in contact with his mail. The plaintiff sought damages, statutory penalties, attorneys' fees, and equitable remedies for harm he allegedly suffered as a result of Aetna's unlawful disclosure, and did not claim that he was entitled to relief based on the ERISA plan. According to

the court, there was no indication that the plaintiff's claims were an "alternative" to ERISA's "enforcement mechanism."

The court also rejected Aetna's argument that the plaintiff could have brought his claims under ERISA because the disclosure occurred in the course of Aetna's plan administration. However, merely because the conduct at issue may have occurred in the course of Aetna's plan administration did "not create a relationship sufficient to warrant preemption."

The court also rejected Aetna's contention that it met the second prong of the test because there was no "independent legal duty" that was implicated by Aetna's actions. In particular, Aetna argued that it had obtained the plaintiff's personally identifiable information (PII) and protected health information (PHI) "to perform its duties as plan administrator" and that it sent the plaintiff the notice "to notify him about his plan benefits." In doing so, Aetna said, it "was required to comply with state and federal laws pursuant to its fiduciary obligations under ERISA and the terms of [the plaintiff's] health plan."

According to the court, it was not the terms of the plan that compelled Aetna to comply with state and federal law. Indeed, Aetna was independently obligated by several federal and state laws to protect the plaintiff's PHI and PII, including the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the California Confidentiality in Medical Information Act, and the California Health and Safety Code. Therefore, the plaintiff's claims were not solely and entirely dependent on the ERISA plan. Accordingly, ERISA did not completely preempt the plaintiff's state law claims; the court granted the plaintiff's motion to remand. [*D.L. v. Aetna, Inc.*, No. SA CV 18-893-JFW(JEMx) (C.D. Cal. Aug. 10, 2018).]

Sixth Circuit Holds That ERISA Health Plan Correctly Denied Coverage for Air Ambulance Bill in Absence of Precertification

The U.S. Court of Appeals for the Sixth Circuit recently held that an employee benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) correctly denied coverage for air ambulance transportation for a participant's son where the participant had not obtained the precertification required by the plan for nonemergency transportation.

The Case

When the plaintiff, a Utah physician, began a fellowship at the Cleveland Clinic in Ohio on July 1, 2010, he enrolled his family in the Cleveland Clinic's ERISA-governed employee benefit plan, administered by Antares Management Solutions. The plaintiff's coverage began on July 1 but required about 15 business days to process enrollment paperwork.

On July 7, the plaintiff had his 14-month-old son, J.S., transported from a Utah hospital to the Cleveland Clinic by Angel Jet's air ambulance service. J.S. had been hospitalized since birth for multiple congenital abnormalities, including omphalocele (protrusion of abdominal organs from the navel) and pulmonary hypoplasia (underdeveloped lungs). He required a mechanical ventilator to breathe.

J.S.'s physician had prepared a letter of medical necessity for the air ambulance service. He explained that J.S. could not be safely transported by any other means because of the distance to travel and his health conditions, which required close monitoring for suctioning of secretions, potential airway compromise, and possible respiratory failure. The letter, dated June 3, said that J.S. was "stabilized for transfer and will continue to progress with continued care."

Before the flight, Angel Jet sought coverage information from Antares. Antares was unable to confirm that the plaintiff and his son were members of the plan while their enrollment paperwork was processing and did not pre-certify the air ambulance service. Angel Jet decided to proceed with the transportation on July 7 and submitted a bill to Antares for $340,100.

Antares denied the claim for failure to obtain the precertification required by the plan for nonemergency transportation.

Angel Jet appealed the determination to Cleveland Clinic Employee Health Plan Total Care (Total Care). Total Care affirmed the denial but issued Angel Jet a check for $34,451.75, approximately 10 percent of the billed charges. Total Care explained that the payment was "an attempt to be fair" and reflected the amount its preferred provider of air ambulance services would have charged.

The plan's advisory committee, which adjudicated the plan's final level of administrative review under the plan, affirmed.

The plaintiff, as a plan participant, sued Total Care under 29 U.S.C. § 1132(a)(1)(B). The district court affirmed the plan's denial of benefits. Among other things, the district court concluded that the plaintiff lacked standing and that the administrative benefit determination was not arbitrary and capricious because J.S.'s transportation was not an emergency or pre-certified as required for a nonemergency.

The plaintiff appealed to the Sixth Circuit.

The Sixth Circuit's Decision

In its decision affirming the district court, the Sixth Circuit first considered whether the plaintiff had standing to sue, since it was the provider of air ambulance service that potentially suffered a financial loss, not the plaintiff plan participant. The court held the plaintiff had standing because he "suffered an injury within the meaning of Article III because he was denied health benefits he was allegedly owed under the plan." The court reasoned, "Like any private contract claim, his injury does not depend on allegation of financial loss. His injury is that he was denied the benefit of his bargain."

The court next considered the appropriate standard of review. Disagreeing with the district court, which applied the abuse of discretion standard of review, the court determined that the plan did not contain an explicit enough grant of discretion to the claim fiduciary to warrant deferential review; thus, the court reviewed the determination de novo.

The court next looked at the merits. It explained that the plan "unambiguously" required precertification as a condition of coverage. The plan stated that it would "pay 100% for transportation—including . . . air ambulance" for a sick or injured member outside of the Cleveland area, but it added that "[t]his type of transportation to a Cleveland Clinic Hospital must meet the precertification process." The plan specifically stated:

> **If precertification is required and *NOT* obtained, EHP Total Care is not obligated to reimburse for services even if it is a covered benefit.**

and:

> If the member does not participate in the precertification process before obtaining the service there will be **NO REIMBURSEMENT** for the service.

A claim is not exempt from the plan's precertification requirements, even if it was submitted during the enrollment period, when it would have been impossible to obtain precertification. Under the plan, only an emergency could qualify for an exemption.

According to the court, J.S.'s transportation was not an emergency, because there was no evidence in the record that J.S. required "immediate medical attention" on July 7 and could not wait another week or so for the plaintiff's enrollment paperwork to be processed. To the contrary, the court pointed out, the physician's letter of medical necessity—dated June 3—stated that J.S. was stable and planned for his transportation on a date scheduled over a month later.

Finally, the court rejected the plaintiff's argument that because precertification was "impossible" during the enrollment period because his membership could not be verified, the plan waived the precertification requirement. The court explained that, under ERISA regulations, denial of a claim for failure to obtain precertification would be unreasonable "under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the claimant." 29 C.F.R. § 2560.503-1(b)(3). The court noted, however, that the regulations do not require a plan to exempt nonemergency services and effectively forego any precertification requirement.

The court concluded that because the physician did not show that the transportation was an emergency or obtain the precertification required for a nonemergency, he was not entitled to reimbursement under the plan. [*Springer v. Cleveland Clinic Employee Health Plan Total Care*, No. 17-4181 (6th Cir. Aug. 14, 2018).]

Court Rejects Request to Expand Record for Judicial Review of Claim Administrator's Adverse Medical Benefits Determination

The administrative record compiled by the claim administrator during the administrative process and considered by the court in an action for benefits under the Employee Retirement Income Security Act of 1974 (ERISA) is nearly sacrosanct. There are certain limited instances when a court will consider evidence outside the administrative record. A federal district court in Massachusetts recently considered the scope of the administrative record and when a court may open the record to consider additional evidence.

The Case

The plaintiff, a young woman with a history of bulimia nervosa, had health insurance through an ERISA-governed employee welfare benefit plan through her father's employer, which sponsored the plan. Harvard Pilgrim Health Care of New England, Inc. (HPHC) was the plan's payor of benefits. The plan's claim administrator was United Behavioral Health (UBH).

On May 28, 2015, the plaintiff was admitted to a residential treatment facility specializing in eating disorders. HPHC paid for her

treatment for about two months. On July 30, 2015, UBH informed the plaintiff that HPHC would stop paying for residential treatment on July 31, 2015.

The plaintiff requested coverage for "partial hospitalization" at the residential treatment facility beginning August 1, 2015, but UBH denied that claim on August 4, 2015 on the ground that the requested level of care was not medically necessary. It offered instead to cover outpatient treatment.

The plaintiff appealed that determination. On August 7, 2015, HPHC upheld the initial determination. The plaintiff continued to receive treatment at the residential treatment facility until January 8, 2016, with her family paying for the treatment until she stepped down to outpatient care on October 6, 2015.

The plaintiff sued HPHC, challenging the determination to stop paying for treatment relating to her eating disorder on the ground that it was not medically necessary.

HPHC produced to the plaintiff's counsel a copy of its proposed administrative record. The plaintiff filed a motion to open the administrative record to include the following additional documents:

(1) All internal claim or utilization review notes by HPHC or UBH pertaining to the treatment received by the plaintiff between May 28, 2015 and January 8, 2016, the dates of the plaintiff's stay at the residential treatment facility;
(2) All communications between HPHC and/or UBH, on the one hand, and the residential treatment facility, on the other, between May 28, 2015 and January 8, 2016;
(3) All communications between HPHC and/or UBH, on one hand, and the plaintiff and/or any of her representatives, on the other, between May 28, 2015 and January 8, 2016;
(4) All communications between HPHC and UBH between May 28, 2015 and January 8, 2016 regarding the plaintiff's claim for benefits for her treatment at the residential treatment facility; and
(5) All medical records associated with the plaintiff's treatment at the residential treatment facility between May 28, 2015 and January 8, 2016.

The court denied the plaintiff's motion.

The Court's Decision

In its decision, the court noted, citing to *Orndorf v. Paul Revere Life Ins. Co.*, 404 F.3d 510, 519 (1st Cir. 2005), courts deciding ERISA cases typically "focus" on the administrative record and absent "some very good reason," courts will not look beyond the record. And the final administrative determination "acts as a temporal cut off point." In other words, "claimant[s] may not come to a court and ask it to consider post-denial medical evidence in an effort to reopen the administrative decision." However, the court stated that "additional evidence may be relevant when a claimant challenges the procedure used to make a decision, as opposed to the merits of the decision itself." For instance, evidence outside the administrative record may be relevant if it is "relevant to a claim of personal bias by a plan administrator or of prejudicial procedural irregularity in the ERISA administrative review procedure." And if a claimant can provide evidence of bias discovery outside the administrative record may be appropriate to determine "whether a structural conflict has morphed into an actual conflict. … But any such discovery must be allowed sparingly and, if allowed at all, must be narrowly tailored so as to leave the substantive record essentially undisturbed."

Accordingly, the court first held that no documents or communications from the period after August 7, 2015, when HPHC issued its final determination on the plaintiff's appeal, could be included in the record for judicial review. The court explained that the final administrative decision was a "temporal cutoff point," and it said that the plaintiff had not argued how later materials could be relevant.

The court then held that, with respect to documents and communications created prior to August 7, 2015, the plaintiff had the burden to show either that HPHC/UBH actually had these materials when they made the benefit determination at issue, or there was a "very good reason" to include them in the record.

According to the court, the plaintiff's medical records from the residential treatment facility certainly would be relevant to a claim determination if HPHC/UBH had the records at the time. But they did not have them. The court was not persuaded by the plaintiff's arguments that these records were "the best evidence of what kind of treatment [the plaintiff] was receiving" and that the court should consider these records in determining whether the treatment was medically necessary. The court noted that the plaintiff could have submitted these records earlier, in support of her administrative appeal, but she had not and she failed to explain why she had not. The court concluded that the plaintiff had not put forth "a very good reason" for these medical records to be included in the administrative record.

The court then considered whether case notes taken at the beginning of her treatment at the residential treatment facility until the adverse determination should be included in the record, as well as communications from that period between her or the residential treatment facility, on the one hand, and HPHC or UBH, on the other.

Under Department of Labor regulations, an ERISA plan is required to provide claimants with "all documents, records and other information

relevant to the claimant's claim for benefits." 29 C.F.R. § 2560.503-1(h)(2)(iii). Further, "[a] document, record, or other information shall be considered 'relevant' to a claimant's claim if such document, record, or other information (i) was relied upon in making the benefit determination; [or] (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination." *Id.* § 2560.503-1(m)(8). The court explained that it appeared that neither HPHC nor UBH had actually considered the treatment notes or communications from the prior, covered treatment periods as part of the benefits determination; thus, they should not be in the administrative record.

Moreover, the court concluded, the plaintiff's argument—that her "history of struggling with her condition" was "important" for the court to consider in determining whether her treatment was warranted under the terms and conditions of the plan—did not amount to a "very good reason" to include them in the record. The court stated, "if that type of relevance alone were enough to reopen the record in ERISA benefits cases, there would be no teeth to a rule restricting review to the record before the administrator." [*Fisher v. Harvard Pilgrim Health Care of New England, Inc.*, No. 17-11232-FDS (D. Mass. July 13, 2018).]

Ian S. Linker, the "From the Courts" columnist for *Employee Benefit Plan Review*, is a partner in Rivkin Radler LLP's Insurance Coverage Practice Group. Mr. Linker focuses his practice on ERISA-benefits litigation and other benefits- and insurance claims-related litigation. Prior to joining Rivkin Radler, Mr. Linker worked as in-house counsel for MetLife's litigation department, where he acquired significant appellate experience and a nationwide expertise in ERISA-benefits litigation. In that role, Mr. Linker managed ERISA litigation matters, counseled clients, and trained and supervised attorneys handling ERISA litigation. Mr. Linker also led MetLife's appellate practice group. Mr. Linker can be reached at ian.linker@rivkin.com.

By Ian S. Linker

Retirement Plans under Tax Reform 2.0: How the Family Savings Act Could Affect Employers

On September 13, 2018, the House Ways and Means Committee introduced and approved a trio of bills, referred to collectively as "Tax Reform 2.0." One of the bills, titled the Family Savings Act of 2018 (the FSA), includes numerous provisions relating to employer-sponsored retirement plans.[1]

Although the FSA was approved out of committee on a party-line vote, it contains a number of provisions that have received bipartisan support in prior legislative sessions. For example, provisions relating to frozen defined benefit plans and the expansion of access to multiple employer plans were included in the Retirement Enhancement and Savings Act of 2018, a prior version of which was unanimously approved by the Senate Finance Committee in 2016.

An Executive Order issued by President Trump on August 30, 2018 calls for the expansion of access to multiple employer plans as well as modification of the requirement minimum distribution requirements. Many of the FSA's provisions have been proposed or endorsed by the American Benefits Council. Therefore, even if review and consideration of the FSA is delayed until after the mid-term elections, it is quite possible that some or all of the provisions of the FSA will eventually be adopted in some form.

The following is a list of 10 key provisions of the FSA that could impact employers sponsoring qualified retirement plans.

Multiple Employer Plans

A multiple employer plan is a retirement plan maintained by more than one unrelated employers that is intended to satisfy the qualification requirements under Section 401(a) of the Internal Revenue Code of 1986, as amended (Code). Currently, a certain level of "commonality" is required among unrelated employers in order to maintain a multiple employer plan.

Certain qualification requirements (e.g., eligibility, exclusive, and vesting) are applied as if the unrelated employers are a single employer. Other qualification requirements (e.g., coverage and nondiscrimination testing) are performed by each of the unrelated employers as if it maintained a separate plan for its employees.

If any of the participating employers violates the qualification requirements, there is a risk that the multiple employer plan will be disqualified as to all employers.

Under the FSA, a multiple employer plan is a defined contribution plan that (i) is maintained by employers that have a common interest (other than the plan), or (ii) has a registered "pooled plan provider" which meets specified requirements, including being designated as the ERISA named fiduciary of the plan.

The FSA provides that the violations of one employer will not result in the disqualification of the multiple employer plan. Instead the plan assets attributable to the employees of the noncompliant employer will be transferred to a separate plan or arrangement and only the noncompliant employer will be liable for plan liabilities attributable to its employees.

The FSA provides that, except for the administrative duties assigned to the pooled plan provider, each participating employer will serve as the plan sponsor of the plan with respect to the portion of the plan attributable to its employees. The Secretary of the Treasury will provide future guidance with respect to the administrative duties required to be performed by the pooled plan provider.

Safe Harbor 401(k) Plans

Currently, the rules applicable to safe harbor 401(k) plans require that an annual notice be provided to each participant setting forth the participant's rights and obligation under the plan. Under the FSA, the safe harbor notice is eliminated for 401(k) plans achieving safe harbor status via nonelective contributions (nonelective 401(k) safe harbor plans). The annual notice requirement is retained for 401(k) plans achieving safe harbor status via matching

contributions (matching 401(k) safe harbor plans).

The FSA also provides that a 401(k) plan can be amended to become a nonelective 401(k) safe harbor plan at any time before the 30th day prior to the close of the plan year unless the 401(k) plan was previously a matching 401(k) safe harbor plan for such year.

Lifetime Income Investments

Currently, if a plan no longer offers a lifetime income investment under the plan, a participant may be required to liquidate the investment and pay a surrender charge. The FSA provides that, if a lifetime income investment may no longer be held under a plan, a participant may elect a qualified distribution of the lifetime income investment, via a direct trustee-to-trustee transfer, to another employer-sponsored retirement plan or an IRA within the 90-day period ending on the date the lifetime income investment may no longer be held under the plan.

Custodial Accounts upon Termination of a Section 403(b) Plan

Section 403(b) plans are plans maintained by charitable tax-exempt organizations and educational institutions of state or local governments. Typically, 403(b) plans use contributions to purchase annuity contracts or provide that contributions will be held in custodial accounts for employees. The FSA provides that if an employer terminates a 403(b) plan which holds contributions in custodial accounts, and the custodian is an IRS-approved nonbank trustee, the custodial accounts will be automatically deemed to be IRAs as of the date of the plan termination.

Requirement Minimum Distribution Rules Exemption

The required minimum distribution rules generally provide that distributions from a qualified retirement plan must being by April 1 following the later of (i) the calendar year in which a participant reaches age 70, or (ii) the calendar year in which the participant terminates employment. The FSA provides that, if the value of a participant's interest under all applicable eligible retirement plans does not exceed $50,000 on the last day of a calendar year, the required minimum distribution rules will not apply to the participant for such year. The $50,000 limit is subject to indexing.

An applicable eligible retirement plan includes a qualified retirement plan under Code Section 401(a) (other than a defined benefit plan), IRAs, individual retirement annuities, tax-sheltered annuities under a 403(b) plan, and a governmental 457(b) plan. IRA holders would also qualify for this exemption.

Deadline for Adopting New Plans

Currently, a qualified retirement plan must be adopted by the last day of the taxable year for which it becomes effective. This is true even if the first contribution to the plan is not made until the due date of the employer's tax return for such taxable year. The FSA provides that, if an employer adopts a qualified retirement plan no later than the due date of the employer's tax return for a taxable year (including extensions), the plan is treated as adopted as of the last day of such taxable year.

Closed and Frozen Defined Benefit Plans

Currently, defined benefit plans that are closed to new participants (closed plans) and defined benefit plans that provide no future benefit accruals (frozen plans) continue to be subject to the minimum participation requirements and nondiscrimination tests applicable to qualified retirement plans.[2]

However, over time, it may become difficult for closed or frozen plans to satisfy the minimum participation requirements or nondiscrimination tests. For example, the group of employees that continue to accrue benefits under a closed defined benefit plan may become skewed in favor of highly compensated employees.

The FSA contains a number of provisions specifically targeted to "applicable defined benefit plans."[3] Specifically, the FSA would:

- *Treat closed or frozen applicable defined benefit plans as satisfying the minimum participation requirements* if such requirements were met as of the date the plan was closed or frozen.
- *Ensure that the benefits, rights, or features provided to a closed class will not fail the nondiscrimination tests* if (i) in the plan year in which the class closes and the two succeeding

plan years, the benefits rights and features satisfy the nondiscrimination requirements without application of the FSA relief, and (ii) any plan amendment after the date of closure that modifies the closed class or the benefits, rights, and features of the plan does not discriminate in favor of highly compensated employees.

- *Allow the benefits provided to a closed class to be aggregated and tested with one or more defined contributions plans* if (i) for the plan year in which the class closes and the two succeeding plan years, the plan satisfies the plan coverage and nondiscrimination requirements without application of the FSA relief, and (ii) any plan amendment after the date of closure that modifies the closed class or the benefits provided to such class does not discriminate in favor of highly compensated employees.
- *Provide special testing rules with respect to benefits, rights and features, and benefit accruals under closed or frozen plans*. If a portion of an applicable defined benefit plan that is eligible for the relief described above is spun-off to another employer, the relief will continue to apply to the spun-off plan provided the requirements for relief continue to be satisfied.

Withdrawals from Retirement Plans for Birth of Child or Adoption

The FSA provides an exception from the 10 percent early withdrawal tax in the case of a "qualified birth or adoption distribution" from an applicable eligible retirement plan. For this purpose, applicable eligible retirement plans include qualified retirement plans (other than defined benefit plans), 403(b) plans, governmental 457(b) plans, and IRAs.

A qualified birth or adoption distribution is a distribution not exceeding $7,500 made during the one-year period beginning on the date of birth of the participant's child, or finalization of a legal adoption of an eligible child by the participant. An eligible child is any individual who has not attained age 18 or is physically or mentally incapable of self-support. Qualified birth or adoption distributions may also be recontributed to an applicable eligible retirement plan.

Conclusion

On a bipartisan, basis legislators have expressed support for many of the above provisions. Adoption of one or more provisions in the FSA would provide welcomed flexibility to employers with respect to the administration of qualified retirement plans.

Notes

1. H.R. 6757, 115th Congress, Second Session, introduced on September 13, 2018.
2. Temporary nondiscrimination relief was provided to defined benefit plans that were closed to new participants before December 13, 2013 and such relief was extended several times, most recently via Notice 2018-69.
3. An applicable defined benefit plan includes a plan that was (i) closed or frozen before April 5, 2017, or (ii) in effect for at least five years as of the date the class was closed or the plan frozen, and during the five-year period prior to closure there was no substantial increase in the benefits, rights, or features under the plan (for purposes of the relief for benefits rights and features testing) and no substantial increase in coverage or benefits (for purposes of the relief under the minimum participation requirements and for benefits testing).

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In Closely Watched Mutual Funds Case, Eighth Circuit Sets High Bar for Labeling Retirement Plan Investments "Imprudent"

David Tetrick, Jr., Darren A. Shuler, and Zheyao Li

In *Meiners v. Wells Fargo & Company*,[1] the U.S. Court of Appeals for the Eighth Circuit clarified the burden plaintiffs must meet to state a claim for breach of fiduciary duty under the Employee Retirement Income Security Act (ERISA) based on the inclusion of allegedly underperforming and expensive investment funds. Because plaintiffs often lack detailed information about the process plan fiduciaries followed to make investment choices, pleading a plausible claim that those fiduciaries have acted imprudently can pose a significant challenge. But the Eighth Circuit refused to water the pleading standard down to account for this reality in *Meiners*.

Rather, the Eighth Circuit held that "[t]o show that 'a prudent fiduciary in like circumstances' would have selected a different fund based on the cost or performance of the selected fund, a plaintiff must provide a sound basis for comparison—a meaningful benchmark."[2] As one of the first appellate decisions to tackle this thorny issue head on, litigants should expect *Meiners* to be cited as persuasive authority beyond the Eighth Circuit.

Background

ERISA class action litigation challenging mutual fund fees and performance has been on the rise since the U.S. Supreme Court's 2015 decision in *Tibble v. Edison International*,[3] which confirmed that plan fiduciaries have a continuing duty to monitor investment options and remove imprudent ones. But *Tibble* also left open the question of what exactly is the scope of the fiduciary duty to monitor, and thus, what is required to plead a viable claim that duty has been violated.[4] *Meiners* at least partially answers that question.

In *Meiners*, a participant in Wells Fargo's 401(k) plan accused plan fiduciaries of favoring Wells Fargo's own target date funds as investment options, rather than offering cheaper and better performing alternatives, such as Vanguard target date funds.[5] In particular, the plaintiff alleged that the Wells Fargo plan fiduciaries sought to maximize their own profits by generating fees and "seed" money for their underperforming funds.[6]

The district court dismissed the complaint because the plaintiff's comparison to Vanguard funds was insufficient to show that the performance and fees of the Wells Fargo funds rendered them imprudent investment choices.[7] After reviewing fund prospectuses, the district court held that investors would expect the Wells Fargo and Vanguard funds to perform differently because they have different investment strategies (the Wells Fargo funds have a higher bond allocation).[8] The district court also held that the plaintiff failed to establish cheaper Vanguard and Fidelity funds as reliable comparators, i.e., ones that offer similar services or are of similar size.[9] Finally, the district court found that the plaintiff did not show that the Wells Fargo funds are more expensive "compared to the market as a whole."[10]

The Eighth Circuit's Opinion

The Eighth Circuit affirmed the district court's dismissal. The court acknowledged that plan participants have "different levels of knowledge regarding *what* investment choices a plan fiduciary made as compared to *how* a plan fiduciary made those choices."[11] But, because "ERISA plaintiffs typically have extensive information regarding the selected funds," they are expected to marshal that information and "provide a sound basis for comparison – a meaningful benchmark" by which to evaluate the cost or performance of the challenged funds.[12] And failure to do so equals failure to state a claim under the plausibility standard articulated by the Supreme Court in *Twombly* and *Iqbal*.[13]

As a result, the Eighth Circuit agreed with the district court that comparing an allegedly underperforming fund to one with a different investment strategy does not say anything

about whether it was an imprudent choice.[14] Nor is it enough to allege that "cheaper alternative investments with *some* similarities exist in the marketplace."[15]

Indeed, the Eighth Circuit made clear that its prior decision in *Braden v. Wal-Mart Stores Inc.*[16] (which involved a comparison to cheaper share classes of the same funds) should not be read to support such a watered-down pleading standard.[17] Finally, in considering whether the plaintiff's examples met the "meaningful benchmark" standard, the Eighth Circuit affirmed the district court's close analysis of fund prospectuses that were not attached to the complaint, finding that they were "necessarily embraced by the pleadings."[18]

The Eighth Circuit recognized in *Meiners* that the analytical rigor of its decision contradicted some earlier (unidentified) district court decisions supporting the plaintiff's position.[19] Calling into question "the rationale of these cases," the Eighth Circuit explained that "the existence of a cheaper fund does not mean that a particular fund is too expensive *in the market generally* or that it is otherwise an imprudent choice. Any other conclusion would exempt ERISA plaintiffs both from pleading benchmarks for the funds and from pleading internal processes about selecting funds."[20]

And because the plaintiff in *Meiners* had failed to plead a plausible claim of imprudence based on comparison of the Wells Fargo funds to meaningful benchmarks, the Eighth Circuit determined that it could not reasonably draw any inference that the plan fiduciaries had retained the challenged funds out of improper motives.[21] Thus, even in so-called "proprietary fund" cases like *Meiners*, the Eighth Circuit held that ERISA plaintiffs are required "to pair allegations of self-interest with allegations of an imprudently chosen fund in order to survive a motion to dismiss."[22] Without first establishing that a fund is an imprudent choice based on comparison to an analytically rigorous benchmark, a plaintiff is not entitled to discovery to test their conclusory allegations of unlawful motives and conduct.[23]

Key Takeaways

Following *Meiners*, ERISA plaintiffs alleging breaches of fiduciary duty based on fund fees and/or performance now have a clear burden to meet if they wish to avoid dismissal. Plaintiffs should not assume that their lack of access to information about the process that plan fiduciaries use to select and retain investment funds will entitle them to a relaxed pleading standard.

To the contrary, *Meiners* teaches that the identification of "meaningful benchmarks" by which to measure performance and fees will be required to state a plausible claim of fiduciary breach. Absent such benchmarks, "no inference can be reasonably drawn that the [plan fiduciaries] retained those funds . . . out of improper motives"[24]—not even in so called "proprietary fund" cases.

Although *Meiners* involved the employer's own funds, nothing in the Eighth Circuit's rationale limits it to that situation. In fact, the same week *Meiners* was decided, a federal district court in New York employed similar reasoning to rule in favor of New York University in a case involving allegedly excessive fees and underperformance.[25] In the NYU case, the court identified several additional factors to consider in determining appropriate benchmarks, including the fund's cash holdings, domestic-foreign allocation, and passive versus active management.[26]

Following *Meiners*, courts should demand specific allegations about these (and potentially more) factors before allowing ERISA breach of fiduciary duty claims to proceed to expensive and time-consuming discovery. A complaint lacking such analytical rigor should be dismissed for failure to state a claim.

Notes

1. Slip Op. No. 17-2397 (8th Cir. Aug. 3, 2018).
2. *Meiners*, Slip Op. at 5.
3. 135 S. Ct. 1823 (2015).
4. *Tibble*, 135 S. Ct. at 1829.
5. *Meiners*, Slip Op. at 2.
6. *Id.* at 3.
7. Meiners v. Wells Fargo & Co., 2017 WL 2303968, at *2-3 (D. Minn. May 25, 2017).
8. *Id.* at *3.
9. *Id.*
10. *Id.*
11. *Meiners*, Slip Op. at 4 (emphasis original).
12. *Id.* at 5.
13. *Id.* at 3 (citing Bell Atl. Corp. v. Twombly, 550 U.S. 544, 557 (2007); Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009)).
14. *Id.* at 5.
15. *Id.* at 6 (emphasis original).
16. 588 F.3d 585 (8th Cir. 2009).
17. *Meiners*, Slip Op. at 6-7.
18. *Id.*
19. *Id.* at 7. The plaintiff on appeal had relied on Gipson v. Wells Fargo & Co., 2009 WL 702004 (D. Minn. Mar. 13, 2009); Wildman v. Am. Century Servs., LLC, 237 F. Supp. 3d 902 (W.D. Mo. 2017); Leber v. Citigroup, Inc., 2010 WL 935442 (S.D.N.Y. Mar. 16, 2010); Urakhchin v. Allianz Asset Mgmt. of Am., L.P., 2016 WL 4507117 (C.D. Cal. Aug. 5, 2016); Krueger v. Ameriprise Fin., Inc., 2012 WL 5873825 (D. Minn. Nov. 20, 2012); Moreno v. Deutsche Bank Am. Holding Corp., 2016 WL 5957307 (S.D.N.Y. Oct. 13, 2016); Lorenz v. Safeway, Inc., 2017 WL 952883 (N.D. Cal. Mar. 13, 2017); Terraza v. Safeway, Inc., 2017 WL 952896 (N.D. Cal. Mar. 13, 2017); McDonald v. Edward D. Jones & Co., 2017 WL 372101 (E.D. Mo. Jan. 26, 2017); and Pledger v. Reliance Trust Co., 2017 WL 2624302 (N.D. Ga. Mar. 7, 2017).
20. *Meiners*, Slip Op. at 7 (emphasis original).
21. *Id.*
22. *Id.* at 8.
23. *Id.*
24. *Id.* at 7.
25. Sacerdote v. New York Univ., 2018 WL 3629598 (S.D.N.Y. July 31, 2018).
26. *Id.* at *28-30.

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Back to School: Tuition Reimbursement Benefits for Employers Study Guide

Andrew Gertz

The benefits of tuition reimbursement programs for employers have been self-evident to companies for decades, but sometimes it helps to go "back to school" on this topic and revisit exactly why organizations should consider this a priority program.

One of the best examples dates back to the 1930s.

In 1931, Walt Disney Productions was riding a hot streak. Although it was still on financially shaky ground, Mickey Mouse cartoons were a sensation and the studio was growing. But *Silly Symphonies*, the series featuring one-off stories sans Mickey, still had not reached its full potential in the estimation of Walt Disney.

Although the company was employing more animators than ever, Walt had grander visions for the cartoon series and wanted higher quality productions. And so, as recounted in *Walt Disney: An American Original*, Walt Disney Productions began sending animators to night school at Chouinard Art Institute to learn more about how people and animals moved so that these and real-life scenarios could be caricaturized properly in *Silly Symphonies*.

Not only did the company pay for tuition, but the person that chauffeured employees to and from classes at night was… none other than Walt Disney himself. The positive impact of these classes would eventually lead to the formation of the studio's own Disney Art School.

Times have changed, but tuition reimbursement benefits for employers remain significant. This article summarizes some of the benefits. And, you probably will not have to drive workers-turned-students to class personally today to realize these benefits.

Tuition Reimbursement Helps Companies Attract Talent

The Society for Human Resource Management's (SHRM) 2018 Employee Benefits survey report[1] found 51 percent of organizations now offer undergraduate educational assistance and 49 percent offer graduate educational assistance.

From a job seeker standpoint, this means that one out of every two employers can point to tuition reimbursement programs as a benefit for talent acquisition and retention purposes.

Job seekers often make a list of pros and cons when weighing to accept an offer or stay with their current employer. HR wants—and I'd argue needs—"tuition reimbursement" to be in the pros column favoring them as an employer when top talent begins evaluating their careers and job opportunities.

Although the prevalence of tuition reimbursement programs today is impressive, it still falls short of the prevalence of similar programs before the Great Recession of the late 2000s, when many employers slashed these benefits.

Prior to that economic downturn, SHRM found more than 70 percent of employers offered undergraduate tuition reimbursement.

That means there is still a long road to travel to get back to the earlier heyday of employer-sponsored tuition reimbursement.

And, there is a big reason it may be wise for HR decisionmakers and brokers to view this mission to make up lost ground as a race they cannot afford to lose: millennials….

Tuition Reimbursement Programs Appeal to Millennials

People cannot stop thinking about millennials in the workplace. It makes sense that this would be a hot topic for HR as the millennial generation now comprises the majority of the American workforce.[2]

For a business to have the people they need, they need to be great at fishing from the millennial pond.

In fact, in a recent Allegis Group survey[3] of more than 1,000 HR decision-makers, 49 percent of respondents said that they are concerned with their organization's ability to attract and retain millennials and Gen Zs.

In that same study, 62 percent said that failing to attract and/or retain millennial or Gen Z employees could have a negative impact on the business.

How does that tie back to the benefits of tuition reimbursement for employers?

Well, if we accept that recruiting and retaining millennials is a priority HR goal, than any benefit that helps employers achieve that goal is therefore a priority HR means-to-an-end.

In the State of the American Workplace[4] survey report, Gallup found that 45 percent of millennials say they would change their job for tuition reimbursement benefits. By comparison, only 24 percent of Gen X and Baby Boomer respondents said they would make the change.

Essentially, tuition reimbursement has become 21 percent more important to the workforce over time.

The question for HR decision-makers and brokers than is: Has the tuition reimbursement program been prioritized at least 21 percent more by the organization to keep up with what employees want?

Tuition Reimbursement Helps Employers Build a More Capable Workforce

Remember the Walt Disney example at the beginning of this article. He saw the raw talent of gifted employees and wanted to refine it, to elevate it. The same holds true for organizations today.

Additionally, while paying for college is a pain point for individuals, the actual education received by college graduates today is a sore spot for many employers.

According to a Gallup-Lumina Foundation survey,[5] only 11 percent of employers strongly agreed that graduating students have the skills and competencies that their businesses need.

However, 17 percent of respondents *strongly disagreed* that graduates had the necessary skills for their business.

Companies need to find a way to close talent gaps and ensure they have a better prepared workforce.

What is the answer? Start with the workforce you already have to custom build the workforce you need.

Imagine you are running a Major League Baseball team that needs help in a lot of areas.

You essentially have two main ways of dealing with the situation:

1) Bring in new players to fill the void through the draft, free agency, or trades, or
2) Find a way to get better performances from your existing roster and minor league players.

Here are those same options translated to human capital:

1) Hire someone with the education you need and teach them your organization- or industry-specific competencies, or
2) Take existing employees with organization- and industry-specific competencies and improve or adjust their skillset through education.

Employee tuition reimbursement programs help with both, but let's stick to number two for purposes of this section.

Tuition reimbursement programs give human resources the ability to properly incentivize workers that already know the ins-and-outs of the company/industry and are known to have the skills that are not necessarily taught as part of an academic education—things such as collaboration, task prioritization, organization, team management, relationship building, creative problem-solving, etc.

If you have a known commodity like that, tuition reimbursement can help you develop your promising "minor league" employers of today into your "major league" contributors of tomorrow.

Tuition Reimbursement Can Reduce Turnover and Costs

If the above-mentioned benefits were not enough, employers can build employee loyalty into tuition reimbursement programs through contractual stipulations. This guarantees the sponsoring organization will have turnover-proof employees for months or years as well as a relatively risk-free investment in their workforce.

The important point is that employers can protect their investment in their workforce with tuition reimbursement program design, fairly exchanging an employee's commitment to the company for the company's commitment to bettering the employee. A win-win.

Education assistance can be particularly helpful for companies in industries with notoriously poor employee retention rates. More than 70 percent of workers in the restaurant industry, for example, changed jobs in 2017, according to the Bureau of Labor Statistics.

As reported by CNBC,[6] many big-name restaurant chains have found success in combatting high turnover with college tuition reimbursement. Starbucks, for example, reported that its program enrollees were 1.5 times more likely to stay with the company and 2.5 times more likely to be promoted compared to employees that did not enroll.

The ability for employers to customize their program makes tuition reimbursement one of the more flexible voluntary benefits for employers as well. Some of the many program guidelines companies can define include:

- Requiring managerial and organizational approval beforehand.
- Requiring that the degree or field of study is tied to the employee's role or company needs.
- Stipulating that tuition will only be reimbursed for courses taken at specific educational institutions.
- Requiring employees to achieve grades at or above certain thresholds—often a 2.0 grade-point average—to receive the full tuition benefit.
- Creating a reimbursement cap like $2,500 per semester, for

example, to keep the benefit within the organization's budget.
- Providing education assistance only to employees that have been with the company for a set amount of time and/or work a qualifying amount of hours.
- Requiring employees to apply for applicable federal financial aid before utilizing company education benefits.

A fair warning to HR regarding financial caps: make sure you are monitoring post-secondary education costs and making cap adjustments accordingly. Failing to do so may lead to a cap that is far too low and leads to underutilized tuition reimbursement.

Ensuring that a tuition reimbursement program balances the need for education with the realities of the business can lead to bottom-line human capital savings as the need to recruit and train new employees is diminished.

In one example, a Lumina Foundation study[7] found that Cigna was able to save $1.29 in reduced turnover and recruiting costs for each $1 the company put into its education assistance program.

Program participants were also found to be more likely to stay at the company, receive promotions, and earn higher salaries than colleagues that did not participate.

Tuition Reimbursement Comes with Employer Tax Savings

In addition to cost savings realized by reducing turnover-related costs, tuition programs can offer employers a way of reducing their tax burdens.

For all employers, adhering to Sections 127 and 132 of the Internal Revenue Code (IRC) or failure to do so will determine the tax-exempt status of companies' educational reimbursements.

The following is an overview, but always seek out the advice of tax advisors prior to making any tax-related decisions.

Section 127: Qualified Educational Assistance Programs

Under IRC Section 127, an employer can deduct *up to $5,250 per calendar year* for each employee that qualifies for and elects to utilize the employer's qualified educational assistance plan.

Per the IRS' Fringe Benefits Guide,[8] Section 127 defines a qualified educational assistance plan as meeting the following criteria:

- The employer must have the components of the qualified educational assistance plan documented in writing.
- The plan may not offer other benefits that can be selected instead of education.
- If the employee has multiple employers, the benefit cannot exceed $5,250 per calendar year for all employers combined.
- Eligible employees include current and/or laid off employees, retired employees, employees on disability, and certain self-employed individuals.
  - Employees' spouses and dependents are not eligible.
  - Employers cannot define employee eligibility in a way that discriminates in favor of highly compensated employees.
- Qualified educational expenses include tuition, books, supplies, and equipment necessary for class.
  - Tools or supplies that the employee may keep after completing the course are not eligible.

Section 132: Education as a Working Condition Fringe Benefit

Section 132 of the IRC provides a way for employers to exclude job-related educational expenses that are not reimbursable under a Section 127 plan from an employee's income for tax purposes.

In addition to current employees, these fringe benefits can also be offered to independent contractors, directors and partners, and volunteers.

There are important differences between these education-related fringe benefits and the educational assistance benefits defined by Section 127, including:

- Unlike Section 127, there is no dollar limitation to education fringe benefits that adhere to Section 132.
- Educational courses must be job-related under Section 132.
- While tuition, books, supplies, and education-related equipment can be eligible under both sections, Section 132 also allows employers to cover the cost of employee meals, lodging, or transportation necessary to attend qualified courses.
- Under Section 132, education fringe benefits are not subject to non-discrimination requirements. (See the table for a side-by-side comparison.)

As mentioned above, in order for courses to be eligible under Section 132, they must be job-related and maintain/improve the employee's job skills, or be required by the employer or the law.

Courses are not eligible if they would be needed to meet the minimum job requirements of the employee's existing role, or if they qualify the employee to enter a new trade or business.

Class Notes

When it comes to attracting, retaining, and developing talent, every HR department is tested. Tax-advantaged tuition reimbursement programs are an important part of companies' larger benefits plans.

Five important reasons are:

1) *A tuition reimbursement program can help make a benefits package more competitive.* Approximately half of today's employers offer undergraduate

Feature	Section 127	Section 132
Written Plan Required	Yes	No
Undergraduate Courses Covered	Yes	Yes
Graduate Courses Covered	Yes	Yes
Courses Qualifying Employee for New Trade or Business Covered	Yes	No
Courses Needed to Meet Minimum Job Requirements Covered	Yes	No
Can Discriminate in Favor of Highly Compensated Employees	No	Yes
Dollar Limitation	$5,250	No
Definition of Employee Includes:		
Current Employees	Yes	Yes
Family Members	No	No
Laid-Off Employees	Yes	No
Employees Retired or on Disability	Yes	No
Independent Contractors	No	Yes
Educational Expenses Covered:		
Tuition	Yes	Yes
Books, Supplies, Equipment	Yes	Yes
Tools or Supplies Employee May Keep	No	No
Education Involving Sports, Games, Hobbies	No (unless specifically job related)	No (unless specifically job related)
Meals, Lodging or Transportation	No	Yes

Source: Based on IRS Fringe Benefit Guide[9]

and graduate educational assistance.

2) *Millennial employees have expressed greater interest in tuition programs.* In fact, Gallup found that 45 percent of millennials say they would change their job for tuition reimbursement benefits.
3) *With tuition reimbursement, employers can overcome workforce talent gaps by educating employees they already have.* Only 11 percent of employers strongly agreed that graduating students have the skills and competencies that their businesses need.
4) *In addition to attracting top workers, tuition reimbursement benefits help employers reduce turnover.* In the case of Cigna, every $1 spent on education assistance equaled $1.29 saved on talent management costs.
5) *Tuition reimbursement programs also give employers a way to reduce their tax burdens.* Companies setting up a tuition program under IRC Section 127, for example, can deduct up to $5,250 per calendar year for each enrolled employee.

Notes

1. *https://www.shrm.org/Research/SurveyFindings/Articles/Documents/2015-Employee-Benefits.pdf.*
2. *http://www.pewresearch.org/fact-tank/2018/04/11/millennials-largest-generation-us-labor-force/.*
3. *https://www.allegisgroup.com/insights/blog/2018/july/employee-value-proposition.*
4. *https://news.gallup.com/reports/199961/7.aspx.*
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6. *https://www.cnbc.com/2018/04/13/restaurants-use-college-tuition-programs-to-combat-high-turnover.html.*
7. *https://www.luminafoundation.org/files/resources/talent-investments-pay-off-cigna-full.pdf.*
8. *https://www.irs.gov/pub/irs-pdf/p5137.pdf.*
9. IRS Fringe Benefit Guide, page 83, *https://www.irs.gov/pub/irs-pdf/p5137.pdf.*

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We're Pregnant: New State Law Protections for Pregnant Employees

Theresa A. Kelly and Alba V. Aviles

Several states across the country (including most recently Connecticut and Massachusetts) have enacted legislation that provides additional protections to pregnant employees. In these laws, pregnancy is broadly defined to include not only pregnancy, but also childbirth and related conditions (such as lactation and expressing milk for a nursing child).

Many of these laws require an employer to reasonably accommodate a pregnant employee unless the employer can demonstrate that doing so would result in undue hardship—a difficult standard to meet. This article provides an overview of the recently enacted legislation in Connecticut and Massachusetts, as well as similar requirements in New Jersey and New York.

Connecticut

In July 2017, Connecticut passed legislation carving out protections for pregnant employees in the workplace. Under this legislation, most employers are required to reasonably accommodate pregnant employees. Common examples of reasonable accommodations are allowing employees to sit while working or to take additional or longer breaks, temporarily restructuring a job if feasible, or modifying work schedules.

Employers should also take preventive measures to ensure they are not discriminating against pregnant employees. For example, an employer must not "limit, segregate or classify an employee in a way that would deprive her of employment opportunities due to her pregnancy." In practical terms, this means that pregnant employees should be provided the same employment opportunities as their non-pregnant colleagues.

To comply with this law, employers must provide employees written notice of the right to be free from discrimination in relation to pregnancy, childbirth, and related conditions. An employer can comply with this requirement by placing a poster, in both English and Spanish, in a "conspicuous place accessible to all employees" at the workplace.

If postings are not used, employers must provide notice to any new employee at the start of employment and, to employees who notify their employer of a pregnancy, within 10 days of that notification. For existing employees, employers were required to provide notice by January 29, 2018.

Massachusetts

Massachusetts passed a similar law called the Pregnant Workers Fairness Act in July 2017, which became effective April 1, 2018. This law amends the Massachusetts anti-discrimination law to include "pregnancy or a condition related to said pregnancy including, but not limited to, lactation or the need to express breast milk for a nursing child" as a protected class. Employers must engage in a "timely, good faith and interactive process to determine an effective, reasonable accommodation to enable the employee or prospective employee to perform the essential function of the employee's job or the position to which the prospective employee has applied."

Like Connecticut, Massachusetts provided guidance on how an employer may reasonably accommodate pregnant employees in the workplace. Although an employer may require an employee to provide documentation from a healthcare professional before providing a reasonable accommodation, it must not request documentation for the following accommodation requests:

(i) more frequent restroom, food, or water breaks;
(ii) seating;
(iii) limits on lifting more than 20 pounds; and
(iv) private non-bathroom space for expressing breast milk.

Employers must provide written notice to employees of their right to be free from discrimination in relation to pregnancy or a pregnancy-related condition. The written notice must be provided in a handbook, pamphlet, or other means of notice distributed to employees.

Employers must provide notice to new employees at the commencement of employment, to existing employees by the effective date of the act, and to employees who notify their employer that they are pregnant or have a need to lactate or express breast milk for a nursing child, within 10 days of that notification.

New Jersey

In 2014, the New Jersey Law Against Discrimination was amended to add pregnancy, childbirth, and related conditions as a protected category. Employers must not treat a woman that an "employer knows, or should know, is affected by pregnancy or breastfeeding in a manner less favorable than" others not affected by pregnancy or breastfeeding. Employers must take care here as the statute's plain text prohibits employers from treating women they "*should know*" are affected by pregnancy or related conditions, although at the same time employers generally are prohibited from inquiring about whether an employee is pregnant. Employers must reasonably accommodate pregnant workers unless the accommodation imposes an undue hardship on the employer.

New York

In 2014, the New York City Human Rights Law was amended to include protections for pregnant employees. More recently, it was further amended (on January 18 to be effective October 15, 2018) to require employers to engage in a "cooperative dialogue" —which is similar to the interactive process required under the Americans with Disabilities Act—with pregnant employees who request a reasonable accommodation. Employers must also provide a written determination to the employee requesting an accommodation following the process.

At the state level, pregnant employees are protected by the New York State Human Rights Law, which covers pregnancy-related medical conditions as part of the law's protections against disability and sex discrimination.

Key Takeaways

In light of these laws, employers should review handbooks, policies, posters, and other employee communications addressing pregnancy-related conditions and ensure those communications comply with all applicable laws.

Further, employers should educate and train managers to make them aware of these laws, including recent guidance, to ensure compliance when interacting with pregnant employees and employees who are returning to work after leave.

Finally, employers should consult counsel with any questions on navigating these legal requirements.

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Pharmacy Benefits 2020: Ready to Spend Half of Your Medical Plan Budget on Rx?

CORY EASTON

You move to a new town and walk into the local barbershop to get a haircut. You sit down to get the same trim you have had for years. You go to pay the barber and the barber says "That will be $700." You respond with, "Are you kidding me? I'm not paying that!" The barber says, "Why not, that's the price, and I delivered the service." To which you respond,"Where does it say that I have to pay $700? I would never have agreed to pay that for a haircut." The barber replies, "Nowhere, that is just my price. But since you're new to town, I will give you a 60 percent discount."

"BLACK BOX" PRICING

You would never tolerate that kind of business from your barber or hairdresser but the fact is, this is an everyday reality within the health care system. As a broker, you are confronted with this reality when selecting health care plans for your clients. Hospital and physician PPO networks, lab, MRI, and CT scans, among other things, are all subject to the "Black Box" of healthcare pricing, the great mystery of health care.

Nowhere in the vast, murky world of health care does this exist more than in pharmacy. In fact, pharmacy is the most utilized (average of 11 prescriptions per active member per year; 50-plus prescriptions per retiree per year, the least understood, and yet the most complex of all health care benefits). Consider this: pharmacy experts predict two major dynamics will occur over the next three years:

- By 2019, specialty pharmacy (those high cost, typically injectable drugs) will consume 50 percent of a health plan's drug spend;
- By 2020, pharmacy will represent 50 percent of total healthcare spend for many groups.

There is no question that pharmacy is, and will continue to be, top-of-mind for those who are responsible for consulting on or administering employee benefits. We see the discussion and debate play out almost daily in the media, the trades, conferences, and board rooms across the country with significant regularity.

Rising prescription drug costs and the need for transparency, comprehensive, and creative clinical management have triggered attention of Amazon, the proposed merger and acquisition activity of Cigna and Express Scripts, as well as CVS and Aetna.

And while much has been written about the providers of pharmacy services, little has been discussed about the role and responsibility of the plan sponsor in addressing this challenge.

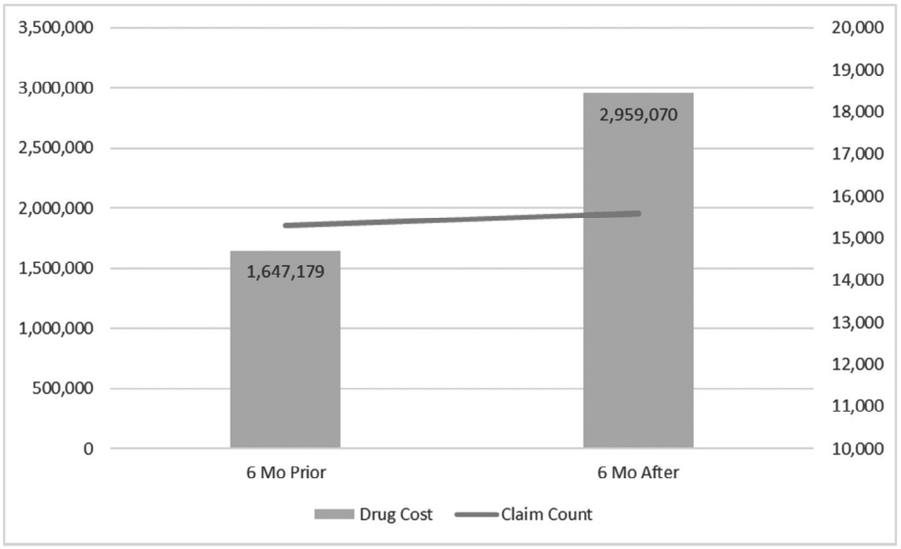
Executive and human resources staff are already stretched thin with myriad responsibilities. No longer can they continue to point fingers at the broker, the pharmacy benefit manager (PBM), pharmaceutical companies, or any other intermediary that works in the space. Pharmacy is no different than any other consumer good. And, how do you get vendors to lower cost? Stop buying the product.

WHAT NEEDS TO BE DONE?

With pharmacy beginning to consume 20 percent to 30 percent of total medical expenses, it is critical that plan sponsors truly understand what they are buying. Collaboration between plan sponsors and expert advisors is essential to negotiating contract terms, identifying clinical opportunities, and effectively managing the benefit.

As an example, Duexis is a costly prescription combination product composed of two inexpensive over-the-counter ingredients: famotidine and ibuprofen. Famotidine is used for stomach ulcers and ibuprofen is commonly used for pain and inflammation. The brand combination Duexis costs $2,300 for a 30-day prescription supply. Comparatively, an over-the-counter supply of both famotidine and ibuprofen offers a 99.8 percent cost savings at $3.05/30 days, a significant difference!

Writing a Summary Plan Description (SPD) exclusion for every single drug, similar to the



Duexis example, would be very difficult to manage and inefficient. Plan sponsors must change the narrative from chasing rebate dollars to driving lowest net cost drugs.

With the knowledge and proven clinical strategy, collaboration with expert advisors support saving significant plan financial resources while enhancing the bottom line. Alternatively, savings can be utilized to fund treatments of rare disease patient populations where no treatment alternatives exists.

The Impact

To better understand this impact within pharmacy benefits, the chart below shows how a single new employee with a chronic, high-cost condition, can literally double pharmacy spending overnight. This depicts one employee joining the plan in September of a 1/1 plan year.

If you are a broker who is concerned about rising health care costs, driven primarily by double-digit unmanaged drug trend increases, this probably got your attention.

Advice to Brokers

Like all good parents, students, athletes, and businesses, you have to practice the disciplined fundamentals of your craft. Managing the single fastest cost driver in health care today is no different—it comes down to executing on fundamentals.

If your client is self-insured or is thinking about becoming self-insured, fundamental pharmacy benefit management begins with a direct contract between the buyer and either the PBM or insurance carrier. Not a handshake, not a "trust me" statement, or a one-or-two page addendum to a medical Administrative Services Only (ASO) agreement. It requires a contract.

This contract should be a well-written, easy to understand document, specific to the pharmacy benefit, that outlines how much your client will be paying for pharmacy benefits. The contract should clearly describe and define how all discounts, fees, and manufacturer rebates will be calculated and paid to your client. The contract should also define the financial and operational performance guarantees and any penalties associated with underperformance on those guarantees. The contract should spell out what rights your client has to their specific pharmacy claims experience, including details about each and every claim that their plan has paid for, if they are a self-insured buyer. Additionally, the contract should detail the audit rights to ensure they have the ability to validate that all guarantees made to them by the carrier or PBM have been met.

The five fundamental questions of pharmacy contracting your client should be able to answer when purchasing PBM services:

1) Do they have a contract *specific* to their pharmacy benefit?
2) Does their contract clearly list out the discounts/fees/rebates that are applied to your claims utilization?
3) Does their contract clearly define under what circumstances those discounts/fees/rebates are applied to their claims?
4) Does their contract clearly state what detailed information they will have access to relative to their claims utilization and experience?
5) Does their contract contain audit rights that allow them to validate that their carrier or PBM is compliant with their financial obligations under the contract?

It should be noted that employers who sponsor benefit plans are not acting as fiduciaries when they design the plan and determine what benefits will be offered, which employees are eligible, and other decisions about plan design. But, they are subject to fiduciary rules when they make decisions about the interpretation of the plan and about payment of claims.

Conclusion

It is no secret that there are many variables that impact what clients pay for pharmacy benefits. There are just as many, if not more, games that can be played within the body of the pharmacy contract that can materially impact the outcome of their drug spend. It sounds complex but it does not have to be. It does, however, start with the contract. It is the first fundamental of prudent plan management and ultimate transparency in managing pharmacy costs today and in the future.

Once the contracting process is mastered, only then can one move to more prudent, yet advanced clinical management protocols allowing the advisor and plan

sponsor to take advantage of not only the best contracting and pricing, but also the best clinical management structure. Please trust that when bringing these three elements together, management of pharmacy trend occurs naturally with little disruption and dissatisfaction and without compromise to the quality of patient care.

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